

## South Bucks Hospice

# South Bucks 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

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

# Summary of findings

## Overall summary

The location had not previously been inspected. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents reasonably well and learned lessons from them. Staff collected some safety information and used it to improve the service.
- Staff provided good care and treatment and gave patients enough to eat and drink. Managers had started to monitor 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.
- 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 planned care to meet the needs of local 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 and did not have to wait too long for treatment.
- Leaders ran services well and had started to use information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them 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.

However:

- Some areas of the clinical areas were still carpeted which posed an increased infection risk.
- Not all consumables were in date and some were found with patient details displayed.
- Not all patient records were completed fully.
- Not all areas of clinical governance were clear.

# Summary of findings

## Our judgements about each of the main services

Service	Rating	Summary of each main service
<b>Hospice services for adults</b>	Good 	We rated this service good for safe, effective, caring, responsive and well-led.



# Summary of findings

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# Summary of this inspection

## Background to South Bucks Hospice

South Bucks Hospice is a day hospice supporting patients aged 18 and over in South Buckinghamshire living with life-limiting or life threatening illness through the provision of specialist palliative care on an outpatient basis. They also support the families and carers of patients and those bereaved as a result of cancer, or a life-limiting illness, or Covid-19.

The hospice supported people at any stage in their diagnosis to adapt physically, psychologically, socially and emotionally to their condition, to keep well and to cope with any health and care needs at home, wherever possible. The support offered could start at any stage of illness including as soon as an illness had been diagnosed and whilst it may still be curative.

At South Bucks Hospice, palliative care was delivered by a multidisciplinary team of experts, such as nurses and counsellors. They provided support to individuals through:

- Pain and symptom management
- Lymphoedema management
- Counselling
- Physiotherapy
- Complementary therapy
- A wide range of support groups
- Practical support, advice and guidance e.g. housing and benefit application support
- Advance care planning
- Bereavement support
- Spiritual care

They also signposted patients to other appropriate services who could help with their care and wellbeing.

The hospice, at the time of the inspection, supported around 550 people per year, of which approximately 65% had a cancer diagnosis.

The hospice has been registered with the CQC since November 2020 to provide the regulated activity:-

- Treatment of disease, disorder or injury

The service had a registered manager, who had been the registered manager since January 2022. This was South Bucks Hospice first inspection.

## How we carried out this inspection

We carried out a short-announced inspection on 14 June 2022.

We visited the hospice and spoke with staff who deliver services, members of the senior team and the chair of trustees. We spoke with nine members of staff, which included nursing, administrative, executives and other non-clinical staff. We also spoke with two service users at the time of inspection and four service users post inspection. We reviewed five sets of care records.

# Summary of this inspection

We inspected South Bucks Hospice using our comprehensive inspection methodology.

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>.

## Areas for improvement

Action the provider **MUST** take is necessary to comply with its legal obligations. Action a provider **SHOULD** take is 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.

### **Action the service SHOULD take to improve:**

- Should ensure carpeted clinical areas are placed on the risk register as they pose an increased infection risk.
- Should ensure consumable checks are carried out more regularly to identify out of date stock.
- Should ensure consumables with patients details displayed are kept in a secure environment.
- Should ensure patient records are audited more regularly to improve standard of record keeping.
- Should ensure patient safety and quality information is discussed during governance meetings and is a set agenda item.

# Our findings

## Overview of ratings

Our ratings for this location are:

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

# Hospice services for adults

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

## Are Hospice services for adults safe?

Good 

This location had not previously been rated for safe. We rated it as good.

### Mandatory training

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

South Bucks Hospice had a mandatory training matrix which defined the mandatory training requirements of staff and volunteers. Mandatory training was split into departments and job roles.

We assessed the mandatory training requirements and found the matrix was comprehensive and met the needs of patients and staff. Training was a mixture of face to face and online training.

Managers and the human resources manager monitored the matrix and alerted staff when they needed to update their training. Staff we spoke with told us there were no barriers to accessing mandatory training. Senior staff, through conversation with the inspection team, could demonstrate they reviewed and had oversight of the staff's mandatory training completion rates.

Staff compliance was 85% at the time of the inspection. However, staff had been booked and were waiting to attend face to face training sessions on duty of candour and moving and handling. This training was occurring in the months following the inspection. Once these training courses had been attended compliance would be at 96%.

### 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.**

South Bucks Hospice had an up to date safeguarding children and adult policy to guide staff when dealing with adults and/or children where abuse was either identified or suspected. The policy covered other elements of safeguarding

# Hospice services for adults

such as radicalisation and female genital mutilation. The policy outlined the types of abuse staff may come across, including radicalisation and female genital mutilation, and contained contact details for the local authority social services duty teams, including the out of hours contact details. There was an easy to follow flow chart for staff to use if they had safeguarding concerns.

There was a safeguarding lead for the hospice who had completed level 4 adult safeguarding training and they could demonstrate knowledge of the correct way to report an adult or child safeguarding concern.

Safeguarding was part of the staff induction and mandatory training. Staff had the appropriate level of safeguarding training for their role and could demonstrate how to identify concerns, make a safeguarding referral and who to inform if they had concerns. Safeguarding training was up to date.

