Thames Hospice

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Inspection report

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

Ratings

Overall rating for this location	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Outstanding ☆
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Outstanding ☆

Summary of findings

Overall summary

This location had not been previously rated. We rated it as outstanding because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, had effective and embedded understanding in how to protect patients from abuse, and managed safety well. The service had designed a state-of-the art facility to enhance the care given to patients and their loved ones. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked collaboratively and used a holistic approach for the benefit of patients, involved and supported patients to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients and their loved ones with compassion and kindness, respected their dignity and privacy, and went above and beyond expectations to meet their individual needs and wishes. Staff were devoted to doing all they could to support the emotional needs of patients, families and carers to minimise their distress. Staff helped patients live every day to the fullest.
- Services were planned and tailored to meet the complex needs of individual people, and the local population, in partnership with the wider health economy. The hospice's services were delivered flexibly, by a responsive and passionate multidisciplinary team, providing choice and continuity of care for patients, their families and carers. The hospice planned and worked to improve awareness and access to palliative care for hard to reach communities. The service made it easy for people to give feedback. People could access the service when they needed it.
- Leaders ran services effectively using best practice systems and supported staff to develop their skills. Staff understood the service's vision and values, and these were fully embedded in their working practices. Staff were motivated to provide the best care they could for their patients. There was a shared purpose on improving the quality and sustainability of care and people's experiences. Staff were proud to work at the service, there was strong collaborative team working and staff felt respected, supported and valued. Staff at all levels were clear about their roles and accountabilities. Leaders operated effective governance processes and used innovative approaches to drive and improve the delivery of high-quality person-centred care. The service engaged well with patients, staff and the local community to plan and manage services. Strategies and plans fully aligned with plans for the wider health economy and leaders demonstrated commitment to system-wide collaboration.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	Outstanding ☆	Services were provided from one location. We rated the service as outstanding overall as it was rated outstanding for caring, responsive and well led and good for safe and effective.

Summary of findings

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Background to Thames Hospice

Thames Hospice provided both specialist palliative care services for patients aged 16 and above living with life-limiting conditions. It provided services to patients living in East Berkshire and South Buckinghamshire at its inpatient unit in Maidenhead, and at home via the community palliative response team. The hospice was a charitable organisation.

The hospice first opened in 1987 and was known as the Thames Valley Hospice. In 2005 it merged with the Paul Bevan Cancer Foundation and became known as Thames Hospice Care. In 2013 it rebranded and became known as the Thames Hospice with facilities in Ascot and Windsor. Thames Hospice designed a new state-of-the-art facility to bring all their services under one roof. This facility opened in October 2020. This inspection report covers this new location and the services provided from there.

All services were run from their purpose-built facility. The hospice had 28 ensuite bedrooms split across three wings, a day therapy unit which offered a day therapy service, patient and family support, a therapy service, lymphoedema service, physiotherapy and medical outpatient clinics. The community team included a community palliative care response team, the rapid response community palliative care team and a 24-hr palliative and end-of-life care telephone service.

The hospice was registered to provide the regulated activities:-

- diagnostic and screening procedures
- treatment of disease, disorder or injury

The service had a registered manager, who had been the registered manager of the previous locations since February 2020. They had continued in this role when the new location opened in October 2020.

Thames Hospice was inspected at its previous locations in 2016 under a different CQC inspection methodology and was rated as good.

We carried out a short-announced inspection on 2nd and 3rd August 2021. We inspected Thames Hospice using our comprehensive inspection methodology.

How we carried out this inspection

During our inspection, we inspected the inpatient unit, the day therapy unit and spent time on home visits with the community palliative care response team. We spoke with approximately 28 members of staff, including volunteers, registered nurses, health care assistants, nursing assistants, allied health professionals, reception staff, medical staff, senior managers and trustees. We spoke with seven patients and two relatives. We attended meetings and handovers, observed patient care, reviewed patient records including prescription charts and do not attempt cardiopulmonary resuscitation decisions. We reviewed hospice policies, procedures and other documents relating to the running of the services.

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.

Summary of this inspection

Outstanding practice

We found the following outstanding practice:

- The hospice had recently extended its service to support and care for people aged 16 to 18, as they realised there was a gap in services in the local area for this age group. This involved collaboration with local children's hospices and organisations to establish a transitional service for people moving from children to adult services.
- Thames Hospice had designed, built and staffed a state-of-the-art facility. The specialist end of life and palliative care facility had been designed with the patient, their loved ones and the community at the centre. In doing so it could provide more care to people with life-limiting illnesses and their families, develop a service that met the needs of the communities it served and adapt to changes in healthcare in the future.
- There was a safeguarding culture at the hospice. Systems and processes had been embedded and staff went above and beyond to make sure people were kept safe from harm. They worked with the patient and other agencies to keep people safe.
- The hospice had developed a nursing assistant role, the first of its kind to be introduced into the hospice sector and unique to Thames Hospice. The nursing assistant role helped support the registered nurses and give healthcare assistants career progression whilst improving the care received by patients.
- Leaders encouraged innovation and participation in research. They proactively looked for ways to engage the wider healthcare community in palliative care services through education, training and collaboration.
- The hospice had introduced a management module for doctors undertaking their specialist palliative care training. This covered areas such as, clinical and charity governance, the medical director role and board governance. Thames Hospice were only the second hospice to offer this training course.

Our findings

Overview of ratings

Our ratings for this location are:

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

Outstanding ☆

Hospice services for adults

Safe	**Good**	●
Effective	**Good**	●
Caring	**Outstanding**	☆
Responsive	**Outstanding**	☆
Well-led	**Outstanding**	☆

Are Hospice services for adults safe?

Good ●

This location had not been previously 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

Thames Hospice had a mandatory training metric which defined the mandatory training requirements of staff, including clinical and non-clinical staff working at the hospice. Mandatory training was split into job roles and staff would have a personalised list of training for them to complete. The hospice also had a mandatory training schedule that volunteers needed to complete.

We assessed the mandatory training requirements and found the metric was comprehensive and met the needs of patients and staff. Training was a mixture of face to face and online training. The online training included questions at the end of the course to help embed the course content.

The hospice had identified additional computers were needed for staff to access online training. Two computers had been provided and placed in an area which was easily accessible for all staff. In addition, managers were encouraged to identify and plan time for staff to complete their training.

Staff we spoke with told us there were no barriers to accessing mandatory training.

All staff and volunteers were expected to keep up to date with their training. Staff could check when training was due on the hospice’s computer system. The system would send out reminders to staff via email that their mandatory training was due, needed to be completed or was outstanding. In addition, managers would be alerted by the system when their staff’s training needed updating.

Mandatory training rates were monitored each quarter of the year by the senior management team to make sure mandatory training was being kept up to date.

Staff completion rates for quarter one (April to Jun 2021) were 99.9%. We were therefore assured staff were completing their mandatory training.

Safeguarding

The hospice made safeguarding a priority for all and worked hard to ensure everyone knew how to protect patients and themselves from abuse. The service worked well with other agencies and went above and beyond to ensure patients were safe from harm. The service promoted a safeguarding culture. Staff and volunteers had training on how to recognise and report abuse and they knew how to apply it.

Thames Hospice had a clear safeguarding leadership structure with the chief executive having overall responsibility for safeguarding at the hospice. There was also a trustee safeguarding champion who offered independent scrutiny and provided the board oversight of safeguarding across the organisation.

The hospice had a safeguarding panel which provided leadership, governance and review. The panel met formally four times a year and all safeguarding incidents were reviewed with a focus on their management, outcome and learning. The panel also worked to ensure all safeguarding policies and training for staff and volunteers were compliant with current legislation and were up to date. During our inspection we attended the safeguarding panel meeting and listened to the measures the hospice had taken internally and with external organisations to protect people from harm and make sure they were safe. From discussions we could see the hospice was fair and non-judgmental with the patient and their welfare at the heart of decisions made and actions taken.

The hospice operational lead for safeguarding was responsible for improving the co-ordination of safeguarding processes at the hospice. They made sure there was a clear message about what safeguarding was, who was involved and how the hospice and the wider community worked together to keep adults and children safe.

The hospice had up to date safeguarding policies and procedures to guide staff and volunteers when dealing with adults and/or children where abuse was either identified or suspected. These covered other elements of safeguarding such as radicalisation and female genital mutilation. Safeguarding was part of the staff and volunteers' induction and mandatory training. In addition, the hospice ran an annual safeguarding awareness week. The week saw additional communication to staff from the safeguarding leads to ensure safeguarding continued to be on everyone's agenda.

There were safeguarding posters throughout the hospice which had been designed to stand out, it included photos of the safeguarding leads and whom to contact if you had concerns. Safeguarding leads also wore safeguarding badges so they could be recognised. Safeguarding leaflets were also available for patients and visitors detailing forms of abuse and what actions to take if needed. Safeguarding details could also be found on the hospice's website.

Staff had the appropriate level of safeguarding training for their role and could recognise the signs of abuse. They gave us examples of when they had raised safeguarding concerns and how they had gone about it. Staff throughout the inspection demonstrated they put people's safety at the centre of everything they did and there was a safeguarding culture at the hospice.

Safety was promoted in recruitment procedures and employment checks. Staff had Disclosure and Barring Service (DBS) checks completed before they could work at the hospice. We saw staff had submitted a DBS check prior to employment. 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.

Thames 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 the hospice, homecare services and outpatient services. In addition, new protocols and procedures had been produced in response to the COVID-19 pandemic. This included a new procedure for when staff, patients and visitors arrived at the hospice.

COVID-19 was still a risk when the inspection took place and therefore COVID-19 measures were in place at the hospice. During our inspection, we saw the following COVID-19 measures carried out to protect patients, visitors and staff:

- Temperature checks at the entrance
- Rapid lateral flow tests available to test day patients and visitors for COVID-19 at the entrance
- Face masks available at the entrance and throughout the hospice
- Hand sanitiser available throughout the hospice
- Signs to remind patients, visitors and staff of the need for social distancing to reduce the spread of the virus
- Posters highlighting the importance of good hand hygiene

Staff could explain the procedures they would follow if they had concerns about a patient or visitor’s infection status.

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.

We observed staff following good general infection control practices to minimise the spread of any infection; they wore face masks, were ‘bare below the elbow’ and cleaned their hands before and after contact with every patient. Staff had access to hand washing facilities and personal protective equipment, such as gloves and aprons in a variety of sizes. Community staff carried a supply of infection, prevention and control (IPC) equipment for use when they visited patients at home, such as hand sanitising gel, gloves and cleaning wipes.

The hospice had been designed to help mitigate the risk of infection. For example, areas such as bathrooms and patient bedrooms, had floors with rounded edges with the flooring material extending up the wall. This helped prevent dirt getting caught in the joint from floor to wall and meant ease of cleaning and better infection control.

Effective measures were in place to ensure the health and safety of everyone who came into contact with a deceased person’s body after death. Staff we spoke with were knowledgeable about these IPC measures and could describe how they washed and prepared the body after death.

