The Hospice Charity Partnership

John Taylor Hospice

Inspection report

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

Ratings

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

Summary of findings

Overall summary

Our rating of this location improved. We rated it as outstanding because:

- The hospice consistently employed a variety of measures to assure effective high-quality care. Staff held a specific meeting to look at compliance with national guidance. Outcomes for patients were positive, consistent and met national standards. Compliance with preferred place of death, the integrated palliative care outcome scale and use of advance care planning was very high. There was evidence of excellent multidisciplinary working to ensure patients were able to die in their preferred place.
- Staff went above and beyond to honour patient's wishes at the end of their life; we heard many examples of how staff had achieved this. Patients' feedback was consistently positive. Staff were creative when helping to support patients, and they did all they could to ensure patients' and families' emotional needs were met.
- The service had implemented new ideas and worked with other hospices and services to prevent hospital admissions. Managers encouraged staff to work in new ways to meet the needs of the population; they identified gaps in services and how these could be filled.
- The service was constantly striving to improve, staff were encouraged to start new forums in relation to gaps in the service. The service had implemented a learning disability and neurodiversity group. The group looked at how they could improve the service for patients with a learning disability or those who were neuro diverse.
- The service was innovative in response to the COVID-19 pandemic and changing landscapes. We heard lots of examples of innovation, continuous improvement and learning. Wellbeing was very much on the agenda for the management team and they worked hard to make the hospice a good place to work for all staff.

However:

- Not all mandatory training was up to date due to the impact of COVID-19 pandemic and some of the training information was difficult to interpret.
- Staff appraisal rates were low due to the impact of the COVID-19 pandemic.
- There was no lock on the door directly into the viewing room.
- Some of the wording in the safeguarding policy did not reflect current guidance.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	**Outstanding** ☆	Our rating of this service improved. We rated it as outstanding see summary above for details:

Summary of findings

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Summary of this inspection

Background to John Taylor Hospice

John Taylor Hospice provides specialist care for people living with a terminal illness and their families. The hospice works in partnership with many organisations to provide joined-up services and also provides advice and support to other professionals on issues surrounding specialist palliative and end of life care. The hospice also provides consultants in palliative care, specialist doctors and allied health professionals.

John Taylor Hospice also provides education and training and undertakes research to further the understanding of end of life care. John Taylor Hospice is a charity. Funding is provided by local clinical commissioning groups, donations from the public, and grants and trusts. All services are free for the people cared for by the hospice.

There was a registered manager in post. Hospice services include an inpatient unit, hospice at home services, bereavement services, support from community nurse specialists as well as a wellbeing service. The service is registered with the CQC to provide:

- Personal Care.
- Treatment of disease, disorder or injury.

How we carried out this inspection

We carried out an unannounced comprehensive inspection over two days. We looked at all key questions including if the service was safe, effective, caring, responsive and well led.

The inspection team included a CQC lead inspector and a specialist advisor with expertise in end of life care. The inspection was overseen by Sarah Dunnett, Head of Hospital Inspection.

During the inspection we spoke to 27 members of staff and 12 patients and their families including patients receiving care from the hospice at home service. We reviewed seven sets of patient records.

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

Outstanding practice

We found the following outstanding practice:

- The hospice consistently employed a variety of measures to assure effective high-quality care. Staff held a specific meeting to look at compliance with national guidance. Outcomes for patients were positive, consistent and met national standards. Compliance with preferred place of death, the integrated palliative care outcome scale and use of advance care planning was very high. There was evidence of excellent multidisciplinary working to ensure patients were able to die in their preferred place.
- Staff went above and beyond to honour patient's wishes at the end of their life; we heard many examples of how this had been achieved. Patients' feedback was consistently positive. Staff were creative when helping to support patients, and they did all they could to ensure patients' and families' emotional needs were met.