There were safeguarding posters throughout the hospice explaining whom to contact if you had concerns.

Staff also completed mandatory training in preventing radicalisation – basic Prevent awareness. Staff were up to date with this training at the time of the inspection.

Safety was promoted in recruitment procedures and employment checks. Staff and volunteers had Disclosure and Barring Service (DBS) checks completed before they could work at the hospice. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

## 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.**

South Bucks Hospice had infection control policies and procedures to help control infection risk. These and other related policies covered the actions required by staff to minimise the risk of infection and cross infection. In addition, new protocols and procedures had been produced in response to the COVID-19 pandemic.

All areas of the hospice were visibly clean and tidy and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and demonstrated all areas were cleaned regularly and deep cleaned when needed. The hospice had housekeeping staff who were responsible for cleaning patient and public areas, in accordance with daily and weekly checklists. Cleaning equipment was stored securely in locked cupboards. This meant unauthorised persons could not access hazardous cleaning materials.

The hospice used carpet in non-clinical areas to give the building a less clinical feel. All clinical areas other than one had vinyl floors for ease of cleaning and better infection control. There were plans in place to remove the carpet from the clinical area as it was acknowledged it posed an infection control risk. However, this had not been placed on the hospice's risk register.

Staff received training in infection prevention and control (IPC), records showed staff were 100% compliant with training requirements.

Staff followed guidance on the use of personal protective equipment (PPE), and we observed all staff wearing face masks when in the hospice. Staff had received training in the appropriate use of PPE and used it when in the hospice.

# Hospice services for adults

The hospice used audit to ensure standards of hand hygiene were regularly monitored, and results were used to improve IPC practices if needed.

The hospice had recently set up a health and safety committee with an agreed terms of reference and a set agenda. There was a monthly meeting where issues regarding IPC could be raised, actioned and monitored to maintain IPC standards at the hospice.

## 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 hospice moved into the brand-new purpose-built building in April 2017. The building had been designed to be open and welcoming and not feel like a clinical environment. The hospice had a well-maintained garden courtyard where patients and visitors could enjoy the outside. There was a good size car park where visitors could park their cars for free.

On entering the hospice, there was a reception desk where patients and visitors were required to sign in and out. Access to the other areas in the hospice, such as the clinical areas, activity room, dining room and training room was off the main reception area. There was a lift and stairs available to the first and second floors. The lymphoedema team ran their services from the first floor and had their own waiting area and reception/nurses desk to assist patients. Staff offices were located on the second floor of the building. There were quiet rooms available for staff, patients and their families for breaking bad news or for quiet contemplation.

The hospice carried out environmental risk assessments to make sure the environment and equipment were safe for all and if any actions or mitigations were needed. In addition, the building was 'walked' regularly by the management team and there were weekly fire, alarm testing and water checks carried out.

Staff told us they had enough equipment to provide safe and effective care and treatment to patients. The hospice maintained a central equipment register. This had details of all medical equipment used in the hospice and when it required servicing and electrical testing. During our inspection, all equipment we looked at was stored neatly and the required safety checks were up to date.

Storerooms and cupboards were tidy, well organised and items stored correctly according to policies and procedures. This meant consumables were easily located for staff. We checked a sample of consumable items for expiration dates and found some out of date bandages and some consumables with patients details on in a trolley in the lymphoedema clinical room. We raised this with the hospice during the inspection. We were told the service carried out hosiery expiration dates every six months.

Staff carried out daily checks of emergency equipment. There was a defibrillator (used to treat a life-threatening abnormal heartbeat) and an emergency resuscitation bag situated on the ground floor in the clinical area. There were emergency call bells in the toilet and bathrooms. There were no call bells in the clinical areas of the hospice. In these areas, staff would call a set extension number which would ring all phones in the building to alert others that help was needed.

There were evacuation chairs on each stairwell which staff were trained to use.

# Hospice services for adults

Clinical and domestic waste was disposed of separately in the correct colour coded waste bags. All the sharps bins we inspected were properly assembled, labelled, signed and dated in line with best practice and filled below the line indicated on the bin.

## 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 completed risk assessments for each patient on admission and updated them when necessary. We reviewed five patients records and saw appropriate risk assessments had been completed and reviewed. These included an initial assessment, a holistic assessment, an evaluation and full care plan.

Key information meant staff knew about and dealt with any specific risk issues. The care plans were detailed with guidance for every aspect of the patient's needs, for example, allergies and advanced care planning. There was a personal emergency evacuation plan (PEEP) for each patient assessed by the nursing staff as requiring one. A PEEP is a plan for a person who may need assistance, for example a person with impaired mobility, to evaluate a building or reach a place of safety in the event of an emergency.

Staff knew in advance which patients were attending the hospice that day. Patients requiring additional assistance or support were highlighted on the daily list of attendance and measures put in place accordingly. For example, if they had mobility issues.

Staff liaised with colleagues working within integrated local services, including acute and GP surgeries. There were established lines of communication and hospice staff would refer or signpost patients to other healthcare professionals if required.

Generally, acutely unwell patients would not visit the hospice. However, staff were trained in what to do if someone became unwell and deteriorated and who to escalate to if this should happen.