Staff were required to complete IPC training during their induction and then annually at the level appropriate to their role as part of their mandatory training.

There were effective systems to ensure standards of hygiene and cleanliness were regularly monitored, and results were used to improve IPC practices if needed. The hospice had a designated lead for IPC who was available to provide support, advice, training and updates for staff. The designated lead monitored compliance with IPC policies and attended link IPC meetings at the local trust. In addition, the trust supplied a named link for the hospice to contact if they had any issues relating to IPC. A hospice IPC group had been set up in April 2021 with a meeting held every other month. We reviewed minutes from these meetings and could see it was an effective way to monitor, promote and maintain IPC standards at the hospice. An audit programme was used to increase and maintain standards and help prevent the spread of infection. There had been an infection control deep dive audit in June 2021, with a resulting green rag rating. Green denoted a favourable value. There were minimum actions required following the audit such as the need for paper towel dispensers by the sinks.

Since opening in October 2020 there had been zero incidences of healthcare acquired infection at the hospice.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment had been planned with the patient, their loved ones and the community at the centre. It offered privacy and dignity to people whilst keeping them safe and free from harm. Staff were trained to use up to date equipment and managed clinical waste well.

The hospice moved into the brand-new purpose-built building in October 2020. The specialist end of life and palliative care facility had been designed with the patient, their loved ones and the community at the centre. The hospice was surrounded by landscaped gardens, had views of Bray Lake and had a large car park where visitors could park their cars for free.

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. As the facility was under a year old when we inspected there was still a building team on site to fix any issues that occurred. In addition, health and safety and fire risk assessments were carried out. We saw evidence that action plans were acted upon. For example, wires from electrical equipment had been hanging down in rooms used by patients and their visitors. These had now been hidden in trunking and were no longer a hazard.

On entering the hospice, there was a reception desk where day patients and visitors were required to sign in and out. The reception also included the hospice café and a shop which was open to all at the hospice and to the wider community. There were two private areas available for patients and families to reflect. Access to and from the inpatient unit (IPU), clinical areas and the day hospice was off the main reception area and was secured with an intercom/key pad to prevent access by unauthorised persons. These areas also had their own reception desks to assist patients and their families.

All patient facilities were on the ground floor of the building. The IPU had 28 ensuite bedrooms, split into three wings. All rooms had access to outside space with the majority having views of the lake or the landscaped gardens. Rooms were spacious, light and airy. Equipment and furnishings had been chosen to meet the needs of individual patients with varying disabilities. For example, a smart speaker had been installed in each inpatient unit bedroom. This device enabled patients with life-limiting conditions such as motor neurone disease or multiple sclerosis, who had limited use of their arms, to be able to call a nurse for assistance through voice activation. The patient's comfort, safety, infection control and quality of life had all been considered when equipping the room. Each room had space for families to stay over and a private terrace outside. Patients could be moved out on the terrace whilst still in bed if they wished to spend time outside but were unable to leave their beds.

Patients, their loved ones and staff had been thought about in the design of the IPU. For example, corridors and doors were wide for ease of moving equipment and beds. There was lots of storage areas available, with some areas lockable or with access via a staff fob. This meant access to areas unsuitable for patients and visitors was controlled. Each wing had a large bathroom that could be used in addition to the ensuite facility in the patient bedrooms. The large bathrooms included hoists to provide safe transfer of the patient without putting unnecessary strain on the carer or the person being moved, and specialised baths that could be tailored to suit the needs and mobility of the patient.

The hospice had appropriate facilities to safely place deceased patients. The Willow Suite included the cold store room which could hold up to six deceased patients while awaiting collection by funeral directors. We reviewed records which showed the room was maintained at the correct temperature. The cold body storage register was completed each time it was used. The register included details regarding the patient. The Willow Suite also had a quiet room for loved ones to reflect, its own secluded private garden and a dedicated viewing room for loved ones to spend time with their deceased relative prior to the body being collected by the undertaker.

The day therapy unit (DTU) and wellbeing services was spacious and well designed. The area included a large activity room with appropriate seating, tables and amenities, bi-folding doors that could be opened out onto a terrace with views of the lake. There were individual rooms that could be used for outpatient appointments, clinical rooms and complementary therapy. The area also had four counselling rooms with views of the lake, these rooms had been designed to be calming with colour and soft furnishing choices. Safety features such as call bells and emergency alarms were found in each room. The DTU included a rehabilitation centre with specialised equipment to help patients minimise their symptoms, optimise functioning ability and quality of life.

WIFI access and USB points were available for charging devices throughout the hospice.

The hospice had updated much of its equipment when it opened its new facility, for example, new beds and seating. The hospice maintained a central medical 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.

Staff told us they had enough equipment to provide safe and effective care and treatment to patients both at the hospice and in the community. We checked a sample of consumable items for expiration dates and all were in-date. Storerooms were tidy, well organised and items stored correctly according to policies and procedures. This meant consumables were easily located for staff.

Staff carried out daily checks of emergency equipment. There were two defibrillators (used to treat a life-threatening abnormal heartbeat) and an emergency resuscitation bag situated on the IPU. There was a defibrillator located in the DTU. In addition, there were emergency call bells in all locations. These were checked weekly to make sure they worked. Records showed all checks were up-to-date and completed. This showed there was a consistent and regular approach to safety checks.

Clinical and domestic waste was disposed of separately in the correct colour coded waste bags. We observed staff disposing of waste in the appropriate bins. 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 in all the hospice services completed risk assessments for each patient on admission and updated them when necessary. Inpatient risk assessments were completed on arrival to the unit. Community patients were triaged over the telephone within 24 hours of receiving the referral. A face to face visit was carried out within five days of referral. Initial assessment for all patients on admission included review of discharge plans, whether the patient was to be resuscitated in the event of a cardiac arrest, if the patient was for escalation (or if there was a ceiling of care in place), anticoagulation status, and mental capacity status, and was reviewed throughout the patients journey. Risk assessments were in patients' notes. When a risk was identified, we saw actions were taken to minimise any potential harm to the patient, such as from falls or pressure damage. We reviewed two sets of notes on the inpatient unit and saw comprehensive risk assessments were carried out. These included risk assessments for moving and handling, falls, nutrition and hydration and pressure damage.

In both the inpatient unit (IPU), and out in the community, appropriate equipment was identified and ordered, such as bed rails and pressure relieving mattresses. Clinical staff we spoke with told us there was no problem obtaining equipment from the suppliers, with most equipment available on the same day.

The IPU assessed patients daily at the morning IPU handover. All aspects of the patient's care was discussed. Patients who had deteriorated or their symptoms had increased overnight were identified and priority was given for these patients to be reviewed by the doctor. During this meeting other areas of concern were discussed, such as psychological or spiritual issues, and the appropriate member of staff or team identified to visit the patient within an agreed timeframe. Other shift changes and handovers that occurred during the day included all necessary key information to keep patients safe when handing over care to others. All relevant clinical and non-clinical information was passed to the next shift including review of any spiritual or pastoral care needs.

The hospice provided a 24-hour palliative and end of life care telephone service to give advice to people with palliative care needs and their families, as well as to healthcare professionals who needed guidance and support on delivering palliative care. If needed, patients would be signposted to other healthcare professionals, for example, to call an emergency ambulance, or the hospice's palliative care response team would make an urgent visit to the patient who was in distress.

The day therapy unit reviewed patients prior to attending the unit for assessment of their condition and symptoms management. Each time patients attended the day unit they would be assessed by the clinical team to make sure their condition had not changed. If support was needed this would be identified and actions taken. For example, a review by the hospice's medical team or referral to their GP.

Staffing

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

A staffing review was undertaken in January 2021 for the staffing levels required for the new hospice. This was then reviewed in April 2021 as patient occupancy was higher than expected and the service had opened two new services, young adults and ambulatory day care.

The hospice had enough nursing staff and support staff to keep patients safe. In general, the inpatient unit had three registered nurses, with at least one being senior and working as the lead nurse for the wing, and three healthcare assistants/nursing assistants on each of the three wings during the day. In addition, there was a floating registered nurse who worked across all three wings and would be available to support if needed. The head of the inpatient unit would work in a supernumerary role. This would reduce to one registered nurse and two healthcare assistants/nursing assistants on each wing with one floating registered nurse across the three wings overnight. However, we were told there was a flexible approach to nurse staffing as it could be dependent on the complexity of patients admitted to the unit.

The hospice had employed a nurse consultant and they oversaw the nurse-led beds on one of the wings of the inpatient unit. The nurse-led wing provided care for patients who needed non-complex end-of life care and for patients who were expected to stay a bit longer, up to 6 weeks under the continuing healthcare contract the hospice had with the local commissioning group.

The hospice had introduced a nursing assistant role. A role that was unique to the hospice and was developed to support the nursing workforce and to give a progression pathway for senior healthcare assistants. The purpose of the role was to support the assessment, planning and delivery of care under the leadership of a registered nurse to patients requiring palliative or/and end of life care. The nurse assistants had additional skills including, being able to care for catheters, venepuncture and cannula and control drug witnessing. At the time of inspection six senior healthcare assistants had passed the course and were working as nursing assistants. A further seven senior HCAs had started the course in April with another cohort due to start in January 2022.

The day therapy unit (DTU) ran 5 days a week and was covered by two registered nurses and three healthcare assistants. They were supported by an activity coordinator, complementary therapist and volunteers. The DTU also ran a lymphoedema service run by a team of nursing staff with specialist training in the management of lymphoedema.

The hospice employed two physiotherapists who worked across the inpatient and day therapy units. Although the hospice did not employ occupational therapists (OTs) directly they had access to OTs via a service level agreement with the local community NHS trust.

The palliative care response team employed community clinical nurse specialists. The service had a caseload of approximately 30 patients per 1 FTE CNS. We were told there was some flexibility in this number depending the level of support required by the patient. At the time of inspection, the service provided varying levels of support to 493 patients. The service employed 14.95 FTE CNSs.

The hospice had low numbers of vacancies. At the time of the inspection, the hospice had 4.2 (16%) full time equivalent (FTE) staff nurse vacancies, 1.5 (4%) FTE vacancies for healthcare assistant and 0.7 (18%) FTE medical team vacancies.

The hospice had their own medical team which was led by the medical director in palliative care medicine. As of August 2021, the hospice employed three consultants with another due to start in October 2021, two speciality doctors, two GP trainees and one foundation year two doctor.

There was always a consultant or speciality doctor on the inpatient unit Monday to Friday 9am to 5pm. They were supported by GP trainee and/or foundation doctors. There was a member of the medical team present on the inpatient unit Saturday and Sunday 9am to 5pm.

Out of hours and overnight there was no doctor present on the unit but they were available on-call and would attend the unit if required. There was also a second doctor on call, either a consultant or specialist doctor, who could be contacted to provide advice and support, as needed. Nursing staff we spoke with on the inpatient unit told us medical staff were easy to get hold of out-of-hours and would always come into the unit when needed.

Managers employed bank staff when needed to ensure safe staffing establishment was met, and/or to meet patient acuity. Managers told us agency staff were never used. Managers made sure all bank staff had a full induction and understood the service.

