

## Saint Francis Hospice

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### Inspection report

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### Ratings

Overall rating for this service

Outstanding ☆

Is the service safe?

Good ●

Is the service effective?

Outstanding ☆

Is the service caring?

Outstanding ☆

Is the service responsive?

Outstanding ☆

Is the service well-led?

Outstanding ☆

# Summary of findings

## Overall summary

This inspection took place on 18, 19, 20, 21 and 26 April 2016 and was unannounced. The service was last inspected in February 2013 and at that time was meeting the regulations we looked at.

Saint Francis Hospice is an independent charity and one of the largest adult hospices in the UK. A team of specialist consultants, doctors, nurses, a range of other health and social care professionals and volunteers provide care and support to people with a life-limiting illness, their carers and family members. This is provided through an 18 bed in-patient unit and a day therapy unit. There were also two community teams based at the hospice, a "Hospice at Home" team, and a "Specialist Community and Crisis Support" team and these provided support in people's own homes. At the time of our inspection there were 17 people receiving care in the in-patient unit and approximately 120 in the community and day therapy services.

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

The service provided outstanding care and support. Management, staff and volunteers were highly motivated and committed to ensuring that people had the best possible care. The staff provided people with positive care experiences and ensured their care preferences were met. The hospice website contained feedback from people who used the service and comments included, "Coming to the hospice is the best thing that has happened to me in a long while. I look forward to seeing my friends, having a laugh as well as discussing my problems." "I had no idea that a hospice was anything more than a place to spend your last couple of weeks in care, but after coming here I realised it was such an uplifting experience." "You are not made to feel like you are ill and you get to see a doctor or a nurse if you need to. It is a really great asset."

People received a strongly person centred service. They were supported to make choices and to have as much control as possible about what happened to them both before and after their death. They and their family members were consulted and involved in planning their care and supported to make decisions on their preferred place of death. People who used the service, their families and carers, staff, volunteers and outside organisations were all involved in developing the future of the service.

Staff were clear about their roles and responsibilities. People received care from a multi-disciplinary staff team who received excellent and effective training and good support from the management team. This provided them with the knowledge, skills and confidence to meet people's needs in an outstanding and individualised manner. There was a very proactive approach to the personal development of staff and the acquiring of new skills and qualifications. A system of competency based assessments ensured staff could demonstrate the required knowledge and skills to meet people's needs effectively. Volunteers also received training and support to assist them in their roles in the hospice and in the community.

The services were committed to deliver excellent care and to work collaboratively with partners to deliver and inspire better care for those affected by life limiting illness. Staff worked closely and in partnership with external health and social care professionals and other organisations to improve the service within the hospice and in the local community. Staff were encouraged and supported to undertake research and act as education facilitators to share best practice and ensure high quality outcomes for people with life-limiting conditions and those closest to them.

There was strong emphasis on the importance of good nutrition and hydration and a commitment to providing people with what they wanted to eat and drink in a flexible manner. For example, staff went out to buy people specific food if it was not available at the hospice.

People were safe at the service. They were supported by kind, caring staff who treated them with respect. Strategies to minimise risk were robust and enabled staff to support people as safely as possible both in their own home and in the service. The provider's recruitment process was robust and ensured that staff and volunteers were suitable to work with people who needed support. Safeguards ensured that people who were unable to make decisions about their care had their human rights protected.

The staff team worked closely with other professionals to ensure that people were supported to receive the healthcare that they needed wherever this was provided. Systems were in place to ensure that staff were trained and competent to administer people's medicines safely and when they needed them.

There was a 'no blame' culture with staff encouraged to report any clinical incidents, accidents or near misses. These were fully investigated and used as a learning tool for improvements and to safeguard people from harm.

People's cultural and spiritual needs were respected and care and support was provided in line with their culture and traditions. Staff had received training and were aware of different religious and cultural practices at the time of and after death. There was a dedicated room where people could spend time with their loved one after they had passed away to privately say their goodbyes. Relatives also used this room to prepare the body of their loved one in accordance with the traditions of their culture.

Relatives told us staff understood their emotional needs and focused on their wellbeing as well as the wellbeing of their family member. There was a family support team which provided pre and post bereavement counselling for patients, friends and relatives. They also provided a children's counselling service if needed.

Although there were very few complaints and concerns raised the provider had a positive approach to using them to improve the quality of the service. Each complaint was investigated and, where necessary, appropriate action taken to improve the service provided.

The management structure showed clear lines of responsibility and leadership and there was a strong governance process in place. An external business school had been commissioned to review governance and as a result of this the governance structure was changed and strengthened to ensure that it was effective. Emphasis was placed on continuous improvement of the service. There was a robust audit program in place which was carried out over the course of the year. Where the need for improvement was identified, remedial action was taken to improve the quality of the service and care.

The management team demonstrated a strong commitment to providing people with a safe, high quality and caring service and to continually improve, extend and develop the service to reach as many people as

possible. This included promoting the fact that the service was there for people with a range of life limiting conditions and needs not just for those with cancer. For example, by setting up a heart failure group. They also hosted and contributed to an event for younger people living with dementia and their carers to introduce them to the hospital and the support that was provided.

Robust systems were in place to enable people to receive support and advice whenever they need it. This included a new 'Orangeline' telephone service aimed at helping people to feel less lonely and isolated and also a 24/7 specialist advice line. The hospice also had a store of 'recycled' equipment which they provided to people at short notice. This meant that people did not have to wait for items they needed for their safety and comfort.

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

We always ask the following five questions of services.

### Is the service safe?

Good ●

The service provided was safe. People received safe care both at the hospice and in their own home. Staffing levels ensured that people received a safe service that met their needs.

Systems were in place to ensure that people received their medicines safely and when they needed them.

The provider had robust strategies to minimise risk and enable staff to support people as safely as possible both in their own home and in the service.

The recruitment process was safe and effective. Staff and volunteers were appropriately checked to ensure that they were suitable to provide care and support to people who used the hospice service.

### Is the service effective?

Outstanding ☆

The service was effective. People received support from a very skilled, experienced and committed staff team. The team was able to meet people's assessed needs, preferences and choices. Staff received well co-ordinated and comprehensive training which was monitored to ensure their knowledge was kept up to date.

People were involved in making decisions about their treatment and care needs. Safeguards were in place to ensure that people who were unable to make decisions about their care had their human rights protected.

There was strong emphasis on the importance of good nutrition and hydration and a commitment to providing people with what they wanted to eat and drink in a flexible manner.

People were supported to receive good healthcare both from the hospice and other health and social care professionals.

### Is the service caring?

Outstanding ☆

The service was caring. People and their relatives spoke consistently about the caring and compassionate attitude of

staff.

Relatives told us staff understood their emotional needs and focused on their wellbeing as well as that of their family member.

Staff were respectful of people's cultural and spiritual needs.

The service provided excellent end of life care and people were enabled to experience a comfortable, dignified and pain-free death.

### Is the service responsive?

Outstanding 

The service was responsive. People benefitted from person-centred care. The service was flexible and responded quickly to people's changing needs or wishes.

Advice for people, their families, carers, GPs and healthcare professionals available 24 hours a day via a dedicated helpline. People told us that this lessened their anxiety and helped them to receive better care when they needed it.