## 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.**

The service was nurse led and had enough nursing and support staff to keep patients safe. The hospice employed specialist palliative care and lymphoedema nurses to run the clinical services. They were supported by a physiotherapist, complementary therapist, psychotherapists and counsellors and an almoner to offer and signpost practical help and support to patients, their families and carers.

Managers adjusted staffing levels daily according to need. Senior staff reviewed staffing in advance, based on planned day care attendees, and the individual needs of each patient attending.

The hospice were supported by volunteers who carried out a range of duties depending on their skills, expertise and training. This included drivers, gardeners counsellors and administrators.

# Hospice services for adults

The hospice did not use bank or agency staff.

At the time of the inspection there were some staff vacancies, this included the head of clinical services. This role was being covered by the chief executive and the lead palliative care nurse.

## 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.**

Patient notes were comprehensive, and all staff could access them easily. The hospice was using an electronic patient record system and had increased its functions to become more paper light. At the time of our inspection the hospice were using a mixture of paper and electronic patient records.

We reviewed five sets of patients records and saw they contained relevant and up to date information. Care plans were individualised, and records included, patient history, medicines, relevant risk and clinical assessments. The allergy status of all patients was also recorded.

Records contained information on advance care planning and do not attempt cardiopulmonary resuscitation (DNACPR) documentation.

Records reviewed during the inspection were accurate, comprehensive and provided a clear picture of the care and treatment each patient received. However, we did find some admissions including missing information on current medications and demographics not completed.

Senior staff audited patient records for completeness and to highlight improvement and training needs. However, these audits were carried out annually. This made it hard to improve the standard of record keeping in a timely way. Post inspection we were told, although not a formal audit, weekly checks were being carried out by the service leads on certain aspects of patient records, to improve data entry and reporting.

## Medicines

The hospice did not prescribe medicines.

Patients who were required to take medicines during their hospice visit would be responsible for administering their own drugs. However, under certain circumstances the nurses could assist them with this. If medication was given by the nursing staff it would be recorded on the electronic patient record.

The patient's own medicines could be stored for the duration of the patient's visit in the hospices medicine cabinet if needed. If this occurred the hospice had a sign in and sign out system for the medication.

The clinical staff would refer to the patient's GP if they had concerns regarding their patients' medication.

## Incidents

## Hospice services for adults

**The service had processes in place to recognise, report, investigate and share learning from incidents and near misses. 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.**

All incidents and accidents were reported in line with the South Bucks Hospice incident policy. The policy included definitions of incidents and their level of harm and how incidents should be reported, investigated and actions taken.

Staff told us they knew what incidents to report and how to report them. This included when anything went wrong, near misses and accidents within the service. Staff said they understood what constituted an incident but none of the staff we spoke with had reported an incident.

The hospice used a paper incident reporting form. This form went to the chief executive and they were responsible for overseeing incidents and ensured these were investigated and actions put in place to mitigate the incident reoccurring.

From June 2021 to May 2022 there had been three incidents reported. All incidents were non-clinical and did not involve patients. In the same time frame the hospice had reported no serious incident or never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need to have happened for an incident to be a never event.

We were told incidents were a standing agenda item on the monthly clinical committee meeting held with the clinical team. Post inspection we reviewed three sets of minutes from this meeting and saw this was the case.

Duty of candour was part of the hospice's mandatory training and staff we spoke with understood their responsibility to be open and honest with the patient when something had gone wrong. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. There had been no incidents at the hospice where the duty of candour had needed to be applied.

The lead palliative care nurse monitored patient safety alerts and would cascade to the teams if actions needed to be taken.

### Are Hospice services for adults effective?

This location had not previously been rated for effective. 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 protected the rights of patients subject to the Mental Health Act 1983.**

# Hospice services for adults

Clinical guidelines and policies were developed and reviewed in line with National Institute for Health and Care Excellence (NICE), the Royal Colleges and other relevant bodies. A process was in place for policies to be updated with any new or amended guidance.

Staff followed up-to-date policies to plan and deliver according to best practice and national guidance. Policies and protocols were available on the hospice's intranet and a folder of hard-copy controlled policies was located in staffing areas for staff to refer to.

Patients had an individualised plan of care which reflected their personal needs.

The hospice undertook audits to ensure healthcare was being provided in line with standards. However, the hospice had highlighted that its audit programme was still in its infancy and significant improvements needed to be made to ensure audits were robust and added value to the safety and quality of services provided. Post inspection we were told the service leads had developed an audit programme and this was now being implemented across the services.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Awareness of the requirements of the acts was included in mandatory training.

## **Nutrition and hydration**

### **Staff gave patients enough food and drink to meet their needs and improve their health.**

Staff completed patient nutrition and hydration assessments at initial assessment and reviewed them when needed. Patients would be referred to their GP or signposted to other services if needed.

There were drink stations located in communal areas for patients to get refreshments, including tea and coffee.

## **Pain relief**

### **Staff assessed and monitored patients regularly to see if they were in pain.**

Patients attending the hospice had an initial assessment which included discussions on pain and pain management. We were told by the clinical staff that it was important to manage and get patients' pain under control as this helped improve patient's quality of life.

The clinical team monitored patients' comfort and pain levels during their subsequent hospice visits, and if needed, patients could access the hospice's pain and symptom management clinic for further support and advice.