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.

The hospice predominantly used an electronic patient records system. We reviewed two sets of patients notes and found them to be completed in full and were up to date. They included relevant risk and clinical assessments including escalation and ceiling of care plans, known allergies, nutritional and pain assessments, medical and nursing clinical management plans and pathways, and were linked to the integrated palliative outcome scale (IPOS) phase of illness and advance care planning. Communication with patients and their families was clearly documented throughout the records.

Access to the electronic patient records system was role based and staff that completed records were expected to do so contemporaneously. The hospice had enough computers, including computers on wheels to ensure staff could do this. Hospice staff who cared for patients in the community had access to the same electronic system via laptops. This meant they could up-date patient records at each visit.

Local GPs used the same system as the hospice and there was agreement to share patient information. This meant staff could share details of hospice care with other professionals and agencies and they had immediate access to up-to-date patient information.

Advance care planning and do not attempt cardiopulmonary resuscitation (DNACPR) documentation was embedded at the hospice. We saw evidence of advance care planning in patient notes we reviewed and in patient discussions at handover and MDT meetings. We reviewed three patient DNACPR forms. All were correctly completed. The hospice had recently adopted the Recommended Summary Plan for Emergency Treatment and Care (ReSPECT) process for advance care planning to document patient's wishes in emergency situations and for end of life care. At the time of inspection, the hospice was training its staff in the use of ReSPECT documentation before it was rolled out to patients.

Senior staff audited patient records against best practice and identified areas for improvement where needed. We reviewed the documentation audit from May 2021 to Jun 2021 and saw five audits were carried out. Audits included, if patients' ethnicity was recorded and mobility assessments completed on admission. Audit results were analysed. If issues were found, senior staff worked with their teams to understand why issues had occurred and if a change of system or additional training was needed to improve the standard of record keeping. Audits results showed record keeping was mostly good at the hospice.

Medicines

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

Staff followed Thames Hospice policies and procedures when prescribing, administering, recording and storing medicines. The hospice commissioned pharmaceutical products and clinical pharmacy services from local NHS hospitals through a service level agreement. The pharmacist was based at the hospice for four days a week and there was an on-call pharmacist available at other times if needed. The pharmacist would monitor stock, storage, review patient prescription records and facilitate staff training. They also attended the monthly hospice medicines management meeting where issues were discussed, and action plans put in place.

During our inspection we found medicines were stored appropriately in locked cupboards. We checked a selection of medications in the inpatient unit and found all were in date and kept in line with manufacturers advice. Fridge temperatures were recorded daily, and staff sought advice from the pharmacist when temperatures were found to be outside recommended ranges.

Controlled drugs (CDs), medicines that are controlled under the Misuse of Drugs legislation (and subsequent amendments), were stored in separate locked cupboards. The hospice had a separate drug cabinet for patients own medicines.

We checked the CD register and found entries were completed in line with best practice. Controlled drugs brought in by patients were stored securely and there were adequate controls in place to prevent misuse. The hospice had a controlled drugs accountable officer as required by legislation.

Controlled drugs were frequently used to manage patients’ pain. The hospice permitted single nurse administered controlled drugs (SNAD) to ensure patients received them promptly when needed. However, the nursing assistants had completed competencies as part of their training to be able to double check CDs. This system helped to reduce drug errors.

At the time of the inspection drug prescriptions and administration were recorded on paper records. Patient allergies were documented on the front page. We reviewed two patient prescription records and found they were signed, dated, timed and legible. We saw patient medicines were regularly reviewed, including the use of ‘as needed’ medicines. Anticipatory medication, medicines prescribed in advance to help alleviate end of life symptoms such as anxiety, pain and nausea, were standardised and printed on the drug chart. Once the doctor had prescribed and signed the page, a registered nurse could give these drugs on a once only basis. This made sure patients had access to medicines when needed. Opioids were prescribed, depending on patient complexity, on admission to the inpatient unit and were therefore not printed on the standardised list.

The hospice had decided to implement electronic prescribing. The electronic system was arriving in September 2021 and training for all relevant staff was to take place over the following few months. The hope was a computerised system would reduce medicine errors further and support patient safety.

Nurses wore drug round tabards when administering medicine to patients so the nurse would not be interrupted. This helped to reduce time spent completing drug rounds, improved efficiency and accuracy by reducing distractions and hence increased patient safety.

The hospice was in the process of implementing patient group directions (PGDs) to address pain relief and ‘just in case’ drugs which were required at end of life. PGDs allow healthcare professionals specified within the legislation to supply and/or administer a medicine directly to a patient with an identified clinical condition without the need for a prescription or an instruction from a prescriber. The PGDs had been written and signed off internally but were waiting to be authorised by the local clinical commissioning groups. Once this had occurred the hospice's education team had designed a training course for staff to attend to make sure medication was administered safely and effectively.

Patients being cared for in the community had their anticipatory medicines and controlled drugs for pain relief managed by the district nurse service. The community clinical nurse specialists (CNSs) worked closely with district nurses and GPs to make sure patients had the appropriate medicine management to manage their pain and/or symptoms. The hospice's CNSs did not carry medicines when completing home visits.

The hospice was training two CNS to become non-medical prescribers, a health professional who is not a doctor but can prescribe medication. The course took a year to complete. The hospice had received funding to train two nurses per year for the next four years. This meant, going forward patients in the community could be prescribed medication without waiting to see their doctor. This could help to relieve their symptoms quicker without compromising patient safety.

Medicines were disposed of safely and records of destruction were maintained. Unwanted or expired medicines were kept separate from other medicines and were disposed of correctly.

The hospice had a medicine management group. This group met monthly to review policies and procedures, address medicine related alerts and looked at medicine incidents. Incidents relating to medicines were relatively low, May 2021 – seven incidents, June 2021 – four incidents and July 2021 – six incidents, with 16 causing no patient harm and one causing low patient harm. The medicine management group would review and investigate each incident and make sure action was taken to minimise recurrence. Information from this meeting fed into the Thames Hospice patient care and quality meeting which reported to the Board. We reviewed meeting minutes and saw the hospice had good oversight in their medicine management.

Incidents

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

Thames Hospice took incidents very seriously as they were passionate in ensuring patients and their families had the best experience possible when using the hospice services which were often at a period of emotional distress.

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

The hospice used an electronic reporting system for reporting incidents. All grades of staff could access the incident reporting system and those who worked remotely could access the system through their laptops. Staff said they knew what constituted as an incident and were encouraged to report incidents or near misses so that effective measures could be taken to minimise ongoing risk to people or the organisation. There was a no-blame culture and staff said they felt confident in reporting incidents.

The incident reporting policy required a review of incidents and accidents by a panel of Thames Hospice senior management representatives. The panel met on a monthly basis to review all reported accidents and incidents, common themes identified, reviewed actions taken and recommended further appropriate actions and closed reported incidents when all actions were completed. We reviewed minutes from the incident and accidents meeting and saw the hospice had a robust system for the reporting and investigating incidents.

From April 2021 to June 2021 there had been 89 incidents reported. 58 were Thames Hospice incidents and 31 were reported for the record only or as near misses. 72 out of the 89 incidents were clinical incidents, with drug incidents and patient slips, trips and falls being the highest occurrence. 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. Clinical incidents compared favourably with other hospices that took back in the Hospice UK benchmarking tool. The tool allowed the hospice to compare their quarterly and annual results with other similar sized hospices.

Staff we spoke with confirmed they received feedback from reported incidents, both those relating to their immediate area of work and those that had been reported elsewhere in the hospice. This promoted shared learning from incidents throughout the hospice. Staff said learning from incidents is communicated to them mainly at handovers, team meetings, emails and notice boards. Staff confirmed managers supported them when they were involved in incidents. Staff were encouraged to reflect on incidents they had been involved in. Staff could give us examples of when procedures had changed or additional training had occurred due to an incident. All staff we spoke with during our inspection were committed to providing an excellent service to their patients. Staff told us they saw learning from incidents as a vital tool to help them achieve this.

The hospice held mortality and morbidity meetings to discuss patient deaths or adverse incidents affecting patients. These meetings gave an opportunity for the clinical team to review deaths as part of their professional learning and reflective practice in a safe space. Talking through patient case studies was seen as a way to improve quality of care given to patients and their families at the hospice.

Clinical staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. The hospice had a duty of candour policy which staff could access through the trust intranet. 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, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A notifiable safety incident includes any incident that could result in, or appears to have resulted in, the death of the person using the service or severe, moderate or prolonged psychological harm. Staff we spoke with were aware of the importance of being open and honest with patients and families when something went wrong, and of the need to offer an appropriate remedy or support to put matters right and explain the effects of what had happened. From October 2020 to July 2021, the hospice had 36 incidents which required the duty of candour to be instigated. 35 of these were related to slips, trips and falls.

Patient safety alerts were a set agenda at the governance and health and safety committee. Heads of services ensured actions from patient safety alerts were acted upon where needed and information shared with staff.

Safety thermometer

The service used monitoring results well to improve safety.

Staff monitored safety performance to indicate how safe the service was in providing harm free care. The prevalence of patient harm because of falls, pressure damage and healthcare associated infections was monitored and reported monthly.

From October 2020 to June 2021, the service reported 16 hospice acquired pressure damage, 36 falls and zero healthcare associated infections (MRSA and C. Diff).

The hospice was committed in reducing patient falls and continued to look at ways to do this. For example, they had invested in and were using fall mats which linked to nurse mobile phones. This alerted nurses immediately if a patient had got out of bed without calling for assistance. An impact on patient falls had been seen as nurses were getting to the patient before a fall had occurred.

Measures were also in place to prevent pressure damage occurring/worsening. These included on going daily review of pressure relieving mattress settings and a timed patient turning record at the nurse's desk on each of the inpatient wings.

Are Hospice services for adults effective?

Good ●

This location had not been previously 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.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The head of governance and quality managed a central database of policies and procedures for the hospice that enabled tracking of policy review dates. A process was in place for policies to be updated with any new or amended guidance. The database provided staff with up-to-date links to policy documents.

We reviewed a range of policy documents held by the hospice. These all clearly recorded references for guidance that had been relied on in the development of each document. This included guidance from a range of organisations including the National Institute for Health and Care Excellence, the Royal Colleges and Hospice UK.

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.

Patients had an individualised plan of care which reflected their personal needs. If the patient was at end of life this was supported by the individualised care and communication record for a person in the last days or hours of life. This was in line with national standards and guidelines.

At handover meetings, staff routinely referred to the psychological, emotional and spiritual needs of patients, their relatives and carers. All members of staff at the handover were able to contribute to the discussion, including allied health professionals and spiritual care staff.

The hospice undertook a comprehensive range of audits throughout the year to ensure healthcare was being provided in line with standards. The hospice used the audits as a quality improvement process to improve patient care and outcomes through systematic review of care against explicit criteria. In addition, the hospice was using audits to respond to patient concerns or feedback, for example a patient mouth care audit had been recently carried out. The hospice was promoting a culture of patient safety and wanted staff to see how the audit programme and specialist audits contributed to this.