Systems were in place to ensure that people's needs were comprehensively assessed. Detailed and current information about people's needs and wishes and what was important to them was recorded and communicated to staff.

The provider had a positive approach to using complaints, concerns and feedback to improve the quality of the service.

### Is the service well-led?

Outstanding 

The service was well-led. The management team demonstrated a strong commitment to providing people with a safe, high quality and caring service. They worked to continually improve, extend and develop the service to reach as many people as possible.

The service had a strong commitment to deliver excellent care and to work collaboratively with partners to deliver and inspire better care for those affected by life limiting illness.

The service was robustly monitored by the management team and the provider to ensure that people received a safe and effective service that reflected their needs and wishes.

People's views were sought and valued. They were involved in developing the service. They used a service where staff felt valued and listened to and were involved in shaping

improvements. Staff were proud of the service.

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# Saint Francis Hospice

## Detailed findings

### Background to this inspection

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

This inspection took place on 18, 19, 20, 21 and 26 April 2016 and was unannounced. The inspection team consisted of a lead inspector, a pharmacist inspector, a specialist nurse advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before our inspection, we asked the provider to complete a Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information we held about the service which included a report of a visit carried out by Havering Healthwatch in October 2015. We also received feedback from four external palliative healthcare professionals and a commissioning and contracts officer.

During the course of the inspection we spoke with, either in person or on the telephone, 10 people who used the service, 12 relatives and two visitors. We also spoke, in person, to 25 members of staff and two volunteers. This included the chief executive, chair of board of trustees, registered manager, directors of corporate services and quality and care, health and safety officer, supplies manager, interim head of human resources, head of education, catering manager, pharmacist, interim Specialist Community and Crisis Support manager, manager of Hospice at Home team, volunteer services manager, in patient unit manager, eight nurses (including clinical nurse specialists), two senior healthcare assistants, a care coordinator, and four healthcare assistants. We spent time in the inpatient and day therapy units, observing care and support. We joined handover and multi-disciplinary meetings and met with the Hospice at Home and Specialist Community and Crisis Support teams.

We looked at six people's care records and 17 medicines records. We looked at other records relating to the management of the hospice. This included five staff and three volunteer recruitment records. We also looked at duty rosters, accident and incident reports, complaints, compliments, health and safety,



maintenance, governance and quality monitoring records.

# Is the service safe?

## Our findings

People told us that they felt very safe when using the services provided by the hospice. This was as an inpatient, a day unit user or when being supported in their own home. Comments included, "Safe place, yes. It's a godsend." "Safe yes, I enjoy it here. Staff are absolutely brilliant, very good, make me feel at ease."

Relatives also told us that people were safe when using the service and that they had confidence in the staff who provided support in people's own homes. One relative said, "I trusted them with [my relative]." Another told us that their relative had been "absolutely safe" with hospice staff and that this had given them the confidence to let them care for the person whilst they rested. In feedback provided to the hospice we saw that the family of a person with a learning disability had written, "It was the only time in her life that we were happy to leave her in someone else's care. That's how much we trusted you."

From our observations, discussions and from looking at staff rotas we found that staffing levels and skills mix were sufficient to meet people's needs and to provide personalised and individual care both within the hospice and the community. People consistently told us staff had time to spend with them and make sure their individual needs were met. In the in-patient unit people told us that staff were always available to support them when needed. They also said that staff never rushed and had time to talk and to explain. For example, one person said, "I do know what medication I have been prescribed, the nurse always has time to discuss any issues with me." Another told us, "They always have time if I feel unwell."

The registered manager carried out an in depth patient focussed review of inpatient staffing levels and skill mix in January 2016. This found that the agreed staffing establishment safely met people's needs. It also recommended some changes to make the unit more efficient and these were being implemented. For example, a discharge coordinator was being recruited and the mix of staff gradually changed to give more nurses on duty. In addition to medical and nursing staff, volunteers also assisted in the unit. Their duties included taking people's meal orders, making and serving refreshments, checking that refreshments were available in visitors lounge and assisting at meal times. This allowed staff to provide direct care and support.

Staff and volunteers were provided with guidance and training so that they understood their role in keeping people safe from abuse. Staff had received safeguarding training both via e learning and face to face training and this was renewed each year. We saw in a staff team brief that the safeguarding management team had been attending training and were going to provide training to update staff on legislative changes. Staff knew what to do if they suspected or saw any signs of abuse or neglect and told us that they did not have any concerns about the way people were cared for and treated. They were clear that they would report anything of concern and confident that action would be taken. People who used the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent it from happening.

The provider's recruitment process was thorough and ensured that staff and volunteers were suitable to work with people who need support. This included prospective staff completing an application form and

attending an interview. We looked at five staff files and found that the necessary checks had been carried out before they began to work with people. This included proof of identity, two references and evidence of checks to find out if the person had any criminal convictions or were on any list that barred them from working with people who need support. Nurses' registration with the Nursing and Midwifery Council was also checked to ensure that they were allowed to practise in the United Kingdom. There was evidence in staff records to confirm that all they were legally entitled to work in the United Kingdom. A similar process was followed for volunteers. They completed an application form, attended an interview and two references were taken. If the person was going to work directly with people who used the service checks were again made to find out if they had any criminal convictions or were on any list that barred them from working with people who need support. The provider followed safe recruitment practices and this help to safeguard people.

There was a health and safety officer who took overall responsibility for health and safety management. Twelve members of staff had been trained as health and safety representatives and had completed managing safety training to enable them to carry out this task effectively. There was a major incident procedure and also a business continuity plan. We saw that these were reviewed and updated when needed. Staff had received emergency training and were aware of the procedure to follow in an emergency. They were also highly aware of the processes and importance of actively raising concerns. Systems were in place to keep people as safe as possible in the event of an emergency arising.

The premises and equipment were appropriately maintained. Records showed that equipment was serviced and checked in line with the manufacturer's guidance to ensure that it was safe to use. Gas, electric and water services were maintained and checked to ensure that they were functioning appropriately and were safe to use. The records also confirmed that appropriate checks were carried out on hoists, pressure relieving mattresses and fire alarms to ensure that they were in good working order. Systems were in place to ensure that equipment was safe to use and fit for purpose. A fire risk assessment was in place and staff were aware of the evacuation process and the procedure to follow in an emergency. People were cared for in a safe environment.

The provider had a system in place to record, monitor and learn from accidents, incidents and near misses. For example, a quality and care assurance group met on a two monthly basis to review these and discussed any high risk issues. This group reported to the clinical governance committee and ultimately the board of trustees. This enabled the board to be aware of and oversee high level risks and the action taken to minimise these. An external palliative healthcare professional told us that they regarded the hospice as an organisation which maintained the health and safety of patients, visitors and staff through the development of appropriate policies and training, some of which were developed with community partners.

The provider received alerts about patient safety in respect of medical products, equipment and medicines and circulated these to the appropriate staff. They were actioned and signed off and the health and safety manager monitored that this had happened. This ensured that the staff team were aware of these and took any necessary action. Systems were in place to ensure that people's safety was not compromised.