The clinical team would also escalate to the district nurse service or to the patient's GP if pain medicine needed to be reviewed or was not effective.

## **Patient outcomes**

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

# Hospice services for adults

The hospice used both objective and subjective evidence to measure the effectiveness of care and treatment. For example, measuring the amount of swelling in lymphoedema patients, range of movement for physiotherapy patients or asking how a patient is feeling.

Each service collected data and information at the start, during and end of treatment. This information was analysed, compared and reviewed to demonstrate the outcome of treatment for their patients.

Although the hospice collected data it did not have clear service performance measures. Work had just been completed by the service leads to identify the performance measures and quality indicators needed to evidence the effectiveness of the care and treatment provided to patients by their service. The next part of the project was how to utilise this data to develop impact reporting.

The hospice had introduced the Outcome Assessment and Complexity Collaborative (OACC) tool. The OACC is a suite of measures used to assess the care that matters most to people and their families at the end of life, such as control of their pain, breathlessness and fatigue, the opportunity to discuss worries, or to achieve one more personal goal before they die. By collecting this data the hospice teams caring for patients were able to plan care, treatment and support to best meet the needs of each individual patient.

The hospice was starting to use information from local audits to improve care and treatment.

## 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.**

All staff with a professional qualification were subject to pre-employment checks to ensure their professional qualification was active and with no restrictions in place. We reviewed staff files and found they contained relevant information to demonstrate staff suitability and competence for their role.

The trust had a well-planned induction programme for newly appointed staff. This was a set programme for staff to orientate themselves with the hospice, their department, the expected behaviours and training in procedures and policies. This was tailored to the individual's role at the hospice.

Clinical staff had to complete competency training on specific areas to ensure they had the appropriate skills and knowledge to manage patients safely and effectively. The hospice had role specific competency matrix which detailed the competences required for each grade of staff. Completed competencies would be recorded by the human resources manager as a central record.

Clinical supervision was provided to staff by an external hospice health professional. Clinical supervision was a safe and confidential environment for staff to reflect on, discuss their work and their personal and professional responses to their work. The focus was on supporting staff in their personal and professional development and in reflecting on their practice.

Volunteers were used throughout the hospice and were trained and supported for the roles they undertook. Volunteers had the required Disclosure and Barring Service checks and mandatory training before they started volunteering at the hospice. All staff understood the value of having volunteers at the hospice and they were seen as a vital part of the team.

# Hospice services for adults

Managers supported staff to progress through regular monthly development meetings and yearly constructive appraisals of their work. Staff had the opportunity to discuss training needs and were supported to develop their skills and knowledge. Staff told us they found the appraisal process useful and they were encouraged to identify any learning needs they had, and any training they wanted to undertake. Poor or variable performance was identified through the appraisal process, complaints, incidents and feedback. Staff were supported by their managers to improve their practice where indicated.

## Multidisciplinary working

**All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.**

Multidisciplinary (MDT) working was a fully embedded practice which helped bring a joined-up approach to delivering care and treatment to the patient.

Staff held regular and effective MDT meetings to plan and deliver holistic patient care. All teams were represented, including clinical, the almoner and therapies. Patient was discussed in detail, with care and treatment planned in accordance with their physical, psychological, emotional, spiritual and social needs, as well as supporting the patient's choice. The well-being of each patient's family was also discussed, and plans put in place to make sure they were also supported.

The hospice had good links with other healthcare providers in the local area, including GP surgeries, community palliative care teams and other hospices. Information and support was shared to offer joined up services, care and treatment for patients.

## Seven-day services

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

The hospice did not provide urgent or acute services and therefore services were not available seven days a week. The hospice offered services between 9am and 5pm Monday to Friday.

## Health promotion

**Staff gave patients practical support and advice to lead healthier lives.**

Staff assessed each patient's health and well-being when they were referred to the hospice. Care and treatment offered to patients with life limiting illnesses were aimed at improving quality of life rather than offering a cure. Services offered by the hospice supported patient's physical, psychological, spiritual and social needs.

The hospice offered complementary therapy to patients cared for by the hospice. Therapy programmes were tailored to individual needs and goals. A variety of methods were used to help patients, such as mindfulness and relaxation techniques, and complementary therapies, such as massage. The benefits of complementary therapy for end of life patients included improved sleep through increased relaxation and ease of symptom pain which improves quality of life. Therapists were qualified professionals and were registered with the appropriate regulatory bodies.

# Hospice services for adults

The hospice physiotherapist offered tailored programmes to patients to help improve their quality of life by optimising their mobility and wellbeing and to live as independently and fully as possible.

The lymphoedema service offered support to people living with lymphoedema in any part of the body including head and neck, trunk and genitals, arms, legs and breast. The clinic offered support groups to patients which included applying and removing hosiery, exercise, simple lymphatic drainage and skin care.

Patient treatment plans could include manual lymphatic drainage, a gentle form of skin stroking to improve patients' lymphatic areas and help patients feel more comfortable.

The hospice facilitated support groups where patients with similar conditions could come together to share experiences, offer emotional support, share education and practical help to each other.

The individual and family support team offered support to patients and their loved ones. The hospice had a trained team of counsellors to help patients and their loved ones with emotional and psychological support when adjusting to the diagnosis of a life-limiting condition.