Summary of this inspection

- The service had implemented new ideas and worked with other hospices and services to prevent hospital admissions. Managers encouraged staff to work in new ways to meet the needs of the population; they identified gaps in services and how these could be filled.
- The service was constantly striving to improve, staff were encouraged to start new forums in relation to gaps in the service. The service had implemented a learning disability and neurodiversity group. The group looked at how they could improve the service for patients with a learning disability or who were neuro diverse.
- The service was innovative in response to the COVID-19 pandemic and changing landscapes. We heard lots of examples of innovation, continuous improvement and learning. Wellbeing was very much on the agenda for the management team and they worked hard to make the hospice a good place to work for all staff.
- The hospice had contributed in the area of research and studies and had a research steering group in place. Areas of research the hospice staff had been involved in included meeting patient needs during the COVID-19 pandemic (day hospice). The impact and implications of COVID-19 on the relational, social and healthcare experiences of hospice care in the West Midlands and The Medicines Management Challenges of injectable Controlled Drugs Prescribed for Anticipatory Symptom Control at the End of Life in conjunction with a local university. The complementary therapy service submitted their first poster to the supportive and palliative care virtual showcase event, 280 people accessed the poster gallery.
- The hospice personal health budget team were shortlisted for a national award in 2021. The project supported 155 patients across Birmingham with support ranging from household chores, to providing beds and linen so people could die at home in comfort and with dignity surrounded by their loved ones. The hospice had undertaken presentations and shared how to refer patients for the government initiative with many external professional teams. Feedback from families included thank you for finding the dog walker, the afternoon tea was lovely, and you don't know how much this means to me.
- The hospice provided a range of learning opportunities to support different specialities in students' development. The hospice provided teaching, mentoring and support to both postgraduate and undergraduate medical students and post graduate speciality trainees. This included tutoring and training students in holistic palliative care to consolidate their learning. They also welcomed physiotherapist and occupational therapists' students from local universities to gain an insight into their role in palliative and end of life care. The hospice had achieved the placement of excellence gold leaf certificate in August 2019 for exceptional student evaluation feedback.
- To keep up with the changes due to COVID-19 pandemic, the complementary therapy service adapted to include a postal service, phone meditations, complementary videos and virtual sessions. The hospice launched the support at home telephone service in 2021 where volunteers telephoned the patient on a weekly basis. The hospice had contributed in the area of research and studies and had a research steering group in place.
- The complementary therapist had been shortlisted by a professional association for complementary, beauty and sports therapists as a finalist for its excellence awards 2021.The complementary therapist also won the inspirational therapist award in a national competition in March 2022.
- The specialist respiratory service involved the management and support of a caseload of patients with chronic life limiting respiratory disease who had complex symptoms that were unresolved with basic measures.
- Hospices of Birmingham and Solihull (HoBS) was set up at the beginning of April 2020 response to the COVID-19 pandemic. This was a collaboration between John Taylor Hospice and three other providers with direct pathways to local ambulance and hospital trusts and as a result had achieved a collective and responsive palliative care service for end of life patients across Birmingham and Solihull.
- The hospice occupational therapist, physiotherapist and respiratory nurse ran a fatigue, anxiety and breathlessness' programme. The specialist course included education, advice and self-management techniques. We spoke to one hospice at home patient who had completed the course, they told us the course was fabulous and how it really helped with their breathing.
- The hospice had set up a palliative support register. The aim of the register was recognised as a way to enable key information about the individual's preferences for care at the end of life to be recorded and accessed by a range of services.

Summary of this inspection

- The hospice had gone out to recruitment for an equality and diversity business partner.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service SHOULD take to improve:

- The service should ensure that mandatory training is up to date and that there is a clear system for recording this, including when mandatory training had been completed elsewhere.
- The service should ensure staff appraisals are up to date.
- The service should ensure that action is taken to ensure the security of the viewing room.
- The service should ensure wording in its safeguarding policy reflects up to date guidance.

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

Our rating of safe stayed the same. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff, however due to the impact of the COVID-19 pandemic not everyone had managed to complete it.

The mandatory training was comprehensive and met the needs of patients and staff. However, not all staff were up to date with annual refresher training due to the impact of the COVID-19 pandemic. We saw that plans were in place to address this.

Managers provided staff with a mixture of online and face to face training. However, the COVID-19 pandemic had impacted on some training figures. We reviewed the hospice percentage module completion report and found compliance with individual modules varying between 50% and 100% completion. Ongoing work was underway to align the two hospice sites that had merged in regard to clinical skills training and statutory and mandatory training. Staff had presented a paper to the provider's people committee in January 2022 and highlighted the need to align the training.