Providers of health and social care have to inform us of important events which take place in their service. Our records showed that the provider had told us about such events and had taken appropriate action to ensure that people were safe.

People told us that they were happy with the way they were supported with their medicines. One person said, "I speak to the nurse and if I need any extra I ask and it is explained to me."

There was an effective system in place for obtaining medicines. Medicines were obtained from the local pharmacy. Commonly prescribed medicines were kept as stock, to avoid delays in starting treatment. Effective arrangements were in place to order medicines which were not kept as stock. People were encouraged to bring in their medicines on admission, so that medicines could be checked and used until the hospice was able to obtain supplies. People we spoke with on the day of our inspection told us that they had not experienced any delays in receiving their medicines.

All medicines were stored safely and securely, in locked trolleys within a secure treatment room in the in-patient section of the hospice. A small supply of medicines was held in a locked cupboard in the day therapy centre. No medicines were held by the Hospice at Home or Specialist Crisis and Community support teams. Controlled Drug (CD) cupboards met legal requirements. Lockable cupboards were provided at people's bedsides to provide safe medicines storage if they wished and were able to self-administer their medicines.

Medicines requiring cold storage were kept within a locked alarmed refrigerator in the treatment room. Minimum and maximum temperatures of the medicines fridge were checked and logged every day, providing evidence that these medicines were kept at safe temperatures to remain effective. Although the clinical rooms were kept cool, no temperature monitoring was carried out, so there was no evidence that all medicines were kept at the manufacturer's recommended storage temperatures to remain effective. The provider told us that a suitable thermometer had been ordered so that temperature monitoring could be started.

People received their medicines consistently as prescribed. There were 17 inpatients. We looked at their prescription charts and these were fully and clearly completed, with no gaps or omissions. The hospice consultant and doctors prescribed medicines directly onto individual prescription charts. Medicines were never transcribed onto prescription charts by nursing staff which reduced the risk of an error being made. People confirmed to us that their treatment choices were discussed with them and that they received their medicines on time when they needed them.

There was a separate chart written up by the prescriber for the administration of medicines via a syringe driver (a portable pump that is used to provide a continuous dose of medicine through a syringe). These charts were reviewed by the prescriber every 24 hours. There were records to confirm that nursing staff had received training and been assessed to ensure they were competent in the use of syringe drivers. Once they had been assessed as competent, these syringe drivers were set up by one nurse, and were not checked by a second nurse, except for newly qualified nurses, or nurses who had only recently been assessed as competent. It is safest practice to have a second check when calculating doses and setting up a syringe driver, however this is not a legal requirement.

Written information was provided to people about off-licence and unlicensed medicines (medicines being used outside the terms of their UK product licence, or medicines that may not be licensed in the UK, which is common practice in hospices). There was evidence in people's care records that doctors had discussed these medicines with people, so that people were able to make an informed choice about their treatment.

There was good assessment and recording of people's pain. A pain chart was in use, to record a description of the pain experienced by a person and the level of pain. The chart also recorded the action been taken by staff e.g. prescribing and administration of medicines, and what the level of pain was after the medicine was administered. So we were assured and were told by people that there was good pain management.

There was also evidence of good control of other symptoms. People were prescribed "when required" or "PRN" medicines for control of other symptoms, with a variable dose so that nursing staff were able to use

their judgement in deciding the dose to be administered. The indication, dose range and maximum daily dose of the PRN medicines were stated clearly on prescription charts. For pain relieving controlled drug patches, the pharmacist had helped to devise a patch application record, which stated the minimum time period needed between reusing an application site, to reduce the risk of side effects, and to record a daily check that the pain patch was in place, which was good practice.

There was good medicines governance. The hospice had a Quality and Care Assurance management group which reviewed medicines incidents quarterly. Staff told us that there was an open reporting culture for incidents and that they felt confident to report incidents as this was used to identify learning and not to blame people. 'Near-misses' were also documented for learning. The number of incidents per staff member was logged, to see if there were repeated incidents and whether someone needed medicines refresher training.

Controlled drugs (CD's) were managed safely. Incidents with controlled drugs were investigated using the internal incident reporting system. There were safe processes for ordering and disposing of stocks of controlled drugs. CD stocks were checked and recorded daily. The pharmacist carried out an annual Hospice UK CD audit in line with good practice for CD management.

All staff with responsibilities for administering medicines to people had received appropriate training and their medicines competency assessed. Newly-recruited nurses received good medicines induction training, including a training pack, and this induction pack was also used for bank nurses. The induction pack included information about medicines commonly used for palliative care.

On admission to the hospice, people's medicines were checked to ensure that they were correct and to lessen the risk of error. Pharmacy staff had access to people's summary care records to check their current list of medicines and their allergy status. A pharmacist from the local trust visited the hospice twice a week to attend ward rounds, review people's medicines, screen prescription charts, review policies and to provide advice to staff and patients. Planning for people's discharge from the hospice was discussed at the weekly therapeutics meeting, and the pharmacist was able to order medicines in blister packs for people who required this. Medicines and discharge planning were also discussed at the ward handover meeting.

There was a detailed medicines policy in place. Information about medicines was available including information on how to administer medicines via different routes. For example, via a tube directly into the stomach. The policy included a procedure for administering medicines covertly when it was judged to be in a person's best interests, in line with the Mental Capacity Act 2005. If people wished to self-administer their medicines the policy included details of risk assessments which were required. There was a process in place to supply medicines when people were on leave from the hospice. Separately dispensed and labelled supplies were obtained from a pharmacy local to the hospice for leave over 24 hours. For less than 24 hours leave, medicines were supplied by nursing staff in a labelled pot. The staff we talked with agreed that it might be safer to supply the complete dispensed pack if possible, to avoid introducing risks by re-dispensing medicines.

There was effective communication between hospice teams and other services who shared responsibility for administering medicines. Responsive assessment and timely changes made to people's medicines when they were at home, to enable their symptoms to be managed effectively and reduce the risk of errors. Neither, the "Hospice at Home" team or the "Specialist Community and Crisis Support" team held or prescribed medicines. However they liaised with each other to provide advice to the local NHS trust prescribers about people's medicines, if a medicines change was needed.

## Is the service effective?

### Our findings

People who used the service and their relatives told us that they received excellent care from skilled and competent staff. This was in reference to the services provided in the hospice and in people's own homes. Feedback from people using the inpatient unit included, "Staff are very good and aware of what I need," and "Staff are there when you need them and not in the way all the time." One relative told us, "Whenever I rang up they seemed to have all the answers. Very professional and they showed the carers we have at home different aspects of how to do things for [my relative]. Another described staff as, "Indispensable. We could not believe how good and knowledgeable they were." An external palliative healthcare professional told us that the hospice was held in high regard as the specialist palliative care centre locally.

There was an excellent training facility on site, The Pepperell Education Centre. This offered a wide and comprehensive education and training programme to staff, volunteers, external health and social care professionals and carers. The centre provided courses and study days and encompassed both specialist palliative care delivery and topics of wider interest. The reason for this was that the service wanted "to see every individual in our community have access to excellent end of life care, delivered by enthused and well-informed health and social care professionals."