The hospice had a range of health promoting and information leaflets which patients could take away with them to give information, advise and encourage participation in their health care.

## **Consent, Mental Capacity 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. They used agreed personalised measures that limit patients' liberty.**

The hospice had up-to-date policies on Mental capacity act (MCA) and deprivation of liberty safeguards (DoLS) and consent. Staff completed mandatory training in the MCA and DoLS. At the time of the inspection 100% of staff required had completed their MCA training and were booked on a course to update their DoLS training the week after the inspection.

Staff understood the importance of consent when delivering care and treatment to patients. In most cases this was implied consent and not documented. However, when an intervention was required, formal written consent was sought.

Staff demonstrated a good knowledge and understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), and the procedures and documentation used by the hospice to assess a patient's capacity. Staff were aware when patients lacked the mental capacity to make a decision, best interest decisions were made in accordance with legislation and took into account patients' wishes, culture and traditions.

The hospice used the advance care planning framework to help make decisions about the care patients would like at the end of life and do not attempt cardiopulmonary resuscitation (DNACPR) forms to document each patient's wishes in emergency situations.

# Hospice services for adults

## Are Hospice services for adults caring?

Good 

This location had not previously been rated for caring. We rated it as good.

### Compassionate care

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

Staff were aware of the importance of providing compassionate care and the impact their actions had on the patient and their families during this time of their lives. Support was always given by caring and empathetic staff who put patients and their loved ones at the heart of everything they did. During our inspection we saw pleasant interactions between staff and patients. We saw staff treat patients with warmth and care, they were courteous, professional and demonstrated compassion to all patients.

Staff introduced themselves to patients and all staff wore name labels on their uniform which enabled patients to easily identify which staff member was providing their care/support.

Patients were treated with dignity and respect at all times. Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients. Peoples' privacy and dignity was always considered. Staff always knocked before entering a room.

Patients we spoke with during our inspection commented positively about the care and treatment they had received.

The hospital monitored patient feedback from their patient satisfaction survey. Post inspection we reviewed patient satisfaction surveys for the different services carried out at the hospice, which showed 100% of patients were satisfied or very satisfied with their care. Patients used word such as caring, excellent, helpful, warmth and understanding, kind and professional manner when describing their care and their interactions with staff.

### Emotional support

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

All staff demonstrated a deep understanding of the emotional impact living with a life-limiting condition had on patients and their relatives and consistently took account of this when providing care and treatment.

During our inspection we were told by staff emotional support came in different forms depending what was required by the patient and those close to them. The services at South Bucks Hospice worked together as a multidisciplinary team to support the emotional needs of the patient and their families.

Staff listened to patient's worries and addressed their concerns.

# Hospice services for adults

The individual and family support team offered emotional support to the patient and their families who may be struggling with how to cope with the challenges of serious illness and the changes it brought. Support was offered on a one-to-one basis, with family or in groups. They undertook anticipatory grief work and identified coping strategies, which included working with patients and their wider families. The team offered bereavement support to bereaved relatives and friends before and after the death of their loved ones. This included individual counselling or group sessions. We saw positive feedback from service users for the support that was provided which included 'you helped me beyond words', '...going through my journey with me made me feel so much less alone' and 'I had felt nervous about my condition but I left feeling more positive'.

The hospice had an almoner who offered and signposted practical help and support to patients, their families and carers, such as advising on benefits, which helped alleviate stress and worries at a difficult time in their lives.

The hospice could provide pastoral care which offered emotional, psychological and spiritual support to patients, relatives and staff of all, any or no faith.

The hospice had a strong focus on wellbeing and provided a range of complementary and creative therapy programmes to support people's emotional needs.

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

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

Staff were committed to working in partnership with patients and their relatives, involving them in decision making processes about care and treatment.

Staff made sure patients and those close to them understood their care and treatment and supported patients to make advance decisions about their care. The hospice used advance care plans so patients could plan for future health and treatment options if they should lose their decision-making capacity. These plans captured their values and wishes and enabled them to continue to influence treatment decisions even when they could no longer actively participate. We saw advanced care plans in records we reviewed.

Patients we spoke with and the patient satisfaction surveys we reviewed showed information was explained gently and with sensitivity, questions were never ignored or remained unanswered. We were told staff had time to answer questions and would answer in a way they could understand.

## Are Hospice services for adults responsive?

This location had not previously been rated for responsive. We rated it as good.

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

# Hospice services for adults

**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 care.**

The COVID-19 pandemic changed how the hospice operated and the services it could offer. As a result of this the hospice had looked at the services previously offered to see if care, treatment and services met the needs of the local people they were trying to reach. The hospice, over the 18 months prior to the inspection, had restructured its service provision to make sure services were focussed on providing palliative and end of life care to patients and their families that was needed in the community.

Research has shown there are increasing numbers of people living with long-term conditions, often with multiple, complex health needs. South Bucks Hospice wanted to make sure there were offering support to as many people as possible, at the right time and giving them the services they needed now and in the future.