Following the inspection, managers told us their - cardiopulmonary resuscitation (CPR) training completion rates were 20% for medical staff, 49% for the inpatient unit and 25% for hospice at home staff. However, training figures had been difficult for staff to collate due to various reasons such as the merger with another hospice, COVID-19, different types of life support training, the way training was being delivered and changes to staff groups requiring the training following a review of education approaches of both hospices. Managers told us cardiopulmonary resuscitation (CPR) training for clinical staff had also proved difficult to complete due to the as face to face training was not possible due to the COVID-19 pandemic. To improve compliance rates, additional training had been added to the training system including basic life support (BLS) level one and two and paediatric basic life support level two, Sessions for face to face CPR training were about to resume with sessions booked for February and March 2022 with 10 staff per session booked onto this.

Managers recorded overdue updates on CPR on the risk register; managers noted this as being due to a lack of face to face training due to COVID-19 and the merger with another hospice. Managers had recruited a new clinical educator who was due to take up the post in February 2022.

Staff received training on learning disability awareness (89%), and dementia awareness (80%); some staff had also attended the update on Learning from Lives and Deaths - People with a Learning Disability and autistic people (LeDeR) in 2019.

Managers checked mandatory training and alerted staff when they needed to update their training. A monthly report was produced on any incomplete training and sent to the line manager to follow up. Managers were responsible to ensure they allowed staff time during their working hours to complete the modules. Individual staff also received an email around what training they needed to complete, and managers discussed training in staff one to one's.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. Staff received safeguarding training in safeguarding adults and children; 87% of staff had completed their adults safeguarding level three qualification, 70% level two and 82% had completed their children's safeguarding level one; it was not clear from the data provided what the hospice target rate for compliance was. The hospice safeguarding lead was trained to level four and staff knew who the safeguarding lead was.

Trustees told us how the hospice required them to be trained to level one in safeguarding adults. They also told us how they could transfer any training they had completed from other employment, so they did no need to repeat it; this was not clear within the mandatory training figures provided.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The safeguarding lead/registered manager had implemented safeguarding folders with relevant safeguarding information such as flow charts, contact numbers and types of abuse.

Staff were able to tell us about a time when they had raised a safeguarding concern. Safeguarding information including types of abuse, reporting abuse and local contact numbers were available throughout the building should a patient or family need it. Staff provided us with examples of what constituted a safeguarding concern.

The registered manager/safeguarding lead was trained to level four in safeguarding adults and attended regular training events facilitated by the local adults safeguarding board. Staff discussed safeguarding incidents in patient safety group meetings; minutes of the meeting dated September 2021 detailed a specific safeguarding incident and shared the successful outcome following a referral to the local authority. Staff also discussed safeguarding incidents and outcomes in the hospice quarterly integrated quality assurance report.

There was a safeguarding adults and children policy in place. The policy had links to relevant guidance. Roles and responsibilities, definitions and indicators. However, some of the terminology used was out of date. For example, the policy used the term vulnerable adults instead of adult at risk.

The hospice had a chaperone for intimate examination policy in place. Training records showed 75% of staff had completed chaperoning training.

The workforce and development team had processes in place to ensure all staff had the appropriate Disclosure and Barring Service (DBS) checks in place. The team were able to run a report and create a reminder when staff were due for renewal.

Outstanding ☆

Hospice services for adults

Cleanliness, infection control and hygiene

Staff used infection control measures when visiting patients on wards and transporting patients after death.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. All areas visited were visibly clean and clutter free. The hospice had a housekeeping team who were highly visible and active doing their job during the inspection.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Housekeeping staff completed and displayed cleaning rotas in patient areas including the cold body storage area. Staff completed any additional infection prevention control tasks.

The hospice care after death policy detailed measures staff should take if the deceased had been suffering from an infectious disease. The policy detailed a list of infectious diseases for which infection control measures should be taken and the actions relatives and friends viewing the body should take.

Staff followed infection control principles including the use of personal protective equipment (PPE). Personal protective equipment (PPE) was readily available and used appropriately by all staff. We saw good infection control measures were in place. The hospice had a director of infection prevention and control (DIPC) who supported with any interpretations of guidance. The DIPC attended board meetings and reported any issues via the governance route.

All staff adhered to the arms bare below the elbow policy. Staff wore PPE and washed and gelled their hands regularly; hand gel was readily available throughout the building and posters displayed the five moments of hand hygiene. We reviewed the clinical dashboard for October to December 2021 and noted there had not been any healthcare associated infections. Leaders completed hand hygiene audits and shared feedback of findings with staff. Compliance rates for November to December 2021 were 90% and above.