Nutrition and hydration

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

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Staff completed assessments in nutrition and hydration. Staff used the Malnutrition Universal Scoring Tool (MUST) on admission to assess patients at risk of malnutrition and dehydration. This was reviewed weekly or when there was any change in the patients' condition and recorded in the patient records. Individual patient care plans were established from the assessment and in consultation with the patient. Patients who needed assistance to eat and drink were identified through the initial and ongoing assessments. Referrals to dietitians, speech and language therapists, or occupational therapists were available if required.

The catering department prepared freshly made meals on-site. Hot and cold food options were available for each meal. Patients were able to select their preferred meal and drink options from a menu, which also included snacks. The service catered for all types of needs including vegetarian, soft, dairy and gluten free and any religious or cultural requirements. Specially trained volunteers would take menu choices from patients on the inpatient unit (IPU). These would be signed off by the nursing staff to ensure they were appropriate.

Staff provided support and advice to families of patients nearing the end of life with limited or no oral intake, this included giving mouth care to patients to maintain their comfort. For patients that could not maintain their own hydration, subcutaneous or intravenous fluids could be offered depending on the patients' requirements. Staff fully and accurately completed patients' fluid and nutrition charts where needed. We observed water jugs in inpatient's rooms and the hospice was in the process of purchasing ice machines so ice was easily available for patients.

Each wing in the IPU had a self-catering kitchen area for patients and their relatives to make drinks and refreshments. The on-site café provided a range of meal options during the daytime, while vending machines and microwaves were available for patients and relatives to obtain food out of hours.

Pain relief

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

Pain was a common symptom suffered by patients cared for by the hospice and its services. Clinical staff discussed pain and pain relief with patients during admission to the inpatient unit. This was documented in the patient's record. Patient pain levels were then regularly reviewed using recognised tools and staff gave pain relief in line with individual needs and best practice. Other recognised tools were used to help identify distress cues in patients who because of cognitive impairment or physical illness had limited communication. Staff also regularly assessed patients' ability to tolerate oral medicines with alternative administration routes prescribed if necessary, such as intravenous infusion.

During our inspection we observed patients' pain levels being discussed at the morning handover, during medical rounds and at the weekly multidisciplinary team meeting. Care plans included pain control monitoring and treatment including effectiveness.

Patients received pain relief soon after requesting it. The hospice permitted single nurse administered controlled drugs to ensure patients received pain relief promptly when needed. Patients we spoke with told us they were regularly offered pain relief and were given it promptly when they needed it.

Nursing staff were trained on the use of syringe drivers which were used to administer a continuous subcutaneous infusion of drugs which helped to control pain.

Anticipatory medicines with individualised indications for use, dosage and route of administration were prescribed for patients identified as being in the last days of life. These included medicines for pain, agitation, respiratory tract secretions, nausea/vomiting and dyspnoea (difficult or laboured breathing). Prescribing medicines in anticipation can prevent a lapse in symptom control, which could cause distress for the person who is dying and those close to them.

Patients attending the day therapy unit would have 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.

Patients being cared for at home had their pain managed by GPs, district nurses and specialist nurses. The community palliative care response team monitored patients' comfort levels during their visits. They would escalate to the district nurse service or to the patient's GP if pain medicine needed to be reviewed or was no effective.

Patient outcomes

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

The hospice had systems and processes in place to monitor, audit and benchmark the quality of services, and the outcomes for patients receiving care and treatment.

Information on clinical quality outcomes, for example healthcare associated infections and acquired pressure damage, were monitored and tracked over time. Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Data was reviewed and discussed by the relevant focussed groups and committees. We attended and reviewed meeting minutes and saw evidence that action was taken in response to any areas of concern.

The hospice had introduced the Outcome Assessment and Complexity Collaborative (OACC) tool to measure patient outcome. 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 multidisciplinary team caring for patients were able to plan care, treatment and support to best meet the needs of each individual patient.

The hospice was also implementing the Phase of Illness measure and the Australian Karnofsky Performance Status (AKPS). Phase of Illness describes stages of advanced illness according to care needs of the individual, family and suitability of care plan, with Phase 1 being stable and Phase 5 being bereavement. The AKPS is an assessment tool for functional impairment. It is used to improve understanding of patient needs, ability to carry out daily activities and to assess patient prognosis.

We saw reference to all these outcome measures in patient notes, handover notes and when staff were discussing patients. Staff told us they were useful tools that were becoming embedded into how they worked in the inpatient unit and used to give effective care and treatment to patients throughout their journey.

The hospice physiotherapy team supported patients in a variety of settings including the inpatient unit and the rehabilitation centre. The team completed holistic patient assessments and set realistic and achievable goals with the patient. They then worked alongside the patient to achieve these goals. For example, being able to walk to the bathroom or sit up in bed.

The hospice monitored patient’s preferred place of death outcomes. The hospice worked hard to achieve this for patients. During our inspection we observed staff working across hospice services and with other healthcare agencies to make sure they supported patient choices. From Oct 2020 to Jul 2021 of those patients that expressed a preferred place of death (PPD), 76% of patients died in their PPD. Staff told us all patients on arrival at the inpatient unit (IPU) were asked about their PPD and this was added to their records. On some occasions where patients died quickly due to the nature of their illness and fast progression, their PPD was not possible.

Thames Hospice took part in the annual FAMCARE audit which measured satisfaction with end of life care amongst bereaved relatives. Specialist palliative care services across the UK and Ireland took part in the audit. Surveys were sent to the next of kin of people who had died at the hospice over specific dates, which for 2020 was from 01 Jun to 31 Aug 2020 when the Thames Hospice was located at their old location. At the time of inspection, information was being collected for the 2021 FAMCARE audit. When results were available, they would be used to make improvement and to benchmark the quality of services.

The hospice also took part in Hospice UK benchmarking. The benchmarking allowed the hospice to compare their quarterly and annual results with other similar sized hospices. Since the hospice moved location it was now being compared with large-sized hospices. The hospice’s result compared favourably with other hospices. For example, falls per 1000 occupied bed days were similar. However, medication incidents per 1000 occupied bed days, and inherited and acquired pressure damage incidents per 1000 occupied bed days, were significantly lower.

The hospice used patient and relative feedback tools to measure patient outcomes. This included IPU survey results, patients in the community and real-time feed-back. Information was sought on a range of quality indicators and the findings were used to make improvements to services where needed. For example, the hospice was developing a booklet for patients and next of kin to help explain the side effects of treatment. This was done in response to patients and their families saying they would like more information as they could not always remember conversations had with clinical staff at such an emotive time.

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 four staff files and found they contained relevant information to demonstrate staff suitability and competence for their role.

All staff working at the hospice had an induction programme relevant to their role. The education team provided training for all new staff with a bespoke induction agreed with individuals and their line manager. Although staff received a clinical and departmental induction, the director of people, who had been in post since May 2021, had identified there was no corporate induction to learn about the hospice and its place in the local health community, and to meet senior staff at the hospice. Therefore, a new corporate induction day was being introduced, running the first Monday of every month if there was a need, starting September 2021. This meant staff would receive an induction to the hospice as a whole and its place in the local health community, information specific to their role and the department they would be working in.

Clinical staff had induction workbooks for their first six months to ensure their practice was of the standard required by the hospice and to identify any gaps in knowledge and skills. Nurses and healthcare assistants worked in a supernumerary capacity alongside an experienced staff member until they were competent to work alone. Staff spoke highly of the induction programme and said it was relevant, useful and met their needs in the new workplace.

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 metrics which detailed the competences required for each grade of staff. Completed competencies would be recorded by the education team as a central record.

Clinical supervision was provided to staff. This was provided on a one-to-one or group basis. 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. One off supervision sessions were arranged to support staff following any significant events or incidents. During our inspection we saw evidence of the importance the hospice put on clinical supervision. The education team were working closely with the clinical team to deliver effective supervision.

Trainee doctors had a clinical supervisor who they worked with regularly during their placement. Medical staff we spoke with told us they felt supported from senior medical staff and could approach them for advice at any time.

Thames Hospice had a dedicated education team which included practice educators. The team played an active role by providing support, educational input, development activities and internal training days for staff and volunteers working in the hospice. Staff we spoke with talked highly of the team, the developmental opportunities given to them and the educational support the education team provided to the them. In addition, the education team provided educational courses for the wider healthcare community in palliative and end of life care.

Staff could attend external training courses if they added value for the individual attending and benefit to the hospice. Staff we spoke with said managers were supportive if they asked to go on training courses and could give us examples of courses they had been on. Staff also told us it was expected of them to disseminate their learnings to their colleagues when they returned from training courses, which they were happy to do so.

Volunteers were used throughout the hospice and were trained and supported for the roles they undertook. There was a head of volunteering who made sure volunteers had the required Disclosure and Barring Service checks and mandatory training before they started volunteering at the hospice. Volunteers who worked in more specialist areas, such as transporting patients or taking patient's drink and food choices, had additional training to make sure they were competent for the roles they undertook. All staff understood the value of having volunteers at the hospice and they were seen as a vital part of the team. All managers, who had volunteers working in their departments, attended a one-day course on managing volunteers to understand the role they played and what their duties were whilst working at the hospice. This meant there were clear guidelines as to what a volunteer should and should not do. This safeguarded both the patients and volunteers. Volunteers we spoke with said staff were supportive and happy to help them in their roles.

Managers supported staff to progress through regular 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 and the education team to improve their practice where indicated.

Multidisciplinary working

Staff, teams and services were committed to working collaboratively to benefit patients. They had a holistic approach to provide care for the patient. Staff supported each other to provide good care.

We observed excellent multidisciplinary team (MDT) working throughout the hospice. MDT working was a fully embedded practice which helped bring a joined-up approach to delivering care and treatment to the patient. This facilitated better communication between healthcare professionals, patients and relatives and positively impacted on the care and treatment patients received. Staff and volunteers throughout the hospice, in every role and department, saw themselves as one team, working together with the common goal of providing the best quality seamless care to their patients.

Staff held regular and effective MDT meetings to plan and deliver holistic patient care. We observed the inpatient unit morning handover and the weekly MDT meetings for both the inpatient unit and the palliative community response team (PCRT). All teams were represented, including clinical, pastoral care and support teams. Each 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 PCRT clinical nurse specialists (CNS) had good working relationships with the GPs, surgeries and district nursing teams they worked with. CNSs attended Gold Standard Framework (GSF) meetings with local GPs where they discussed each patient on the end of life register and how they could best support them. The GSF is a framework which promotes best-practice in end of life care. It is used by many GPs, hospices and hospitals to enable earlier recognition of patients with life-limiting conditions, helping them to plan ahead to live as well as possible.

The hospice had good links with the local NHS trusts, the clinical commissioning groups and local authorities. Information and support was shared to offer joined up services, care and treatment for patients. Thames Hospice also worked closely with other hospices via senior staff and clinical forums to share information, learning and best practice.