The hospice saw their role as providing physical, emotional, spiritual and social and practical care to patients and their families. They had restructured their services to deliver this and had plans in place to develop further services going forward. New services were being offered included a nurse-led symptom management clinic and specialist groups and workshops. In addition, the hospice was starting to run focussed support groups for patients with complex needs who needed specialist clinical and non-clinical advice, and peer support.

The hospice was in the process of launching a hospice user group. Patients and carers would work with the hospice to help improve services and shape the future of the hospice. By involving patients and carers would ensure the services reflected the needs and views of the people who used them.

The hospice provided the use of its facilities to groups run by NHS clinical nurse specialists.

The hospice engaged with the local palliative care network and had good links with another hospice in the local area. This ensured hospice staff were engaging with the wider hospice care systems and had an understanding of the needs of the local population as a result.

Staff and managers were actively involved in building links with local services and the community, including the local GP surgeries and the clinical commissioning groups. To help with this the hospice had developed a new role of clinical engagement lead to raise awareness of the services it offered and to attract new business and opportunities to the hospice.

## Meeting people's individual needs

**The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.**

Care plans and risk assessments for patients were person-centred and consistently tailored to each individual patient's needs. Each person's care plan was devised in discussions with the patient. The care plans were regularly reviewed and updated, and referrals were made to members of the multidisciplinary team (MDT) according to each patient's needs.

Staff had training to be able to support patients with complex needs. Clinical staff told us, if needed, they would liaise and involve relatives, specialist practitioners in the local community and from the local trust who were already involved in the patient's care to make sure they supported patients appropriately and to make sure there was continuity of care.

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Patients were from a variety of ethnicity and backgrounds. The hospice were looking to work with interpreters as currently the hospice were using relatives to support patients when English was not their first language, which the hospice recognised as not best practice.

The hospice's facilities were designed to meet the needs of the full range of people who used its services, corridors were wide for wheelchair users and people with mobility difficulties and there were accessible toilets.

There were multiple quiet rooms which were used for sensitive and confidential conversations and meetings.

## Access and flow

**People could access the service when they needed it and received the right care promptly. The service ensured patients did not have to wait for care.**

The hospice had effective processes to manage admission to the service. Referrals came mostly from GPs, specialist palliative care nurses and community clinical nurse specialists. There was a single point of access for patients who had been diagnosed with a life-limiting illness. Patients would be assessed for eligibility. If the hospice was able to meet the needs of patient, and they would benefit from the hospice services, they would be offered care and treatment.

Nursing teams had a caseload of patients. Their care needs were discussed at clinical and multidisciplinary meetings to decide what care planning could be offered. Depending on the circumstances, this could include access to hospice facilities and therapy sessions, such as reflexology or art therapy.

The hospice had started to review service data, such as patient activity at their governance meetings. By reviewing this data the hospice could look at demand and capacity, make plans for the services, and make sure the service was offering effective and responsive care and treatment for patients.

## 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.**

The hospice followed the up to date complaints, concerns, comments and compliments policy. The policy included a complaints flowchart to follow to make sure all steps were completed correctly. The policy stated the staff roles and responsibilities, and the timescales for dealing with complaints.

Staff were aware of the complaint's procedure. Staff told us they always tried to resolve any issues or complaints at the time they were raised. If this was not possible, patients could be referred to the nurse in charge or a team leader in the first instance. If complaints or concerns could not be resolved informally, patients and/or those close to them were supported to make a formal complaint.

The hospice displayed information about how to raise a complaint and information could also be found on the South Bucks Hospice webpage on the internet. Complaints could be made in person, by telephone, and in writing by letter or email or on the compliments, concerns and complaints form. In addition, patients could raise concerns using the hospice's feedback opportunities such as the service surveys.

## Hospice services for adults

Patients told us they knew how to make a complaint or talk through a concern. We were given an example where a patient had raised a concern about some of the artwork displayed at the hospice. They were asked to come into the hospice to discuss this and if there were any other changes that could be made to make the hospice and its services more friendly from a patient perspective. The artwork was changed the next day and was replaced with paintings made by patients in the art therapy group.

Staff said learning from complaints and concerns would be communicated to them mainly at handovers and team meetings. Staff we spoke with during our inspection were committed to providing an excellent service to their patients. Staff told us they saw learning from complaints and concerns as a vital tool to help them achieve this.

The hospice had received only two clinical complaints since it opened, both related to health professionals referring to the service rather than actions of the hospice.

Complaints were recorded on the complaints/concerns log which the chief executive had ownership of. The log included what actions had been taken in response to the complaint/concern but did not show what date the complaint/concern had been closed.

We were told complaints were a standing agenda item on the monthly clinical committee meeting held with the clinical team. Post inspection we reviewed three sets of minutes from this meeting and saw this was the case.

The hospice received many compliments mainly verbally and from feedback forms. The hospice was working on a way to improve the monitoring of this information.

### Are Hospice services for adults well-led?

This location had not previously been rated for well-led. We rated it as good.

#### Leadership

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

The hospice had a clear management structure in place with defined lines of responsibility and accountability. The hospice was led by a chief executive, who had overall responsibility for the hospice. They were supported by the service leads. The chief executive was accountable to the board of trustees.