The centre also helped in the wider delivery of good end of life care. An external palliative care health professional told us that the education department was leading the way forward in the Gold Standards Framework (GSF) programme and further education and that conferences and specialist study days were always designed to meet local needs and that senior leads for end of life care took part in these. GSF is a practical, evidence based approach to providing high quality care for all people nearing the end of life.

The education centre housed a library which was open to all hospice staff and supported them to further their knowledge and development. Volunteers, external health care professionals and students on related courses could also use this facility. Books, covering a wide range of palliative care topics, including history of the hospice movement and pharmacology, as well as research and education were available. In addition there were journals, articles and other information relevant to increasing staff knowledge and development. This meant the hospice was sharing information to ensure people received the best care possible from hospice staff and others outside the hospice service.

There was a comprehensive training programme in place for staff and volunteers. This was coordinated by the education department. We saw a spreadsheet about the training that people had completed and when this needed to be renewed. When this was the case an email was sent to the department the person worked for and they were booked onto the next course. If the person did not update their training the reason for this was noted so that appropriate action could be taken. For example, if a person was on maternity leave they were booked in on future training once they returned to work.

All staff and volunteers completed a two day induction training which included information about the hospice, philosophy of palliative care, equal opportunities and introduction to communication skills. Patient services staff completed a third day relevant to their role. This included information about end of life

care tools and verification of death. The hospice had a mandatory training programme relevant to people's roles. For example, administration staff and patient service staff. Mandatory training covered areas such as infection control, safeguarding, mental capacity and infection control. A member of staff told us, "Training is excellent here especially mandatory training. We can suggest training ideas."

Nursing staff told us they received all the training they needed to keep their clinical skills up to date, to follow best practice, to develop their skills, knowledge and expertise and to provide people with the best care possible. For example, one clinical nurse specialist told us that their target for this year was to become a nurse prescriber. They said that as a nurse prescriber they could enable people to have quicker access to medicines and more effective symptom control.

The education department ran a series of competency days covering theory and practical skills to ensure staff demonstrated the required knowledge and skills for their work. The registered nurse practical study days included, male catheterisation, blood transfusions, management of feeding tubes and syringe driver training. Staff also attended training in bereavement and 'how to have difficult conversations' which gave them the skills to deal with issues around end of life care and death.

Staff told us that the hospice supported them to develop their skills, knowledge, and expertise and to obtain further qualifications. For example, one senior nurse told us that they had completed their nursing degree since they had been employed at the hospice. Reciprocal arrangements were in place with the local hospital trust for staff to work across settings. This meant that hospice staff had the opportunity to keep up to date with practice in an acute hospital and for hospital staff to further their knowledge and understanding of palliative care and the work of the hospice.

The hospice also provided placements to a variety of healthcare professionals, with in-house mentorship and training. This included medical students, student nurses and counselling students. A student nurse told us that their placement was well managed and that there was a supportive team which they felt part of and extra support was available if needed.

The centre arranged training as training needs were identified. In 2015 all staff attended 'dementia friends' sessions. 'Dementia friends' is an Alzheimers Society led initiative to increase dementia awareness. In addition changes had been made to the environment to make it more 'dementia friendly' in line with good practice guidelines. For example, by using blue toilet seats to make it easier for people to recognise.

When there were changes or updates to relevant legislation we saw that additional training courses were provided to ensure that all the necessary staff received this information as soon as was practicable. For example, in 2015 in response to a court ruling about Deprivation of Liberty Safeguards and Mental Capacity legislation a series of training sessions was arranged. These were mandatory for staff, and volunteers were welcomed.

Staff received supervision (one-to-one meetings with their line manager to discuss work practice and any issues affecting people who used the service) and also an annual appraisal at which performance information was fed into their personal development and training plan. There were also reflective practice sessions where staff could discuss any issues about different situations they had experienced and how they dealt with them. Most staff told us that they also received good support from other members of their team and that they could "offload" and share. They said this gave them emotional protection and enabled them to continue providing personalised and often intense support to people and their families. One member of staff told us, "I always feel as though I am listened to."



As part of providing emotional support for staff 'Schwartz Centre Rounds' had recently been introduced at the hospice. These were a forum for clinical and non-clinical staff from all backgrounds and levels of the organisation to come together once a month and explore the impact that their job had on their feelings and emotions. The aim was to offer staff a safe environment in which to share their stories and offer support to one another. One volunteer told us that they had attended a Schwarz Centre Round and that it had been supportive. There was also an external counselling service available for both staff and volunteers.

All of the above ensured that staff were very well trained and highly competent to carry out the duties required to safely and effectively support people and meet their complex needs. This proactive support system motivated staff to develop their skills and knowledge and all staff were committed not only to providing the best service possible but to continually developing and improving the service provided.

There was strong emphasis on the importance of good nutrition and hydration and a commitment to providing people with what they wanted. The catering manager told us, and people confirmed that there was a menu but if a person wanted something else it was prepared for them. This included catering staff going to the shop to buy something if it was not available in the kitchen. People were asked what they wanted to eat and supported to make choices. For example, we heard one person saying that they did not know what to have for breakfast and they were told they could have whatever they wanted. When the person was undecided and concerned that they might not eat it as they had been feeling nauseous they were reassured not to worry and some suggestions of lighter food made.

Any special dietary requirements as well as likes and dislikes were met. Dietary adjustment and supplements were evidenced in care plans, medicine charts and nursing reports. The catering staff were aware of each person's individual dietary needs and allergies and pureed meals or soft diets were prepared when needed. This was because nurses completed a dietary requirements and needs form when a person was admitted to the inpatient unit. A new form was filled in if the needs changed. For example, if the person needed to move to a pureed diet. The catering manager told us that they pureed different foods separately to try to make the meals look as nice as possible and so that people had the opportunity to enjoy different tastes. When people came into the inpatient unit one of the chefs would go and meet them and get additional details about what they wanted and needed. There were halal and kosher food suppliers and Caribbean meals were ordered in. One person told us, "I have a different diet, but always eat a good meal."

People who used the day therapy unit were also provided with drinks and lunch. Lunch was a variety of sandwiches and fruit and choice of drinks and was served by a volunteer. One person told us, "They provide lunch here. Sandwiches and plenty of drinks, all free. Volunteers are brilliant they do anything for you."

People were supported with eating and drinking when needed. One person told us, "They [staff] are always good, if you need help with the food they are all good." We saw a staff member support a person with eating. They sliced the fruit and supported them to eat one slice at a time at the speed the person was comfortable with. Drinks were available at any time both to people who used the service and their relatives and visitors. Snacks were also always available including yoghurts, sandwiches, fruit, cakes and biscuits. Feedback was sought from people about the food provided. One volunteer told us that they had assisted with a catering survey and that people had been asked what could be done to improve things. They added that anything that came up was addressed. They felt that the catering "could not be faulted."

Catering staff received the necessary training to enable them to provide safe, nutritious and appropriate food that met people's needs. For example, we saw that all catering staff had received food safety and allergy training and that as part of their ongoing development they discussed a relevant topic each month to ensure that they were kept up to date and were clear as to what was best practice in that area.