Seven-day services

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

The inpatient unit (IPU) was operational 24 hours a day, seven days a week to provide timely patient care when needed. The hospice had an open visiting policy. Family, friends and carers were welcome to visit their loved one any time of the day or night.

A consultant or speciality doctor is on the IPU Monday to Friday 9am to 5pm. They were supported by GP trainee and/or foundation doctors. There was a member of the medical team present on the IPU Saturday and Sunday 9am to 5pm. Out of hours and overnight there was no doctor present on the unit but they were available on-call and would attend the unit if required. There was also a second doctor on call, either a consultant or specialist doctor, who could be contacted to provide advice and support, as needed.

The hospice provided a 24-hour palliative and end of life care telephone service to give advice to people with palliative care needs and their families, as well as to healthcare professionals who needed guidance and support on delivering palliative care. This was a dedicated specialist team, who were available 24 hours a day, seven days a week, 365 days a year. They provided guidance on symptom control, practical advice and emotional support. The hospice also had a rapid response team to make urgent visits to patients who were in distress.

The pastoral care team were multi-faith driven and provided 24 hours a day, seven days a week service.

Health promotion

Staff gave patients practical support to help them live well until they died.

Staff assessed each patient’s health and well-being when they were admitted. The specialist teams at the hospice worked together to give personal co-ordinated care to patients. 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 all patients and their carers cared for by the hospice, including in patients’ homes. 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.

The specialist palliative care physiotherapy team 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.

Hospice services for adults

The day therapy unit (DTU) provided services aimed at empowering patients to live well by supporting them to manage their condition, maintain independence and make new friendships. The programme was provided by a multidisciplinary team for all departments of the hospice. All the patients we spoke with during our inspection, told us how attending the DTU had made a huge impact on their health and well-being and had improved their quality of life.

The inpatient unit offered a service where patients could be referred to for symptom management such as pain or breathlessness or respite care.

The patient and family support team offered support to patients and their loved ones. This included during and beyond the patient's illness. The hospice had a trained team of counsellors, which included a team dedicated to supporting children and families, to help patients and their loved ones with emotional and psychological support when adjusting to the diagnosis of a life-limiting condition. The positive feedback we saw for these services showed how much they had helped patients and their families in their most difficult of times.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

The service had up-to-date policies and procedures regarding consent and the Mental Capacity Act 2005 and staff completed mandatory training in the Mental Capacity Act (MCA) and mental health awareness. As of June 2021, 95% of staff had completed their MCA training and 96% of staff completed their mental health awareness training.

Staff we spoke with understood the importance of consent when delivering care and treatment to patients. We observed staff seeking consent from patients prior to examination, observations and delivery of care. In most cases this was implied consent and not documented. However, when an intervention was required, formal written consent was sought.

Staff were also aware patients may make decisions that they did not agree with. We were told if patients do not consent then they do not proceed. When this happened, staff said it was their role to mitigate any risks as far as practicably possible. Staff would document when consent had not been given.

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. Information was documented in the patient's records. If the hospice was making difficult or complex decisions to deprive a person of their liberty, then the hospice would follow the legal framework to do so and work in close partnership with the local authorities.

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. We reviewed four sets of patients records and all were filled out comprehensively and correctly.

Are Hospice services for adults caring?

Outstanding ☆

Hospice services for adults

Outstanding ☆

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

Compassionate care

Staff and volunteers were highly motivated and treated patients and their families with compassion and kindness, respected their privacy and dignity, and went above and beyond expectations to meet their individual needs and wishes. Patients and their families were truly respected and valued as individuals

All staff, including volunteers, 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. All conversations and observations, without exception, with staff during our inspection demonstrated this. Big and small acts of kindness were embedded in how staff looked after their patients, whether it be arranging a wedding, picking flowers from the hospice gardens to put in a patient’s bedroom if they liked fresh flowers or holding a patient’s hand when they were scared.

Staff were discreet and responsive when caring for patients. Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients. People’s privacy and dignity was always considered. Staff always knocked before entering a room. The hospice used a light system on the doors to inpatient bedrooms which was a discreet way of letting staff know when patients and those close to them did not want to be disturbed or there was an infection risk. We observed these were respected by staff. Feedback from patients also confirmed this. For example, one relative wrote, ‘you cared for … with the greatest respect whilst maintaining their dignity and without your support I honestly don’t know what we would have done’, whilst another wrote ‘superb, dignified, empathic … thank you all so very much’

Staff consistently endeavoured to provide compassionate care tailored to patients’ individual needs and wishes, particularly for those approaching the end of their life. Staff wanted to make end of life care as good as it could be for the patient and their family or carers and went above and beyond to achieve this. During our inspection staff shared examples with us. For example, cleaning the hearing aids of a patient visiting the day therapy unit; arranging an afternoon tea for a patient and their family; liaising with the Home Office to make sure a family member had clearance to visit their relative during the COVID-19 pandemic. We were told, and observed during the inpatient unit handover, how staff would go to great lengths to make sure patients could return home, whether it be to visit as they approached the end of their life or to return home for their final days. Hospice staff would work together to achieve this outcome often with tight timelines. The hospice had facilitated weddings, christenings and blessings for patients and those close to them. We were given examples when staff continued to think about their patients outside of the working hours. The patient’s needs were continuously thought of and staff had innovative ways to meet them. Staff would see things and ideas when not at work and bring them back to the hospice to support or enhance a patient’s well-being under their care. Staff told us no matter how large or small if they could make it happen safely, then they would try their hardest to achieve it.

Staff were able to give us many examples of where the service had gone above and beyond to meet patients’ needs and wishes.

We were told of a patient who wanted to attend the funeral of a loved one but would have required breakthrough pain relief whilst away from the hospice. The hospice arranged for a nurse to attend the funeral with the patient to administer the medication when required.

We were told of a patient who was worried about what would happen to their pets whilst they were an inpatient, and when they died. Staff wrote an action plan with the patient, and involved their family, for the care of the pets. This meant the patient knew their pets were safe and would be cared for after their death.

We were told of a patient whose bed was moved so they had a better view of Bray Lake. Their loved one was having a paddle boarding lesson out on the lake and this meant they could watch.

We were told of a member of staff who took flowers, that had been given to a patient from their family but were now dying, away. The member of staff took the petals home and dried them in the airing cupboard. Then made them into handmade dried flowered bags. The staff member gave them back to the patient, who gave them to their family as a keepsake.

We were told of a relative, whom was known to the hospice, and visited on the anniversary of their loved one’s death to look at their memorial page in the book of remembrance, and to spend some time at the hospice to reflect. Due to the COVID-19 pandemic the relative was unable to do this due to restrictions on visiting. Therefore, a member of staff took a photo of the memorial page and got the hospice’s calligrapher to inscribe a sunflower marker and this was sent to the relative at home.

Staff showed an encouraging, sensitive and supportive attitude to people who used services and those close to them. We saw this in one to one interactions between patients and others involved in their care. Staff displayed warmth and appropriate levels of intimacy. Relationships between people who used the service, those close to them and staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders. Staff were supported by the patient and family support team, which included the counselling and pastoral teams, to reflect on how they cared for patients with compassion. Staff were extremely complimentary of these teams and the support they gave the patients and their families but also the support they gave to the staff.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Patient records we reviewed and observations we made demonstrated the totality of people’s needs were recognised and respected. The hospice offered spiritual support with a team who provided a listening presence, companionship and one-to-one pastoral support for patients and those close to them, irrespective of their beliefs. They spent time getting to know patients and what was important to them, their interests and what lifted their spirits, be that connected to a particular faith, or things like family, sport or music.

Staff ensured that care after death included honouring the spiritual and cultural wishes of the deceased person and those close to them. Family members and carers were asked if they wished to assist with the personal care of the body after death, such as bathing and dressing.

People’s emotional and social needs were seen as being as important as their physical needs. The hospice used patient stories to help others understand people’s personal experience of hospice care, the support and comfort the hospice could bring to patients nearing the end of their lives and their loved ones.

Feedback from patients, those close to them and stakeholders was overwhelmingly positive about the way staff treated people. We looked at thank you cards and feedback received through patient and relative surveys. Words frequently used to describe the hospice services were; ‘fantastic’, ‘understanding’, ‘amazing’, ‘wonderful,’ ‘kindness’, ‘supportive’. Patients and relatives described staff as ‘angels’ and the service they provided as ‘a lifeline’ and ‘helped to get things into perspective’. During our inspection patients we spoke with told us ‘it’s a bit like coming to heaven’, ‘I was scared of coming here but they are so welcoming, soft and gentle’, ‘the staff … they just make you heal’, ‘they are so genuinely kind here’, ‘they are amazing here - I can’t fault them’.

Emotional support

Staff were devoted to doing all they could to support the emotional support to patients, families and carers to minimise their distress. People’s emotional and social needs were seen as being as important as their physical 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 Thames Hospice worked together as a multidisciplinary team to support the emotional needs of the patient and their families.

We spent time in the inpatient unit, day therapy unit and out with the community services and were told by staff about and observed how patients and their loved ones were given emotional support to limit their distress. Staff listened to patient’s worries and addressed their concerns.

The patient and family support team offered emotional support to the individual and 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 was summed up in the following comment, ‘you are amazing never forget that, I am sure I am one of thousands of families who owe so much gratitude to you and the work you do.’

The hospice had a dedicated team to support children and families who were approaching or experiencing bereavement. This team had specialist skills in this area. During our inspection we spoke with families who had experienced a bereavement and were using the support services including the children’s bereavement team. All were complimentary of the services offered and the positive impact it had on them and their children at a difficult time.

The hospice social worker role was multifaceted. It included advising on benefits and advocacy services and supported patients and their families with accessing these as required. They liaised with voluntary and statutory agencies to support discharge from Thames Hospice if needed. Through their experience and training they were skilled at recognising families in distress and facilitating difficult conversations. Patients and their families spoke highly of the support offered and how it had alleviated stresses at an extremely difficult time in their lives.

The hospice had a pastoral care team who offered emotional, psychological and spiritual support to patients, relatives and staff of all, any or no faith. Staff and patient’s relatives gave excellent feedback for the support offered and the comfort it had given them and the patient when needed. The hospice also had a local network of faith leaders and community representatives who were able to visit patients if requested.

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

The hospice had an annual remembrance service, called Light Up a Life (LUAL) at Christmas. The service was a time for people to remember loved ones, enjoy carols and speeches from the hospice ambassadors. This was usually held at the hospice but due to the COVID-19 pandemic in 2020 the service had been streamed digitally on social media, with over 4000 views. The hospice also had remembrance books held in the multifaith quiet rooms.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and ensure they were active partners in their care and treatment. Staff helped patients live every day to the fullest.

Staff were fully 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 including preferred place of death and ceiling levels of treatment. The ceiling level of treatment is the "upper limit" of treatment for a patient in the eventuality of the patient becoming acutely unwell or deteriorating from a chronic illness. By completing advance care plans patients were planning for future health and treatment options if they should lose their decision-making capacity. It captured their values and wishes and enabled them to continue to influence treatment decisions even when they could no longer actively participate. The advance care plans we reviewed during our inspection were comprehensive and documented discussions with the patient and their family. We observed this in the handover and multidisciplinary team meetings we attended. We saw it recorded in care records and through discussions with people who engaged with the service. People told us they felt listened to, respected and had their views considered.