Reception staff asked visitors to complete lateral flow tests to identify if they had COVID-19 on arrival at the hospice. Processes were in place for the testing of staff and patients. There were infection prevention link nurses in post.

The hospice had implemented a COVID-19 forum meeting. The purpose of the meetings was for managers from all clinical and non-clinical areas to discuss COVID-19 related concerns and how they would be managed. The meetings discussed bed availability, personal protective equipment availability, lateral flow testing, vaccinations and staffing. The communications team attended the meetings and team leads were sent a daily update.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff completed I am clean stickers and attached them to equipment to show it had been cleaned.

Environment and equipment

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

Patients could reach call bells and staff responded quickly when called. The patient led assessment of the care environment (PLACE) for 2020 and 2021 had been cancelled due to the pandemic. Improvement to the patient environment continued with plans in place for a bariatric room, young persons' area, refurbishment and an upgraded viewing room.

Staff carried out daily checks of specialist equipment. Syringe pumps for the continuous administration and end of life medicines were kept on site, maintained and used in accordance with professional recommendations. The portable appliance test report dated November 2021 and saw all appliances were tested and recorded appropriately.

The design of the environment followed national guidance. The hospice had space for 20 beds but was commissioned for 16. This enabled double rooms to be single occupancy when required and also provided space for families to stay with their loved ones. Due to the COVID-19 pandemic, the hospice inpatient unit had further reduced its bed capacity to eleven, this meant patients were kept safe.

The service had suitable facilities to meet the needs of patients' families. The hospice had individual en-suite rooms as well as some bay areas. Additionally, there were lots of spaces family and friends could go such as a day room, a quiet corner, visitors' kitchen, meeting rooms and a garden area with a veranda and a summer house.

The multidisciplinary team worked together to identify any equipment needed to provide care and treatment in the home. Following a successful pilot in 2018, John Taylor hospice had been asked to rollout the project of personal health budgets (PHB's) across Birmingham. Patients could use PHB for a range of things including purchasing equipment and had helped prevent delays in getting people home. We reviewed the clinical services annual report and noted during the period 2020 to 2021, 83 patients had joined the PHB project. This supported patients to remain in their own homes and achieve their preferred place of death.

There was a resuscitation trolley located on the inpatient unit. All consumables were in date, staff completed and recorded daily checks in a folder.

There was a viewing room on the inpatient unit for deceased patients waiting for transfer by the funeral directors. The room was suitable for its purpose, however there was no lock on the door directly into the viewing room; this was on the hospice risk register. Following the inspection managers told us arrangements were being made for fob access which they hoped would be implemented prior to April 2022 and that staff were being extra vigilant.

The service had enough suitable equipment to help them to safely care for patients. Equipment was readily available to staff when they needed it.

Staff disposed of clinical waste safely. Waste management procedures were in place; staff used different coloured bags according to the type of hazard. The arrangements for managing waste and clinical specimens kept people safe. There were sufficient clinical waste bins throughout the hospice. An external contract was in place for the removal of clinical waste. There was a guide in place for the labelling, handling and transportation of pathology specimens.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. All patients were monitored through the Australian modified Karnofsky Performance Status assessment tool scale (AKPS) and the Integrated Palliative Care Outcome scale, alongside clinical judgement. Any unexpected deterioration was escalated for review to the medical staff.

The clinical nurse specialist team reviewed deteriorating patients in the community with any unexpected deterioration referred to the appropriate health professional or 999. Staff received training on sepsis with compliance at 100% and there was a sepsis policy in place. Consultants carried out medical reviews most days; ward rounds were consultant led and occurred weekly.

There was a cardiopulmonary resuscitation policy in place. The policy contained adult basic support algorithms, accountability, guidelines for the use of defibrillators, debriefing and support for staff.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed seven patient care records and found staff completed comprehensive risk assessments for people who used the service and staff developed risk management plans in line with national guidance. Patients had individual folders with details such as a manual handling assessment, sling size, type of equipment needed and ability to bath or shower independently.