The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff had received MCA and the DoLS training were aware the implications of this in their practice and sought people's consent before providing care and treatment to them. People's rights to make their own decisions were respected and promoted. When people had been assessed as being unable to make relevant and specific decisions, applications for the authorisation to restrict their freedom in their best interests had been made to the supervisory body under DoLS.

People were supported to receive good healthcare both from the hospice and other health and social care professionals. This promoted their wellbeing and enabled them to remain as comfortable and pain free as possible. Staff recognised that people's healthcare needs could change and demonstrated awareness of how these could be reported and effectively acted upon. One member of staff told us, "We always observe people and if there is a change report it via the care recording system and handover." Another said, "Any signs or changes in presentation could be telling me that they are becoming more ill." Both inpatient and community staff were proactive in ensuring that preventative action was taken and that people were referred to healthcare professionals when necessary. For example, the physiotherapist, dietician or occupational therapist. People remained registered with their GP and we saw that regular GP and other specialist healthcare professionals visits were recorded in people's notes. These notes provided additional information that contributed to the improvement of care and the implementation of best practice.

People, both inpatient and in the community, received holistic care from a multi-disciplinary staff team which meant they had access to specialist palliative care doctors and nurses, physiotherapists, occupational therapists and counsellors. There was also a range of complementary therapies available such as aromatherapy, remedial massage and reiki. Reiki is a Japanese technique for stress reduction and relaxation. One person told us, "I had a reiki session, which was fine and an aromatherapy massage on my feet, very enjoyable." Another said, "Had physio today for initial assessment. The lady was lovely. Well trained, oh yes."

The hospice was in a semi-rural area in its own grounds. The patient areas were light and airy and well decorated. The inpatient area had four units each with four beds and single rooms for those needing or wishing to use these. There was also a day therapy unit, a multi faith room and several small rooms for meetings and consultations. The public areas were accessible for people with mobility problems or who used a wheelchair. There was a visitor's lounge which was being refurbished at the time of the visit and an area with games to keep visiting children entertained. The gardens that surrounded the premises were very well maintained by volunteers and had spaces where people could sit and spend time enjoying these. All rooms had views of the gardens and during our visit we saw that one person had wished to spend time in the garden and their bed had been taken out there. The bathrooms provided a wide range of facilities, including hoists to ensure that people could use them safely. There was also an adjustable height hand basin which meant that wheelchair users could comfortably use this. The environment and equipment available met the needs of people who used the service and was arranged to promote their independence and wellbeing.

# Is the service caring?

## Our findings

People who used the service and their relatives told us that the hospice provided excellent care and that hospice staff and volunteers were outstandingly caring, kind and compassionate. An external palliative healthcare professional told us that the Hospice at Home service provided great comfort to those who are struggling to cope in their own home. Comments from people who used the service included, "Pretty marvellous, it's nice and kind staff." "Staff can't do enough for me" "They have plenty of time to reassure me. They have definitely made a difference." Relatives said, "I could not believe how good they were. They went the extra mile. On [my relative's] last day they stayed longer than arranged until the next nurse arrived." "They were there for us and when [our relative] was in a coma they went above and beyond. They sat with them and massaged their hands. They usually did a three hour shift but when they knew [our relative] was 'going' they didn't leave us but stayed. I don't know what we would have done without them." We found that staff treated people with kindness, respect and compassion and consistently demonstrated a caring attitude.

Some people told us they had been reluctant to use the hospice service but had found it a very positive experience because of the compassionate, enabling care they received from staff. One relative said, "I was reluctant initially and did not want [my relative] to go there as it would be the end, but it's not. I'm glad they came on board." People told us that clinical and non-clinical staff and volunteers made them feel they mattered and took time to understand things from their point of view. Comments included, "Very good staff attitude. Doctors come round daily. Explain procedures. We talk through what services are on offer." "Excellent, the doctors listen, they really care and any problems you can ask them. Even when you go to the day unit you can speak to a doctor."

Clear and detailed information was available about the service provided and also information about other services that people might benefit from. The information was available in leaflets, on the website, via the telephone or in face to face meetings. The hospice had recently launched a new 'Orangeline' telephone service aimed at helping people to feel less lonely and isolated. It was confidential and managed by specially trained staff and volunteers who were there to help with information and signposting to local services, links to other callers via groups or just a 'friendly chat.' The Specialist Community and Crisis Support Service ran a 24 hour, 365 day specialist advice line where patients and their families could speak to a Clinical Nurse Specialist who could assess, offer advice, offer support through crises and put into place any care needed.

People and their relatives told us they felt comfortable to discuss their health needs with staff who took time to explain the healthcare and treatment options available to them. One family member told us, "They have explained the process." One person who used the service said, "They really care and any little problem you can ask them." Another said, "They have talks with you on how you're feeling, your medication and all that, do you need anything, are you in pain, pain killers needed. You have also individual sessions every time you come here."

Staff and volunteers were motivated and committed to providing the best quality end of life care they

possibly could. They told us that they always found out what was important to the person and tried to do what the person wanted. One member of staff said, "We record and respect the preferences of each individual person and get to know them well." For example, one person had wanted to get married and the team had tried to get this sorted out at very short notice. Although this had not been possible they managed to arrange for a blessing. For another person a wedding and small reception were arranged at the hospice.

Staff told us that they felt really privileged to be able to support people and that 'plans for death' not only helped people to decide on their preferred place of death but enabled them to get what they wanted prior to and after they passed away. For example, it was very important for one person that their hair looked nice. Therefore when the person passed away in their own home, a second member of staff went to the person's home after their working hours to assist the member of staff already there to do the person's hair. In the January 2016 newsletter one family had written, "Your care meant he could have his wish and stay at home with his family." One volunteer told us that they always gave extra time to people if it was their first time in the hospice. They explained that this was because people could be scared and need reassurance.

People's privacy was respected and their dignity maintained. One person told us, "I never worry when I need anything, I am very well looked after. I can also be private if I want to be." We saw that staff knocked on doors and then awaited a response before entering. Rooms had notices on them to indicate if they were vacant or in use. We also saw that staff respected this and did not knock or enter rooms in use. This meant that people were able to have private and sometimes difficult conversations without being disturbed. People also confirmed that their privacy was maintained when staff visited and supported them at home. One relative told us, "They were really good without being nosey."

Relatives told us staff understood their emotional needs and focused on their wellbeing as well as the wellbeing of their family member. A member of staff told us that after a person died at home a 'bereavement' call was made to the family. This was always made by someone who had either visited or talked to the family before. In the hospice newsletter of March 2016 we saw that one family had written, "From the day we arrived we were enveloped with love and support from everyone. We trusted you with our dear mum. You showed her love and kindness and care. You also took time to look after us which gave us the strength we needed at that time." Another had written, "I was quite frightened about mum's wish to pass away at home but you made it possible and when the time came it seemed so right."

Bereavement support in the form of a counselling service was available to people and their families and friends to provide emotional and practical support to those who required it. Relatives told us that they were offered counselling and support both before and after their family member passed away. They added that the hospice had also offered support and counselling to children in the family. One bereaved person had written to the hospice to say that their relative had only been in the hospice for 48 hours before they died and therefore had only benefitted from their care for a short time. However, they went on to say that after the person's death they had received ongoing support and counselling that was of enormous benefit.