Relatives of patients we spoke with felt they and their loved ones had received the information they needed to understand about and make informed decisions about their care. Information was explained gently and with sensitivity, questions were never ignored or remained unanswered. We were told they were kept fully informed, staff had time to answer questions and would answer in a way they could understand.

Patients whose preferred place of death was home, were referred to the palliative community response team (PCRT) for daily support and symptom control where possible. We read many thank you messages from family members expressing their gratitude to staff for the care and support they had provided. For example, one relative wrote, 'With the help of the PCRT my husband passed away in comfort with his family around him.'

The hospice used patient and relative feedback to make improvements to the service. All feedback was seen as valuable and a way to improve services. Staff recognised how important the time patients had left was and sought to gain and act on feedback promptly. Staff were committed to helping patients live every day to the fullest and worked tirelessly to achieve this. Feedback showed how much the care and support of staff had meant to patients and how much it had benefitted them. For example, 'I leave the day therapy unit feeling like myself again', and 'thank you for making my husband's last two weeks so special'.

Are Hospice services for adults responsive?

Outstanding ☆

Hospice services for adults

Outstanding ☆

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

Service delivery to meet the needs of local people

The hospice, and its multidisciplinary team, proactively planned its services and provided care in a way that took into account and, quickly and responsively, met the preferences and needs of local people and the communities it served. The hospice, and its team, worked with others in the wider system and local organisations to plan individualised and highly responsive care that promoted equality, including for those with protected characteristics.

The hospice had recognised the urgent need to provide more care to more people in the local area. Therefore in 2016 it launched a five-year strategy focussing on expanding its current hospice, moving to a new purpose-built, state-of-the-art facility and to create a centre of excellence for modern hospice care. This included increasing its inpatient unit from 15 to 28 beds. Stakeholders including the local NHS trusts, clinical commissioning groups (CCGs), users of the service and staff were consulted to plan a service that met the needs of the communities it served and could adapt to changes in healthcare in the future. The new hospice opened in October 2020 and was supporting twice as many people at every stage of their life-limiting condition. Even during the COVID-19 pandemic where face to face services, such as the daily therapy unit, were closed, the hospice ran activities online over social media platforms and keep in contact with patients and their families through telephone conversations.

The services provided by Thames Hospice reflected the needs of the population and promoted flexibility, choice and continuity of care. The specialist palliative care services aimed to ensure local people were cared for in their preferred place of care and death. This was not limited in terms of diversity, ethnicity, culture or aimed at any particular community group. It was available to all people requiring specialist palliative care, symptom management or end of life care. The hospice worked collaboratively with others in the wider system and local stakeholders to design and plan palliative and end of life care services. The hospice provided inpatient services, day services and ‘at home’ palliative and end of life care services to support the local community with individualised person-centred palliative and end of life care.

The inpatient unit (IPU) admitted patients in their last phase of life and saw patients where there was no active or curative treatment. The unit also offered patients with a life limiting illness respite care. Patients could be admitted to the inpatient unit to help relieve pain and manage symptoms, so they were able to return home again.

The hospice had identified, through audit, some patients who had spent time on the IPU and had been discharged to care homes had a shortened mortality potentially because of the move. The hospice worked with the local CCG to provide a continuing healthcare package to these patients. This meant the hospice could accommodate people who were expected to live beyond two weeks. This programme had been successful in alleviating the stress and anxiety associated with a move to a nursing home for patients and their relatives.

Clinical staff were trained to support patients with more complex needs such as patients requiring intravenous antibiotics and fluids and blood and iron transfusions. During the COVID-19 pandemic the hospice assisted the local NHS trust in providing a blood transfusion service as some patients were unable to visit the hospital.

Due to a reduction in hospice inpatient beds in the wider local community, Thames Hospice was approached by the CCG to help support these patients. At the time of our inspection, the hospice had turned the ambulatory care room into an inpatient bedroom and were looking for other ways they could support longer term plans.

The palliative care response team (PCRT) cared for patients in their own homes. The team worked collaboratively with others in the wider system to design and plan palliative and end of care services for patients in the local community. This included local GP surgeries, care homes, district nurses from the local trusts and mental health teams. The PCRT included a rapid response team that could make urgent visits to people in distress. During our inspection we observed visits made by the PCRT, which included visiting a patient who was in need of an urgent admission to the inpatient unit which was facilitated by the team and the patient was admitted that evening.

The hospice had recognised a need during the COVID-19 pandemic for non-medical prescribers in the community. At the time of our inspection, the hospice was funding two community clinical nurse specialists to become non-medical prescribers. A non-medical prescriber is a health professional who is not a doctor but can prescribe medication. The hospice had received funding to train two nurses per year for the next four years. This meant, going forward patients in the community could be prescribed medication without waiting to see their doctor which could help to relieve their symptoms quicker without compromising patient safety.

The hospice provided training and support to care homes, this had increased during the COVID-19 pandemic. For example, the hospice had increased its training of verification of expected death to care home nurses, as GPs were not visiting homes and verification was being delayed causing distress to loved ones.

The day therapy services offered help with specialist palliative care needs so patients could continue living at home safely and in comfort. Patients under the care of the day services had access to treatments which otherwise they would have had to attend the local hospital. For example, lymphoedema clinics, physiotherapy and gentle exercise and occupational therapy. Complementary therapies were also offered such as massage and a bathing service.

The hospice used volunteers. Some of the volunteers were drivers who picked patients up and took them home from the day hospice, which made the day hospice accessible for them.

The hospice was actively working to reach those groups that were deemed vulnerable and historically had not accessed hospice services. The hospice had an overlooked minorities group that met monthly which included representatives from the local community groups and members of the hospice team including the director of nursing, patients and family services. The hospice had recruited an individual into a two day a week liaison role. Their task was to link and reach out to the community. Through this project the hospice had worked closely with a local homeless charity and had been supporting two people who were homeless. The hospice had also set up an Asian woman's group who supported women from the local community, as there was a large Asian population in the hospice's catchment area.

The hospice had recently extended its service to support and care for people aged 16 to 18, as they realised there was a gap in services in the local area for this age group. The hospice had risk assessed and put procedures and processes in place to make sure they could offer a safe service to this age group. They also made sure the right support was available to staff who would be involved in the care of these younger patients. Staff were extremely proud to be able to offer care and support to these patients and their families. Following the expansion of the service the hospice had started to collaborate with local children's hospices and organisations to establish a transitional service for people moving from children to adult services.

At the time of our inspection, the hospice was about to launch its new Living Well service. The aim of the service was to give people, who were at the end of their life or living with a life limiting condition with or without specialist needs, the skills to live well with their condition. The service would be open to all and would provide different and varied activities to ensure people's personal needs and requirements would be met, as well as providing education, support, stimulation and promoting living well with an illness. Before attending the Living Well service patients would need a first appointment completed by a specialist practitioner where patients would be assessed and could be signposted to other services if needed, such as physiotherapy or counselling services. The hospice staff were excited to be starting this new service with the hope of reaching more of the community than the traditional day therapy unit (DTU). They wanted to introduce more patients to the hospice and show the services they could offer to help care for them. The hospice was mindful of the patients who currently attended the DTU and how important this service was to them. Therefore, staff were continuing to run the traditional DTU with alternative drop-in sessions and a lunchtime service still available to them. All new referrals to the DTU would be offered a six-week programme running two days per week. As the Living Well service was new to the hospice staff intended to monitor, evaluate and make changes if and when necessary.

When the hospice was designed leaders wanted it to be integral to the community. For this reason a café, open to the general public, was seen as an important part of the design. The café generated money for the hospice but more importantly helped local people familiarise themselves with the hospice, learn about the services, care and treatment it offered and to become a less scary place. During our inspection, the café was busy with visitors to the hospice and people from the local community who had popped in to enjoy the food and drink.

Meeting people's individual needs

The hospice, and its multidisciplinary team, put people's individual needs and preferences central to the delivery of its services. The service was inclusive and responsive in its tailored care to meet the individual and complex needs of its patients. 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 about what was important to them. 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 supported the choice of patients and their families through advance care planning. The hospice teams worked proactively to deliver care in a way that met the needs of patients. This was evident in the handover and MDT meetings we attended during our inspection and from feedback from patients and their families. Staff were committed to the vision of the hospice, 'quality of life, to the end of life, for everyone' and worked to deliver this to every patient. We heard many examples where staff had fulfilled individual wishes to ensure the time patients had left with their loved ones was memorable and positive.

Where patients had a preferred place of death attempts were made to facilitate this. Partnership working took place with hospice services and other external agencies to enable discharges so patients could die at home if this was their wish. We saw relatives' feedback thanking the hospice for enabling their loved ones to die at home.

Staff had training to be able to support patients with complex needs such as learning disabilities, mental health concerns and dementia. 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. We were given examples when this had occurred.

The hospice's facilities were designed to meet the needs of the full range of people who used its services. The building was designed to be accessible to patients and visitors with all its operational services and inpatient rooms located on the ground floor, corridors were wide for wheelchair users and people with mobility difficulties and there were accessible toilets.

Other facilities in the inpatient unit (IPU) included the sanctuary, a dedicated space offering patients and their loved ones somewhere to have peace away from the IPU. This area had views of the hospice gardens and the lake and was also used to host special occasions for families such as weddings, christenings and blessings. There was the family room, a dedicated space offering families with children an area to relax. This room included a television, a kitchenette, age appropriate toys and its own garden with sculptured wooden animals. The IPU also had a dedicated visitor's bedroom with ensuite facilities. Each of the inpatient wings had its own kitchenette area which included a microwave oven and fridge

Managers made sure staff, and patients, relatives and carers could get help from interpreters or signers when needed. The hospice had a list available of staff and volunteers who could provide interpreting services if needed which included Punjabi, Polish and German. A telephone interpretation service was also available as required.

The hospice offered an alcoholic drink and nibbles to patients before their lunch on the day therapy unit (DTU) and before their evening meal on the IPU if medically appropriate. Staff told us of the benefits to users and non-users, this included extra calorie intake, but also social benefits and a sense of normality in a clinical environment. It also conveyed a sense of valuing the individual as a person rather than a patient. We observed patients enjoying their alcoholic beverage over their lunch in the DTU and could see it was very much enjoyed.