Staff knew about and dealt with any specific risk issues. Staff monitored patient risk, we saw that risk assessments were completed around pressure ulcers, falls, nutrition and mouthcare. Falls and pressure ulcers, were broken down on an individual basis and reported in the hospices quarterly integrated quality assurance report. Staff discussed root cause analysis (RCA's) at a falls team meeting as well as equipment needs and grants. The clinical services annual report included slips, trips and falls, pressure ulcers and medicines management. The most recent falls prevention audit result for the period October to December 2021 was 100%, the pressure ulcer audit was 86% and the nutritional audit 90%.

Shift changes and handovers included all necessary key information to keep patients safe. Processes were in place to ensure handovers were safe. We reviewed a patient handover document and saw it was comprehensive and contained key information to keep people safe.

Nurse staffing

The service used bank and agency staff to ensure they 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, agency and locum staff a full induction.

The service used a collective of permanent, bank and agency staff to keep patients safe. The workforce dashboard showed that in December 2021 sickness absence rates combined were almost 10% and staff turnover was nearly 4%.

On the day of the inspection staffing levels met patients' needs. However, staffing levels had remained a challenge due to the effects of the pandemic on the workforce, alongside staff sickness and vacancies. As a result, significant numbers of bank and agency staff had been utilised to ensure safe staffing and to maintain patient safety. The hospice had a rota of bank nurses' managers could call on to cover staff absence. The hospice had recently held a recruitment day which was well attended.

The service used bank and agency staff to fill any gaps in service. The ratio of bank and agency staff used was 6% in October 2021, 7% percent in November 2021 and 4% in December 2021. Managers told us they would use bank staff in the first instance to fill any gaps but when this was not possible, they would use an agency. The hospice managers tried to source the same staff wherever they could.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Leaders used a data-based decision-making tool to ensure the appropriate amount of staffing and staffing numbers reflected need. Ward managers wrote a safe staffing report every three months, this was then scrutinised at clinical governance meetings.

Managers made sure all bank and agency staff had a full induction and understood the service. Agency staff told us how they completed an induction which including being observed to complete initial tasks such as setting up syringe pumps.

Medical staffing

The service had enough medical staff to keep patients safe.The hospice had a medical team in place with varied skill mix. The team included an advanced nurse practitioner, nurse consultant, GP specialty trainees, specialty doctors and consultants in palliative medicine.

A weekly planner was compiled and shared with all clinical teams to ensure there was clarity over who was available to cover the inpatient unit and the community services each day.

The service always had a consultant on call during evenings and weekends.Out of hours there was a first on call rota of clinicians responsible for covering inpatient care. The first on call clinicians were supported by a combined rota of consultants in palliative medicine.

The second on call consultants were also available to support the community, hospital and ambulance services looking after patients 24 hours a day seven days a week. Admissions to the specialist inpatient units were available 24 hours a day seven days a week and were coordinated through centralised bed management in the day and by the second on call consultants overnight.

Records

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

Patient notes were comprehensive, and all staff could access them easily. Staff completed and managed peoples' individual care records in a way that kept people safe. Staff obtained consent for sharing any records. A consent to treatment policy as in place which provided staff with a definition of consent, covered mental capacity and different types of consent.

All the information needed to deliver safe care and treatment was available to staff in a timely and accessible way, this included any care and risk assessments, care plans and case notes.

Records had details of the patients emotional, social and spiritual needs alongside their physical health needs. Staff could select care plans to make sure they were person centred; records were legible, comprehensive and clear.

Leaders completed a clinical audit report for electronic patient records dated March 2021. One aim of the report was to ensure care needs reflected needs of palliative care and they were actioned promptly. The report made some recommendations including some actions around the integrated palliative care outcome scale and use of the pain assessment tool.

When patients transferred to a new team, there were no delays in staff accessing their records. The hospice employed a discharge co ordinator whose role was to ensure discharges went as smooth as possible and who linked in with relevant agencies and teams. Staff from the hospice at home team had portable electronic devices which gave them access to patient records when out in the community.

Records were stored securely. Staff stored patient records on an electronic system. Staff needed a secure log in to access patient records a secure log. Staff ensured they kept passwords safe and locked computers when they were not in use. The hospice had an information technology team on site who were swiftly able to arrange any temporary log ins.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. We reviewed a sample of medicines and found they were all in date. All new nursing staff had an induction period with the pharmacist around medicines and controlled drugs.