Staff were aware of and respectful of people's cultural and spiritual needs including before, during and after death. Staff told us and records confirmed that they had received training and information to enable them to do this. They said that there was lots of information about religious rites and practices and that they asked about these at the first assessment so that they did not offend people. For example, a member of staff told us when they visited one person they always made sure that they wore trousers and also shoes that slipped off easily when they entered the house. Another member of staff told us that when they had supported a person of the Muslim faith at the time of their death the extended family had been present and had wanted her to participate in the rituals.

The hospice was committed to meeting people's cultural and religious needs. In September 2016 they were offering a course on how different faith groups give end of life care. This was to be in the form of interfaith afternoons. The hospice pastoral care team leader and leaders from Jewish, Muslim, Sikh and Hindu faiths were each going to discuss how their faith provided end of life care to their followers.

There was a multi faith room within the hospice where people could practice their faith or just spend time in peaceful reflection. A service was held twice weekly and people could light candles, write cards for people to be remembered in prayers and read the remembrance book. Items that people of different faiths might need were also in this room. For example, skull caps and a prayer mat.

There was also a room where people could spend time with their loved one after they had passed away. This room was, quiet, comfortable and had lights that could be dimmed, helping to make it a peaceful and homely environment in which people could privately say their goodbyes. Relatives also used this room to prepare the body of their loved one in accordance with the traditions of their culture.

Visitors were welcome at any time. People's families were supported to visit the hospice at times to suit them and the person receiving care. One person told us that when they were an inpatient they thought visiting was at any time. They said, "I think so anytime, as when I was there whenever I opened my eyes [my relative] was there." Children and pets were welcomed. There was a room equipped with toys and games for families with children and an area equipped with a computer and games and internet access for patients. We saw that one person had written a thank you to the hospice saying that their relative had a lovely room where grandchildren could visit and bring their dog to cheer her up. Visitors and relatives were able to get refreshments in the dining area which was shared with staff and patients who wished to use it. If relatives did not want to leave the person then volunteers took refreshments to them so that they could spend more time with them. There were also facilities for families to stay with their loved one.

During handovers and meetings staff spoke about people respectfully and maintained people's confidentiality by not speaking about them in front of others. People's records were kept securely to maintain confidentiality.

People's individual preferences and differences were respected. Care plans had individual preferences recorded. Information about people's history was also included with a clear indication that relatives had been involved. One member of staff said, "We record and respect the preferences of each individual and get to know them well." Another said, "I like getting involved with the history of people, it helps me with looking after them and gives me a chance to talk to them about their past"

People were fully involved in the planning of their care, from symptom and pain management to their end of life care. Staff received training on how to have difficult conversations to enable them to support people to express their views about their preferences and make plans of wishes in regard to their care, support and treatment. These plans gave people the opportunity to let their family, friends and professionals know what was important for them for a time in the future where they might not be able to express their wishes. These advance decisions were recorded, effectively communicated to staff and respected. People's wishes with regard to resuscitation were clearly recorded at the front of their file and this was colour coded for ease of reference. If the person was discharged from the hospice to their own home, a hospital or another care facility their wishes with regard to resuscitation were reassessed and the information was sent with them to ensure that others were made aware of this.

A Healthwatch report from October 2015 stated that the hospice was a noted centre of excellence for end of life care, both in-house and, through outreach, in people's own homes. People were supported at the end of

their life to have a comfortable, dignified and pain-free death.

Hospice staff advocated for people when needed. Sometimes this was with relatives. For example, when a person decided that they did not want any further treatment or wanted to spend their last days in the hospice rather than at home and relatives did not feel the same. They also advocated with external agencies such as housing, welfare or benefits which helped to ensure that people's logistical and financial concerns were put in order efficiently and fairly.

## Is the service responsive?

### Our findings

People told us that the services provided by the hospice were excellent and very responsive to their needs. There were numerous testimonies and feedback from people, friends and relatives about this. All were extremely positive and thanked the staff. Recent comments included, "Your care not only embraces the patient but the whole family as well." "Please continue to do what you do so well. The difference it makes to the experience of the patients and their families cannot be overstated." "You are all wonderful. You didn't only look after [our relative] you looked after us as well which you did in your own special way."

The service was very responsive to people's individual needs. Advice for people, their families, carers, GPs and healthcare professionals looking for information on complex palliative care and life-limiting illness was available 24 hours a day via a dedicated helpline. This helpline was staffed by clinical nurse specialists from the specialist community crisis support team who could assess, advise, manage symptoms and offer support through a crisis. On-going care was then given according to specialist palliative care needs. We attended a handover meeting with this team. Part of the meeting was a discussion about the calls that were received during the night and any that needed to be followed up. The team worked very flexibly to support people and to ensure that they got the assistance they needed especially when they were very near the end of their life. Visits were planned in accordance with need. Non urgent visits usually took place within two days and urgent ones within 24 hours. Crisis visits superseded everything and ideally were made within two to three hours.

People felt that the 24 hour advice line enabled them to be connected to support and advice and to feel less anxious. One relative told us that they had phoned the hospice to say that they just did not know what they were doing. They had received advice and information and someone had visited. They now received a phone call every few weeks to check how things were and if they needed anything.

People received a comprehensive assessment of their needs when they were referred to the hospice. A multi-disciplinary referral meeting was held each day to decide who to offer services to and what to offer. This included referrals from the acute hospital. The list from the hospital was prioritised and then the referral meeting decided if the hospice service was suitable for each person. The detailed assessment and multi-disciplinary discussion ensured that staff making decisions about people's care and treatment had all the relevant information to ensure that the person received timely and effective care and support.

Many people choose to spend their final days in the comfort of their own home and the Hospice at Home team also worked flexibly planning their work to respond to people's needs and support them with this choice. The team contained senior staff nurses and health care assistants who provided both physical, practical and emotional support to people and their families. People's individual needs were assessed and reviewed daily to ensure that they received the same standard of bespoke palliative care as they would in the hospice. Care was provided in blocks of between two to four hours, which could run consecutively when needed. The team worked alongside any existing health and social care professionals. For example, Marie Curie nurses providing night time care.

One relative told us, "They are wonderful. They have helped and supported. They have given us a break and given [our relative] company. They come when needed and often do the little but important things. They are not in a hurry and take their time and explain things." A person who used the service said, "They have been very, very good. They keep me company and have plenty of time to reassure me. One recognised that I needed a different prescription and sorted it out. They definitely make a difference."

The team was working to widen access to services and make the most effective use of the resources they had. For example, they had setup an outreach clinic, led by a clinical nurse specialist, at a local hospital and were about to set up another one in an adjacent borough. An external palliative healthcare professional told us that the hospice staff were responsive to people's needs. For example, a consultant from the hospice had visited one of their patients in the community who had complex needs to provide advice on their management.