The board of trustees were actively involved with the hospice, they had a range of relevant expertise to contribute to the effective running of the hospice. We spoke with the chair of the board. They spoke with pride about the care the service currently provided and the direction of travel of the hospice. The role of the trustees was defined with a summary of their role and their main duties and responsibilities. Members of the board chaired the hospice's sub-committees, which meant trustees were expected to have an awareness of external issues that might impact the hospice. The board of

# Hospice services for adults

trustees met every three months as a board. This ensured they met their governance responsibilities and maintained oversight of the quality and safety of care. At the time of our inspection there were seven trustees from a variety of backgrounds, including clinical and financial. The hospice was actively looking to recruit to the board and hoping for a final number of between ten to 12 trustees.

Hospice services were managed by heads of services. At the time of inspection the head of clinical services role was vacant but being filled by the lead palliative care nurse, who had a wealth of experience working in the palliative care sector, with support from the chief executive. The heads of services worked closely together for the good of patients. This was demonstrated by the weekly multidisciplinary meetings they attended as a group.

The chief executive and heads of services understood the issues, challenges and priorities in their service and beyond. They had worked together when restructuring the services and to produce the business plan to provide high-quality, patient and family-centred palliative and end of life care services.

The hospice provided development opportunities for staff by supporting them to develop management and professional skills. The hospice was aware of the need for succession planning and had plans in place to ensure the continuation of services.

## Vision and Strategy

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

South Bucks Hospice's vision, mission, aims and values were focused on providing high-quality palliative care for patients and those close to them living with life-limiting conditions. The hospice vision was, "Enhancing the quality of life". The mission was, "to provide exceptional specialist care that reflects the personal wishes of those we support" and there were five high level aims underpinning this mission.

South Bucks hospice had developed a three-year strategy for 2021 to 2024 that focused on aligning itself with the future direction of healthcare, to engage with partners in a co-ordinated way and to be ready to respond to changing needs of palliative and end of life care. The new strategy was aligned to national recommendations for palliative and end of life care, and their local integrated care system (ICS).

To help achieve the hospice's strategy a yearly business plan was written and signed off by the board of trustees. We reviewed the business plan for 2022/2023 which had been developed in collaboration with staff, service users and external partners. The plan focused on seven core areas which included, increased awareness of their services in the community and therefore an increase in referrals, promoting the benefits day hospice could bring both in supporting people in the early stages of diagnosis but also as they head towards end of life, and improving data and efficiency to ensure it supports future developments.

The service leads and the chief executive were responsible for overseeing progress against the plan to ensure this was delivered, with review and oversight by the board of trustees.

## Culture

# Hospice services for adults

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

Staff felt positive about working at South Bucks Hospice. They were passionate about the care they provided and were proud to work at the hospice. Staff told us they were committed to providing the best possible care for patients and those close to them. We observed positive and respectful interactions between staff at all levels. Staff told us they all worked well together, they supported and cared for each other and treated each other with respect.

Staff we spoke with were positive about the chief executive, and said they were visible and approachable. Staff told us they could openly discuss issues or concerns which would lead to resolution. They felt valued and their opinions were sought before changes which affected them were taken.

None of the staff we spoke with raised any concerns about bullying or inappropriate behaviours from colleagues. Arrangements were in place to ensure staff could raise concerns safely and without fear of reprisal, including a whistleblowing policy. The hospice had appointed a freedom to speak up guardian (FTSUG) which reflected national guidance and whom staff could talk to in confidence if they had concerns. Staff were aware of the freedom to speak up guardian role.

There was an established set of values, which were:

**Compassion:** we treat everyone with compassion in a caring, safe and supportive environment,

**Aspirational:** we aspire to be the best in everything we do

**Respectful:** we value each person as an individual, treating everyone with dignity and respect

**Enabling:** we enable and empower people

We observed staff worked in a way that demonstrated they upheld the vision and values of the hospice in practice and kept patient care as the basis for all they did. The appraisal process incorporated the values and behaviours expected of staff.

The hospice's equality and diversity policy, for employees, was aligned to the requirements of the Equality Act.

## 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.**

South Bucks Hospice had a governance framework in place through which the hospice was accountable for continuously improving their clinical, corporate, staff, and financial performance. Governance accountability was from the board of trustees, delegated through to the chief executive, service leads and staff for operational management.

# Hospice services for adults

The hospice had three main sub-committees which met quarterly, clinical committee, health and safety committee and the finance and general-purpose committee, where specific operational issues were discussed. Information from the hospice services fed into these meetings. We reviewed minutes from these meetings and saw that meetings were planned, structured, issues discussed and outcomes and next steps made. However, these meetings did not have set agenda's and although we had been told items should as risks, complaints, patient outcomes and clinical incidents were discussed the minutes did not evidence this. Post inspection we were told the hospice had identified this gap and an information governance meeting was being set up and terms of reference have been drafted with team members identified. This meeting would cover processes and systems and use data to monitor the quality of care, as yet the first meeting had not been held. In addition, post inspection we were shown minutes from the monthly clinical team meeting which documented that accidents, incidents and near misses and complaints were discussed in these meeting. However, from the minutes of the sub-committees we reviewed there was no evidence this information was being fed through to the meetings that reported up to the board of trustees.