The hospice had opened during the COVID-19 pandemic where restrictions were in place regarding visitors to the hospice. The hospice had not stopped visitors to the IPU but visitors had to be tested for COVID-19 and adhere to government guidelines. At the time of the inspection COVID-19 specific procedures were still in use at the hospice, with visitors needing to be tested for COVID-19 and PPE to be worn in certain areas. The hospice reviewed their policies every three months or sooner if required and reviewed their organisation COVID-19 risk assessment monthly.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

The hospice had effective processes to manage admission to the service. Referrals came mostly from GPs, specialist palliative care nurses, community clinical nurse specialists and the local acute NHS hospital. Patients could refer themselves if they had been diagnosed with a life-limiting illness. The hospice was able to meet the needs of patients who would benefit from the service at the point they needed it. The palliative care response team (PCRT) provided a single point of access to patients on the palliative end of life care register. Once referred to the PCRT, patients and carers could access support and advice over the phone 24 hours a day, seven days a week. From when the hospice opened in October 2020 to July 2021 the number of patients on the PCRT caseload was an average of 431 per month. This was calculated as individual patients with at least one telephone call or visit from PCRT. In the same period, the PCRT received an average of 965 calls per month and carried out an average of 319 face to face visits per month.

Patients referred to the day therapy unit (DTU) were referred in the same way as patients needing community services. In addition, the clinical nurse specialists (CNSs) working in the PCRT could refer patients to the DTU. Patients admitted to the inpatient unit (IPU), if appropriate, could use the services which we observed during our inspection. When the service changed to the Living Well service the referral process would remain the same.

Referrals to the IPU were through a single point of access and were assessed at the daily handover meeting each morning. Patients were triaged and admitted according to the capacity and occupancy on the inpatient unit and the needs of the patient. Priority of admission was a shared decision-making process amongst the inpatient team with input from all specialities. Patients would be prioritised by the following criteria, patient safety - are they in a place of care?, what are the complexities?, and how long have they been waiting?. We observed this process during the handover meeting and could see the needs of the patients were considered and debated before a decision was agreed on who to admit. Once the decision had been made, the inpatient admission/discharge facilitator would organise and prepare for the patient’s arrival. The admission and discharge facilitator practically and actively supported patient transition into and out of the IPU. Most admissions occurred during the day, but the service would admit out of hours and at weekends when necessary, to meet patients care needs and preferences. At the time of inspection, six patients were awaiting admission to the IPU.

The service aimed to admit patients on the same day as referral wherever possible. From Oct 2020 – to July 2021 data showed average inpatient bed occupancy was 86%. This was in keeping with the hospice target of 85%. For the same period, over 83% of patients were admitted the same day they were referred. The figures reflect that not all patients who had been referred wanted to be admitted the same day. Patient choice was always considered along with clinical need.

There were discharge processes to ensure patients could be safely discharged home to their preferred place of death, wherever possible. These included liaising with the PCRT and other hospice services such as occupational therapy team and pharmacy to ensure an appropriate care package was in place.

During our inspection, we observed there was coordinated care between the hospice services and good links with the local hospital palliative care team, GPs and the local district nurses. This meant everyone involved in the patient’s care were informed of the person’s changing health and social care needs. This benefited patients by providing coordinated care, treatment and well-being at a distressing time.

The patient care and quality monthly meeting reviewed data from Thames Hospice services such as occupancy rate, and length of stay. 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, comprehensively investigated them and shared lessons learned with all staff and other agencies where applicable. The service consistently included patients and their carers and families in the investigation of their complaint and could demonstrate how improvements had been made.

Thames Hospice took concerns and complaints very seriously as they were passionate in ensuring patients and their families had the best experience possible when using the hospice services which were often at a period of emotional distress.

The hospice followed the feedback and complaints policy. The policy included a complaints flowchart to follow to make sure all steps were completed correctly. The complaints policy stated that complaints would be acknowledged within three working days, and routine complaints investigated and responded to within 20 working days. Where the complaint investigation took longer than 20 working days, a holding letter was sent to the patient, explaining why the response was delayed.

The hospice chief executive had overall responsibility for the management of complaints. Complaints were logged on the electronic reporting system. Complainants were offered a face-to-face meeting or a telephone call with the hospice chief executive and appropriate staff such as the director of nursing, patients and family services. At the end of the process a formal letter would be sent to the complainant which had to include how the complaint had been investigated, conclusions drawn, what action was to be taken following the complaint and next steps the complainant could take if they were not happy with the outcome.

All staff we spoke with were aware of the complaints 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. Emphasis was placed on listening to the patient or relative to identify their needs and to address their concerns in a manner that improved outcomes for them, wherever possible. If concerns could not be resolved informally, patients and/or those close to them were supported to make a formal complaint. Staff told us the service received very few formal complaints, which was validated by the number received within the inspection reporting period.

The hospice displayed information about how to raise a complaint and the hospice’s feedback and complaint policy was on the Thames Hospice webpage on the internet. Complaints could be made in person, by telephone, and in writing by letter or email. In addition, patients could raise concerns using the hospice’s feedback opportunities such as, *Have your say* leaflet.

Staff said learning from complaints and concerns would be communicated to them mainly at handovers, team meetings, emails and notice boards. All 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.

From Oct 2020 to June 2021 there had been four formal complaints received. Complaints were reviewed at the quarterly governance and health and safety committee meeting to identify any themes or trends and if any changes in practice were required. At the time of our inspection all complaints had been resolved and closed. We reviewed documentation relating to complaints and saw a thorough investigation of the concerns raised had been conducted which involved the family. The response letter was sensitively written and included the staff’s sincerest apologies for any distress caused. A clear response to the concerns raised was provided including the learning and actions taken to improve. Complaints were investigated and responded to in line with hospice policy.

The hospice monitored feedback and celebrated positive comments. Information was collected from many sources, including feedback cards, social media and from the electronic tablet which patients and visitors used to check out from the hospice, which had an option to score the hospice and write a short comment. The tablet also logged which area of the hospice had been visited. All feedback was collated so the hospice could breakdown compliments by service, examine what was making the biggest impact on people using the service and feedback peoples' thanks to the staff. We reviewed data from the electronic tablets and saw from April 2021 to June 2021 97.2% of feedback was good or above, with 92.0% being excellent the top score. Compliments were discussed at the governance and health and safety committee meeting and common themes identified. These included, the whole family feeling cared for not just the patient, how care was focussed and individual for the patient, and how caring the staff were.

Are Hospice services for adults well-led?

Outstanding ☆

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

Leadership

Leaders at all levels had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced and had successful leadership strategies in place to ensure sustainability in the desired culture. They were highly visible and approachable in the service for patients and staff. They supported staff to develop their skills, including management and leadership skills and take on more senior roles.

The senior management team (SMT) had an inspiring shared purpose and strived to deliver and motivate staff to succeed. The team had a wealth of experience and expertise developed from working in the palliative care sector and different areas of the health service. 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 medical director, director of nursing, patients and family services, finance director, director of people, director of fundraising and marketing and the director of retail. The SMT were 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 and one of the trustees. They spoke with pride about the care the service provided. The role of the trustees was defined with a summary of their role and their main duties and responsibilities. Members of the board chaired various board sub-committees, which meant trustees were expected to have an awareness of external issues that might impact the hospice. The board of 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. Trustees had annual appraisals. At the time of our inspection there were 12 trustees from a variety of backgrounds, including clinical and financial.

Hospice services were managed by heads of services, for example the head of inpatient unit and head of clinical data and administration. Leadership at this level was strong and they were trusted to manage their services and reported into the SMT. The heads of services worked closely together for the good of patients. This was demonstrated in the design and running of the Living Well service that involved many areas of the hospice.

The senior management team and heads of services understood the issues, challenges and priorities in their service, and beyond, and proactively sought to address them. A culture of continuous improvement and service development was a common thread throughout all areas of the hospice. They worked collaboratively within the hospice and with partner organisations, stakeholders and other agencies to deliver high-quality, patient and family-centred palliative and end of life care services.

The hospice provided good development opportunities for staff by supporting them to develop leadership and management skills through both formal and informal learning. Staff were encouraged to learn and build on their prior knowledge. The hospice had promoted from within as well as recruiting from outside. This meant there was a good balance of experience and new ideas in the leadership roles at the hospice.

Staff we spoke with were positive about the leaders of the service. They told us they were very visible, approachable and they felt well supported and we observed this during our inspection. All staff we spoke with told us they could access a member of the leadership team. They told us they felt valued and could openly discuss issues or concerns which would lead to resolution. Staff told us that both the chief executive and director of nursing, patients and family services did back to the floor shifts, including at night. This offered valuable insight, kept senior managers in touch with the reality of working at the hospice and that patients were at the centre of all that they did. Staff at all levels valued this.

Vision and Strategy

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

Thames Hospice’s vision, mission and values were focused on providing high-quality palliative care for patients and those close to them living with life-limiting conditions. Thames Hospice vision was, “Quality of Life to the End of Life for Everyone”. The mission was, “We aim to provide and enable excellent care, comfort and choice to people facing life-limiting illnesses in our community through partnership with our patients, their loved ones and colleagues.”

There was an established set of values, which were:

Compassion – Compassion for everyone in a safe and caring environment

Ambition – The desire and determination to serve everyone in our community

Respect – Respect for everyone’s dignity

Excellence – Committed to excellence in everything we do

We observed staff worked in a way that demonstrated they upheld the vision and values of the hospice in practice and kept exceptional patient care as the basis for all they did. The appraisal process incorporated the values and behaviours expected of staff. We saw the hospice vision, mission and values were publicly displayed throughout the hospice, with the values ‘CARE’ on the main wall in the café overlooking the lake. Staff we spoke with could articulate the vision and values.

Hospice services for adults

Thames Hospice had developed a three-year strategy for 2021 to 2024 that after moving into their new facilities was focused on developing and growing services, reach and reputation rather than on buildings and facilities. The new strategy had been developed in collaboration with staff, service users and external partners, and was aligned to national recommendations for palliative and end of life care, and their local integrated care system (ICS). It had also drawn on the experiences and challenges faced through the COVID-19 pandemic.

The strategy had four main strategic ambitions, relating to staff, delivery of services, finance and charity work. Each of these strategic ambitions had strategic aims that complimented them by offering further detail and clarity regarding the ambitions. A dashboard of strategic aims was used in senior committee meetings and at board to give an overarching view of organisational performance to make sure decisions were in keeping with the strategy and values of the hospice and progress was delivered. Teams had work plans, objectives and key performance indicators to allow systematic monitoring.

Culture

Staff felt respected, supported and valued with an emphasis on strong collaboration and team-working. Staff were very proud to work for the hospice and could articulate why. There was a common focus on providing the best possible care to patients and continually improving the quality of care and people’s experiences. 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 and were confident to do so. The service used these as an opportunity to learn and improve the service.

We observed a culture of commitment, collaboration, support and respect across all departments and teams within the service. It was evident staff were passionate about the care they provided and were proud to work at the hospice. Staff told us they loved their jobs and were committed to providing the best possible care for patients and those close to them. They felt it was a “privilege” to care for people at the end of their life. Throughout our inspection, 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. Every staff member we spoke with remarked on the real sense of team working throughout the hospice. Staff did comment that working in a new larger facility had changed working relationships due to the geography of some of the teams in the building. However, senior staff were aware of this and were looking at ways to address it. For example, the new living well service would see the community and day therapy service working together more closely and organising cross-department training.

Staff told us they felt supported, respected and valued. They described the culture within the service as open and positive. Leaders were visible, accessible and supportive. The senior management team promoted an ‘open door’ culture and it was evident staff felt confident to voice any concerns or issues they had. 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 which staff could easily access from the hospice intranet.