People were admitted to the in-patient unit for a variety of reasons. For example, for an emergency stay, respite care, pain relief, management of a long term life limiting health condition and end of life care. Each person had a care plan that was tailored to meet their individual needs. People and their relatives were fully involved in the process and in identifying what was important to them and what outcomes they wanted to achieve. In all care records seen we found that people's care needs and preferences were well described and in the first person. These had thorough descriptions of requirements with needs being prioritised. They were comprehensive, personalised, well written and easy to follow. Care plans were promptly reviewed to meet people's changing needs. For example, changes of medicines or manual handling requirements were promptly taken into account in care plans.

Care files contained an informative index and explanatory sheet which described the layout of the files and the colour coding of the divided sections. There was evidence that the daily notes correlated with the care planning. The multi-disciplinary notes were chronologically entered and were colour coded per professional discipline visit. For example, social worker orange, occupational therapy pink. This made it easier and quicker to find information and to follow the care pathway the person had experienced. Care was well evidenced and tracked from the point of admission with issues highlighted and prioritised as needed. For example, any dietary or tissue viability issues were well documented and tracked regularly. Care plans also contained a record of input from outside professionals following a referral, and of any changes as a result of their involvement. These notes provided additional information that contributed to the improvement of care for the individual.

A full overview of each person receiving inpatient treatment was discussed in the staff handover meeting between each shift. The daily handover and subsequent recording systems demonstrated that information regarding significant change was communicated across the staff team. The documentation used was updated at each handover. Staff recognised that people's healthcare needs could change and demonstrated awareness of how these needed to be reported and effectively acted upon.

The service had systems in place to widen access for people who would not normally consider that hospice services could be for them. There were clinical leads on specific topics, for example, learning disability, dementia, transient population, sensory impairment and respiratory disease. They met every three months to develop and push this work forward and improve the services offered. One example of this was that the hospice had recently hosted an event for younger people living with dementia and their carers to share experiences and find out more about services available to them. Commenting on the event a clinical nurse specialist had said, "When people are at a different stage of their illness and they need our support, the patients and families will know us and have more confidence in us."



The day therapy service provided a range of specialist medical and therapeutic services. When people attended they had access to health and social care professionals including doctors and nurses, therapies such as complementary therapy, occupational therapy, physiotherapy, family support team and pastoral care. People confirmed that they had been offered counselling and support and also that this had been extended to their relatives. Clinical treatment interventions, such as blood transfusions, could be provided if appropriate. One person told us, "I was given some painkillers earlier and they have arranged for the nurse to visit me when I get home." A relative said, "I think the service is good, they keep an eye on [my relative's] medication and bloods." They also offered a range of support groups and activities. Their approach was to structure sessions around people's individual needs, whether this was receiving therapy, meeting other people or just relaxing in the grounds.

The day therapy unit helped protect people from social isolation. In order to provide the opportunity for outpatients to meet and share experiences those attending a morning session stayed on for lunch and those attending in the afternoon people came early so that they could have lunch together. We found that there was a very calm atmosphere and saw staff engaging with people in a friendly manner. They also had some useful discussions, for example about the benefits of arts and crafts. One person told us, "I enjoy the activities. Made a scarf, bird box and stencilled a hessian bag. Next week they have a makeover session. We can put forward suggestions. When I first came here I had a massage on my feet, they ask me again if I wanted a foot massage." Another person said, "I made a scarf (painting a silk scarf), made a bird box. Made me feel good, I achieved something." The services provided enhanced people's sense of wellbeing.

The hospice family support services worked holistically to provide advice, guidance, emotional support and counselling to people who used the services, their relatives, friends and carers. The family support team consisted of social workers, counsellors and specialist bereavement counsellors. Children and young people received specialist support from appropriately trained therapists. This was provided individually or as part of a family group. In addition to the counselling sessions there were also bereavement support days for children, young people, adolescents and their primary care giver following the bereavement. One relative confirmed that they had been offered counselling for their young grandchild if they needed it. People who used the service and their relatives told us that they had been offered counselling throughout their contact with the hospice. One relative told us, "We've been made aware of the support available from the hospice. We were offered counselling but don't want it at present." Another relative said, "They have contacted me and asked if I need any help. They still send me letters inviting me to things." This meant families had access to emotional support from the service after their relative's death.

The hospice had a large equipment store where items which would otherwise be discarded by the NHS were repaired, sterilised and made available to people. These included walking frames, commodes and specialist armchairs. This meant, the hospice could respond quickly to ensure people had the equipment in their own homes when they needed it. They also had links with other organisations providing a range of equipment and supported people to access these. For example specialist beds and pressure relieving mattresses. This helped to support people to return home as soon as possible especially if it was their wish to pass away in their own home. One relative told us, "They loaned us things straightaway. They sorted out a cantilever table and a wheelchair. Can't fault them at all." Another said, "We contacted the hospice for help. The nurse arranged a pressure mattress."

The provider had a positive approach to using complaints and concerns to improve the quality of the service. The registered manager told us that they did not receive many complaints and any received were dealt with quickly and people received a written response. There was a complaints database which recorded details of the complaint. Complaints were dealt with by the relevant senior manager. There was verbal and written evidence of complaints procedures and responses to them. The complaints records showed that any concerns had been taken seriously, investigated, action taken and lessons learnt. We saw



that outcomes from complaints were linked to change of practice when necessary. For example, the monitoring of noise levels at the nurses' station and improvements in the repair reporting process. Complaints were monitored and discussed at corporate governance meetings to ensure that they had been appropriately dealt with and that the necessary action had been taken to improve people's experience.

## Is the service well-led?

### Our findings

People, their families, staff and external organisations were all very positive about the care provided and the management of the hospice. One person told us, "Well run, yes. It's very good. I think it is excellent. It is always nice and clean and everyone talks to you. It does lots of things, like raising the funds, you can find out about it on their website. It's a very nice place to relax very pretty in the summer. Even down to the garden, people can volunteer to plant and help out relatives and patients." A palliative healthcare professional told us that the hospice was seen as an integral part of the end of life care provision in the area and that there was a commitment from "those at the top" that working with other services was important. Staff told us that they felt privileged to provide the service and felt valued, listened to and well supported. They added that the service was well managed. One member of staff said, "We represent a wonderful organisation."

There was a clear management structure with senior staff allocated lead roles. Throughout the organisation staff understood their lines of responsibility and accountability for decision making about the management, operation and direction of the hospice and its services. The management team demonstrated a strong commitment to providing people with a safe, high quality and caring service and to continually improve, extend and develop the service to reach as many people as possible. The chair of the board of trustees told us that there was a commitment to develop, improve, and be responsive and open to new ideas. They wanted to spread the service to more people without compromising the very good quality of care provided. Staff shared the values and aims of the service and were committed to ensuring that people received person centred care. One member of staff told us, "We all have the same aims and goals. There's a lot of forward planning and there's always room for improvement." People used a service that was continuously developing and improving to ensure that they received the best possible care.

Systems were in place to monitor the quality and safety of people's care and evaluate the care and treatment people received. Satisfaction surveys and complaints were scrutinised to identify whether people's experience of the service could be improved. Where the need for improvements was identified, the group responsible for ensuring they were completed were identified and the actions taken were recorded. There was a 'no blame' culture with staff were encouraged to report any clinical incidents or near misses. These were fully investigated and used as a learning tool to drive improvements in the delivery of care and to safeguard people from harm. Staff meeting minutes demonstrated that any previously identified issues were followed through and addressed.