Information from the sub-committees fed into the quarterly board of trustee meetings. This meeting had a set agenda which included a review of the risk register, committee reports and policies for approval. However, not all aspects of clinical governance were discussed at this meeting. We could see from the minutes and talking to the chair that the trustees had good oversight of the hospice which enabled them to make sure decisions were in keeping with the strategy and values of the hospice and progress was delivered.

We were told by staff working throughout the hospice information would be shared with them in various ways including, handovers, meetings and via emails. Staff at all levels were clear about their roles and they understood what they were accountable for, and to whom.

Arrangements were in place to manage and monitor contracts and service level agreements with partners and third-party providers. Contracts were reviewed on an annual basis, which included a review of quality indicators and feedback, where appropriate.

## Management of risk, issues and performance

**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.**

There were clear and effective processes for identifying, recording, managing and mitigating risks. The hospice had an up-to-date risk policy and related policies and procedures available to staff which were developed to minimise risk to staff and families who use the service.

The hospice had a risk register, which included risks from across the organisation. The register included a description of each risk, the potential impact of the risk, alongside mitigating actions and controls in place to minimise the risk and what further action was required. Each risk was scored according to the likelihood of the risk occurring and its potential impact.

New risks were added as they occurred, which made the risk register a live document and process. Risks were discussed at the hospice's committee meetings, although this was not evidenced in the meeting minutes we reviewed. However, risks were reviewed at the hospice trustee board meeting and we saw evidence of this in the minutes. Existing risks were reviewed and discussed, and decisions made to change the rating of the risk or close if appropriate.

# Hospice services for adults

There was alignment between the recorded risks and what staff identified as risks within the service, such as the recruitment of staff, lack of referrals and the on-going COVID-19 pandemic.

From speaking with staff and reviewing documentation we were assured the service was able to recognise, rate and monitor risk. This meant the service could identify issues that could cause harm to patients or staff and threaten the achievement of their services.

## Information management

**The service did not collect reliable data to understand performance, make decisions and improvements. Information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.**

The hospice was in the process of reviewing how it captured, monitored and reviewed patient data and saw it as one of the top priorities for the hospice.

Although the hospice collected data it did not have clear service performance measures. Work had just been completed by the service leads to identify the performance measures and quality indicators needed to evidence the effectiveness of the care and treatment provided to patients by their service.

The hospice knew further work was needed in how to record, report and monitor this data. It was in the process of setting up the new information governance meeting where performance measures and quality indicators from the services would be analysed and tracked over time. This was to ensure patients were receiving quality care and highlight any unexpected variations in performance which warranted investigation and improvement. The hospice was also investing in information technology (IT) systems to effectively record, monitor and improve the quality of care.

Staff had access to a range of policies, procedures and guidance which was available on the hospice's electronic system. Staff also told us IT systems were used to access the e-learning modules required for mandatory training.

Computers and laptops were encrypted, and password protected to prevent unauthorised persons from accessing confidential patient information.

Data security awareness was included as part of mandatory training for staff. Staff understood the need to maintain patient confidentiality and understood their responsibilities under the General Data Protection Regulations. The hospice had appointed a Caldicott guardian.

There were effective arrangements to ensure data and statutory notifications were submitted to external bodies as required, such as local commissioners and the Care Quality Commission (CQC). There was transparency and openness with all stakeholders about performance. The hospice made its annual Report and Accounts available to the public and was published on its website.

## 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 hospice actively encouraged patients and their relatives to give feedback to help improve services. For example, through patient satisfaction questionnaires, feedback and suggestion cards. Feedback was used to inform improvement and learning and to celebrate success.

The hospice had a presence on social media which included an informative website for people wanting to find out about the hospice and the services that it offered. The website was easy to navigate, used consistent layouts and visual cues for functionality across the site.

South Bucks Hospice was a registered charity and fundraising was crucial to enable the service to continue to provide care to patients. A wide range of events and initiatives were put in place to raise money and to remember those who had been supported by the hospice. This included charity shops, sponsored events and days out and giving in memory. We saw tributes from patient's families who wanted to give back to the hospice for the care and support their loved ones had received.

Staff views were sought and acted on. There were regular all staff meetings which gave employees an arena to discuss ideas and seek practical solutions to improving their working experience. The hospice had not undertaken a staff survey that allowed staff to provide anonymous feedback on the management, leadership and delivery of services. However, plans were in place to undertake one before the end of financial year. Staff we spoke with told us they always felt they had someone to share experiences with. There was an open culture at all levels and staff told us they were able to raise concerns with assurance that these would be addressed.

## Learning, continuous improvement and innovation

**All staff were committed to continually learning and improving services. Staff were actively encouraged to think of ways to improve services.**

The hospice was committed to improving the quality of services offered to patients and their relatives. Since the beginning of 2022 the hospice had reviewed its services, the way that it worked and produced a plan to make changes and improvements to the hospice and the way that it operates.

During the inspection we saw evidence some changes had already occurred, such as the recruitment of new palliative care focused nurses and the facilities manager and the launch of a new symptom management pain clinic. Some changes were in the process of change such as the governance framework and increasing awareness of the hospice in the wider community.

The hospice had just been granted approval to open a bistro style café which would be open to the general public. The hospice saw this as a non-threatening way to engage with the local community and showcase the support that was available to people with a life-limiting illness and that the hospice was not a scary place.