The culture of the service was centred on the needs of patients and those close to them. We heard many examples where staff exemplified this during our inspection, such as the lengths staff went to, to meet the individual needs and wishes of patients and to help them live each day to the fullest. Many of the volunteers who worked at the hospice had done so for many years at the hospice’s previous locations. Many volunteers had connections with the hospice, for example a relative or friend had been cared for by the hospice, and this was the reason they had started to volunteer. This was testament to how positively former service users felt about the hospice and the care they provided.

Senior leaders spoke with pride about the work and care their staff delivered daily. They celebrated staff success by sharing positive feedback received and positive contributions made by staff. Staff at every level were supported with their development needs. This included high-quality appraisal and career development conversations.

Staff well-being and safety was seen as extremely important and this was highlighted more due to the COVID-19 pandemic. The staff had access to a 24 hour telephone-based helpline which gave advice on such issues as stress and anxiety and financial wellbeing. The hospice's own counselling team were available to offer support and advice. Each month in the staff magazine, there would be articles on staff well-being and tips and advice on mental and physical well-being at work. The hospice ran well-being classes for staff, we were told about mindfulness and breathe sessions and the weekly yoga classes. The hospice had a suite of measures to protect staff who worked alone out in the community such as a working alone policy and mobile lone worker alarms.

The hospice was in the process of appointing mental health first aider roles. These people would be the point of contact for staff who were experiencing a mental health issue or emotional distress. This interaction could range from having an initial conversation through to supporting the person to get appropriate help. Staff would be given training to carry out this role.

The hospice's equality and diversity policy, for employees, was aligned to the requirements of the Equality Act. The hospice had an equality and diversity staff group which fed into the governance health and safety meeting.

Managers and staff understood the importance of staff being able to raise concerns without fear of retribution. The hospice had policies on speaking up and raising concerns and whistleblowing. 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 and details of what freedom to speak up was, and who to contact, were seen on staff notice boards and in the staff magazine.

Governance

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

Thames Hospice had a governance framework in place through which the hospice was accountable for continuously improving their clinical, corporate, staff, and financial performance. The board of trustees and the senior management team through the governance management framework oversaw governance within the hospice. The framework and supporting policies provided the structure for managing and reporting on a range of auditable metrics.

The hospice had groups where specific operational issues were discussed, such as the patient safety group, the infection prevention and control group and medicine management group. We reviewed minutes from these meetings and saw they were effective and included the set of decisions, outcomes and next steps or action items.

Information from these meetings, plus addition information such as patient outcomes and the audit program, fed into the quarterly governance and health and safety meeting. We reviewed these meetings and could see they were planned, structured and followed a set agenda, they were thorough in their content and any actions were recorded and these were reviewed at the next meeting.

Information from hospice meetings led into the quarterly board-led committee meetings of which there were four, the finance and investment, income generation and marketing, HR and nominations and remuneration and the patient care and quality.

The board-led committee meetings fed into the quarterly board meetings. We were assured from reviewing meeting minutes and talking to trustees that the board had effective oversight of the quality and safety of care which enabled them to make sure decisions were in keeping with the strategy and values of the hospice and progress was delivered.

Each meeting had a purpose and there were clear lines of accountability. All levels of governance and management functioned effectively and interacted with each other appropriately. Relevant information from the governance meetings was reviewed by the head of service and team leaders to understand how their services were performing. It was up to them to disseminate this to their teams and to act on any issues arising. 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 and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

There were clear and effective processes for identifying, recording, managing and mitigating risks. The hospice had an up-to-date risk management policy and related policies in place, such as the feedback and complaints policy and incident reporting policy. The aim of the risk management policy was; to promote a risk aware culture; ensure appropriate systems were in place for identifying, assessing and controlling key risks; to maintain effective structure for risk management so that a consistent approach was applied, and; to provide practical instruction and tools for risk management.

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 and the risk owner, alongside mitigating actions and controls in place to minimise the risk. 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 reviewed regularly at hospice governance meetings. We saw evidence of existing risks and new risks being reviewed and discussed, and the closing of risks in the minutes of the patient care and quality committee meeting. There was alignment between the recorded risks and what staff identified as risks within the service, such as the recruitment and retention of staff and the ongoing 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.

The service had an up-to-date crisis action and recovery plan which was accessible to staff and detailed what action should be taken and by whom, in the event of a critical incident involving loss of building, information technology or staff. Emergency contact numbers for managers and services, such as electricity, gas and water providers, was included. The plan was reviewed every six months and updated if needed.

Information Management

The service collected reliable, detailed data and analysed it to drive forward improvements. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The hospice had clear service performance measures, which were recorded and reported and monitored by the hospice and the local commissioners. Data collection was detailed and included data on a range of performance measures and quality indicators, which included audit results and patient feedback. We saw evidence from speaking with staff and reviewing documentation that areas of good and poor performance were highlighted and used to challenge and drive forward improvements.

Where relevant, performance was tracked over time to highlight unexpected variations in performance which warranted investigation. This meant staff could identify at a glance, areas of increased performance or performance trends and areas that required investigation and improvement.

The hospice used information technology (IT) systems to effectively monitor and improve the quality of care. For example, there was a computer system where incidents, near misses and complaints were recorded. The hospice employed specialist staff to manage the IT systems and to collect, monitor and analyse patient safety data. It was their role to make sure data collected was accurate, valid, reliable, timely and relevant.

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 Quality Account available to the public and was published on its website.

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.

Staff had access to up-to-date and comprehensive information regarding patients’ care and treatment. The hospice was using an electronic patient record system which was the same as that used by local GPs and district nurses. There were arrangements to ensure confidentiality of patient information held electronically and staff were aware of how to use and store confidential information.

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

Information governance 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. For example, after a meeting we saw patient's confidential information being returned for shredding. The hospice had appointed a hospice data protection officer and a Caldicott guardian. Leaflets on *Confidentiality and your Records* were available throughout the hospice and information was also available on the hospice website.

Engagement

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

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, community surveys and social media. Feedback was collated and a patient satisfaction feedback report produced. This report 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. There was a dedicated team to make sure the website had quality content and the information available was up to date. The importance of this was demonstrated during the COVID-19 pandemic when some services had needed to close due to government restrictions.

The hospice produced a magazine two times a year to supporters of the hospice and members of the public. This magazine gave updates regarding the hospice, patient's stories and the support the hospice could offer. The magazine also offered opportunities for members of the public to engage with the hospice in fundraising activities and on how to become a volunteer.

Thames 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 many tributes from patient's families who wanted to give back to the hospice for the care and support their loved ones had received.

The hospice had a café which welcomed people to the hospice who used the hospice services and those that did not. 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.

The hospice was proactively reaching out to hard to reach communities to offer support to be people that might not normally use their services.

The hospice worked in partnership with other services providing end of life care to ensure patients' individual needs were effectively met. For example, liaising with local NHS trusts, attending gold standard framework meetings with local GPs. The hospice supported other hospices and gave support to local care homes in end of life care.

Staff views were sought and acted on. There was a staff forum which gave employees an arena to discuss and seek practical solutions to improving their working experience. Meetings had an agenda and were minuted. Staff were invited to take part in the annual staff survey. In 2020 the survey was carried out by a consulting firm on behalf of Hospice UK. This meant the Thames Hospice results could be benched marked against the other 21 hospices that took part. Data collection took part between 28 Sep to 30 Oct 2020, which was at the same time as the hospice was moving to its new facility. Therefore, data collected was not from a timepoint this report covers. However, the consulting company surveyed Thames Hospice staff again in April 2021. 60% of the workforce completed the survey and the hospice scored 82% in the key staff engagement indicators. This was higher than the all hospices average score of 78%. The hospice had analysed the results of the survey and had a series of next steps which included things to improve and a timeline to make them happen.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had an excellent understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research. Leaders were proactive in seeking out ways to enhance the wider healthcare in palliative care.

Thames Hospice was committed to improve the quality of services offered to patients and their relatives. All staff were actively encouraged to think of ways to improve their service. During our inspection we were told of many ways improvement had been made and of further developments to the service. This was demonstrated by the planning that had gone into the new living well service. Ideas had come from staff throughout the services on what was needed to give the best care to their patients.

Thames Hospice was working with the local Integrated Care System (ICS) to implement and embed the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) process into the local health community, including Health and Social Care partners and patient-focused organisations. The hospice had worked with 30 organisations across the ICS since the project began. The hospice was now in the implementation phase with roll out of the project starting July 2021. In addition, the hospice's education and training team was offering online ReSPECT training to the wider healthcare community.

The medical director was leading a partnership with a Professor of Sociology at Brunel University to establish the Thames Hospice as a research hub with the hope of starting research in 2022. This would establish the hospice as a regional centre for palliative care research. The hospice had employed two clinical research fellows who had joined the medical team and would be key members of the research hub supporting palliative care research.

The hospice had introduced a management module for doctors undertaking their specialist palliative care training. This covered areas such as, clinical and charity governance, the medical director role and board governance. Thames Hospice were only the second hospice to offer this training course.

The hospice had introduced a nursing assistant role. A role that was unique to the hospice and was developed to support the nursing workforce and to give a progression pathway for senior healthcare assistants. The purpose of the role was to support the assessment, planning and delivery of care under the leadership of a registered nurse to patients requiring palliative or/and end of life care. The education team developed a six-month training programme which aligned with the Qualifications and Credit Framework (QCF) and was both classroom and competency based. After completing the course successfully, the nursing assistants had additional skills including, being able to care for catheters, venepuncture and cannula and control drug witnessing. This was the first role of its kind to be introduced in the hospice sector. At the time of inspection six senior healthcare assistants had passed the course and were working as nursing assistants. A further seven senior healthcare assistants (HCAs) had started the course in April 2021 with another cohort due to start in January 2022. When we spoke with nurses, nursing assistants and HCAs on the inpatient unit they talked highly about the course, the positive impact it was having on the unit and the benefits for patients and their care and treatment. The director of nursing, patients and family service had been invited to present and share details of the training programme and key learnings at the Hospice UK national conference in November 2021.

The hospice had put in a National Lottery bid to establish and run a post COVID-19 bereavement service. The service would be an additional counselling service which focused on supporting those people who have had a poor bereavement outcome due to the pandemic, either directly or indirectly associated with COVID-19. The bid had been supported across the local ICS and the hospice would be working in partnership in terms of their referral pathway and access to the service.

The hospice had been working with the local clinical commissioning group for 18 months in a bid to set up a domiciliary care service. The service would enhance the care already offered by the hospice by providing personal care at home to people at the end of life. The benefits to the patient included the ability to discharge a patient from hospital or the inpatient unit with an internal personal care package. This could be put in place quickly as there would be no liaising with other agencies that sometimes took time. In addition, the hospice would be responsible for the governance and quality of the service.

The hospice, in collaboration with a local NHS trust, was hosting the neurological conditions multidisciplinary team weekly and outpatient clinics for people with neurological conditions. This was starting September 2021.