There was a robust audit program in place which was carried out over the course of the year. These included 26 observational audits covering different areas. For example, care plans, mental capacity, consent, maintenance, catheter care and safeguarding. There was also a programme of 18 annual Hospice UK and in house audits. These included pain management, bereavement support, controlled drugs, infection prevention and general medicines. Quarterly audit update reports were provided by the quality and audit facilitator. These gave details of the audit activity that had occurred in the previous three months and their results. There was a structure in place to monitor the outcome of the audits. Audit activity was reported monthly at the quality and care directorate team meeting, bimonthly at the clinical audit group, six-monthly to the clinical effectiveness group and annually to the clinical governance committee.

We saw that the clinical audit group received a quarterly review of any clinical incidents or near misses that occurred at the service and also any external incidents or safety issues that were relevant. For example, in the period January to March 2016 there had been three medical device alerts received. These were circulated to the relevant clinical and non-clinical areas for review and it was found that none applied to any equipment on site. Other incidents such as falls were also recorded and monitored along with any action that was taken to prevent further incidents. In response to the incidence of falls the service was in the process of replacing all of their beds with low rise beds to minimise the risk of injury to people.

The provider had commissioned a business school to review their governance and to establish if the focus was correct and the right questions were being asked. As a result of this review the governance structure was changed and strengthened. There were now four main governance committees covering all of the operational areas of the service. Each governance committee was chaired by one of the trustees and at least two trustees formed part of the committee. Management groups linked to key roles reported to the relevant governance committee. For example, the clinical governance committee had five management groups reporting to it. They covered quality and care assurance, medicines management, individual experience, education, and widening access. Each committee had its own work plan and information regarding this was cascaded out to the board so they could oversee any high-level issues and risks.

An external palliative healthcare professional told us and we saw that the hospice collected data related to the care services they provided and had an active audit programme to make sure they could demonstrate that they were providing this care to the wider community and not just people with cancer. They added that the hospice carried out a bereavement survey to obtain feedback from those who had experience of the service as well as providing the opportunity for people to provide feedback whilst under its care.

The governance systems demonstrated that people used a service that was robustly monitored by the provider to ensure that it was safe and of a very high standard.

The provider was aware of the importance of forward planning to ensure the quality of service they provided continued to develop. There was a business strategy for 2015 to 2020. The overarching strategic objectives were displayed around the building so that everyone was aware of these. The strategy was developed through talking to people with a life limiting illness and their families and carers, to staff, volunteers and outside organisations. People used a service that was committed to deliver excellent care and to work collaboratively with partners to deliver and inspire better care for those affected by life limiting illness.

We saw that from the strategy an overall business plan had been put in place which was linked to CQC's key lines of enquiry. From the overarching priorities directorate business plans were developed and tasks were allocated to the relevant managers. Areas of the business plan relevant to that manager formed part of their personal objectives. The plans had timescales and were used as a monitoring tool to check that agreed actions had been implemented.

People used a service where staff felt valued and listened to and staff were involved in shaping improvements to the service. The chief executive officer (CEO) held three monthly CEO open forums to which all staff and volunteers were invited. At each forum the CEO gave a short presentation based on the business plan, strategic goals and achievements to date. People could ask questions on the day and also submit questions in advance. We saw that when people had submitted a question but had been unable to attend the forum the CEO had responded to them in writing. In addition staff surveys were undertaken. The last one was in 2014 and for the next one in May 2016 the survey was going to be extended to volunteers as well. Workshops had been held to discuss the results of the last survey. An action plan was then developed and action taken in response. For example, a staff voice group had been set up and the appraisal process

reviewed and changed.

The hospice was responsive to national strategies. For example, National Institute for Health and Care Excellence (NICE) guidance (Care of Dying in last days of life) 2015 and NICE Supportive Palliative Care 2015. An external palliative healthcare professional told us that the end of life care strategy had been the basis for the hospice widening access for people with a range of long term conditions. Also that they had developed specialist nurses with specific interests who attended the appropriate speciality meetings in the community such as GP palliative care meetings. They added that the specialist links had helped develop specific study days for the specialism in the education department.

The hospice team had strong links to the local community, many of whom were involved in events to raise funds for the service. Approximately 800 volunteers supported the hospice. This was both in their shops and in the hospice itself. For example volunteers worked in shops, in the garden, on reception, in the day therapy and inpatient units and transporting people to the hospice.

There were many ways in which hospice staff worked in partnership with other organisations to ensure that they were following current practice and providing a high quality service. They were committed to advise and share their expertise, to develop and improve their practice and to provide the best possible care and support to people. Staff worked in close partnership with GPs, district nurses and other healthcare professionals and provided advice and support to them. A clinical nurse specialist told us that any advice given to the GP was followed up with a written fax to ensure that the correct information was received. One person told us, "The hospice has driven the support provided and pulled it all together. This included the GP and the district nurse." Another wrote in a feedback questionnaire, "We were very impressed by the excellent service we had. It was nothing short of excellent. The coordination between district nurses and the Hospice at Home team was remarkable."

The hospice had recently hosted and contributed to an event for younger people living with dementia and their carers organised by a local memory team. A healthcare professional involved in this project had commented that without the support of the hospice the event would not have been staged. They added that they really appreciated, not just the use of the venue, but the staff giving up their time to support the event. The young adult steering group worked in collaboration with another hospice to set up a young adults group for people aged 18 to 30 with life limiting conditions. We saw that there was a commitment to enable people who were part of this group to be part of its ongoing development. The advertising flyer for the first session said, "As this group develops we would really like to involve you in the design and content. It is important to us that you have your views heard so we would like you to tell us about your needs and inform us about what you really enjoyed doing." People used a service that embraced new ideas about how to improve quality of care.

The hospice provided a service to a Clinical Commissioning Group (CCG) in a different geographical district and were working in collaboration with a hospice in that area. That service managed a OneResponse service which was a 24/7 service offering support and advice for people with palliative or end of life care needs. It was a central point of communication for patients, their carers and professionals. Feedback from the service was that Saint Francis Hospice had worked with them to "pull together a complicated situation". They added that Saint Francis had jointly promoted the service and been willing to improve support to people in that district.

A healthcare professional told us that the hospice's medical director had been a driving force for changing policies and involving external services and partners to improve people's care. This had included setting up a heart failure group. They added that the hospice always involved them, and any other relevant people in

their organisation, if there were any policy developments or strategies which might impact on people in their local area.

Feedback from commissioners was very positive and confirmed that the service was a forward looking organisation that did not "rest on its laurels." and strived for excellence both within the service and the wider community. They told us that the service was, "Impressive, always committed to what they were doing and cared about what they did." They added that it came through very powerfully that staff wanted to do the best for the 'patients'. Commissioners felt that the hospice was a "key player" in the end of life partnership and had good connections with the local health trust. They said the hospice was always looking to reach out and extend their services and to both initiate and try new things and to make sure that other groups were aware of and involved in the services, for example, minority ethnic groups. They added that the 24hr crisis line was for everyone, had a very positive impact on people's wellbeing and the hospice was always developing this further.