There was a Controlled Drugs Accountable Officer in place; the hospice also had an on-site pharmacist and medicines management lead pharmacy technician in post. The pharmacy team attended multi-disciplinary meetings and ward rounds to ensure clinical staff made clinically appropriate choices. The pharmacy team also visited patients who required expertise; examples included patients with complex medical conditions and multiple co-morbidities, patients with complex or persistent symptoms not managed by traditional routes and patients with organ failure who required adjustments to their medication to manage symptoms and avoid toxicity in their own homes.

There was a FP10 prescriptions' policy in place which included details around responsibility of medical prescribers, the pharmacy team had responsibility for their monitoring and audit. A prescribing monitoring audit dated April 2020 to March 2021 showed one area for improvement identified was due to an increase in the use of FP10's to reduce travel contact. The new medical team members and new ward pharmacist were not aware FP10's were limited to urgent use where the usual route was not available. As a result, the new pharmacist was made aware and a reminder sent to all medical staff and lead nurses.

The pharmacy team conducted solo visits or where appropriate with a nurse specialist, therapist or a doctor. The pharmacists were prescribers and prescribed within their expertise, including end of life medications. They also supported the living well centre with teaching and helping patients to self-manage their medicines. The hospice reported medicine incidents to the local incident network (LIN).

An up to date medicines' management policy was in place which detailed processes around the use of drugs outside of marketing authorisation (off label), homeopathic and herbal substances and disposal of medicines. The hospice had a service level agreement in place with a local trust for the supply of drugs and pharmacy services.

Pharmacists completed various medicine audits. We reviewed the latest audits for November 2021 around antibiotic usage, self-administration of medicines, missed doses, and the management of controlled drugs and found the hospice was compliant in most areas.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. One patient told us how they had discussed medicines with their consultant and how they felt listened to resulting in a positive outcome.

Staff completed medicines records accurately and kept them up to date. We reviewed five medication administration charts and found staff documented patients' allergies. Medicines' charts were clear, in date, legible and prescribing was in line with current guidance and quality standards. Staff recorded anticipatory medicines appropriately and when required (PRN) medicines on paper prescriptions. The pharmacy team were available to complete medicines reconciliation on inpatients admitted to the ward.

Staff stored and managed all medicines and prescribing documents safely. Nursing staff kept medicines safe in a locked room, within locked cupboards. Staff kept a record of fridge temperatures. The nurse in charge kept the keys to medicines areas; the hospice pharmacist was responsible for ordering any medicines and controlled drugs.

Staff learned from safety alerts and incidents to improve practice. The pharmacist and pharmacy technician were responsible for new prescription orders and the pharmacy highlighted any alerts or recalls. The hospice was signed up to the Central Alerting System (CAS). The system is a web-based cascading system for issuing patient safety alerts; processes were in place to ensure any alerts were cascaded within the organisation. We saw staff discussed medicines' management in patient safety group meetings including any incidents and actions; staff also discussed CAS alerts in patient safety group meetings and medicines management committee meetings.

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.

Staff knew what incidents to report and how to report them. The hospice used an electronic risk management system to record incidents and staff knew how to use this. Following the merger with another hospice a new risk management system was being built to specification.

Processes were in place for the investigation of incidents. Managers reviewed incidents as staff reported them, and staff discussed incidents in patient safety group meetings. We saw staff discussed incidents in detail alongside any actions.

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. Staff had a good understanding of the basic principles of duty of candour. Staff considered duty of candour when discussing incidents in patient safety group meetings.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff received feedback from incidents via a variety of ways such as by email or within meetings. Staff recorded incident data by team and type on a clinical dashboard. Staff discussed root cause analysis (RCA's) learning and documented this in staff meeting minutes.

Leaders investigated incidents. We reviewed three RCA investigation reports and found leaders identified root causes, lessons learned, recommendations and put arrangements in place for shared learning.

Staff met to discuss the feedback and look at improvements to patient care. Staff discussed incidents in various groups including the patient safety group, the medicines management committee and falls groups. Staff also shared information in the quarterly integrated quality assurance report.

Outstanding ☆

Hospice services for adults

Managers debriefed and supported staff after any serious incident. Managers told us they were always available to debrief and support staff if required and how there was always someone from the clinical senior leadership team on call; staff could also discuss any worries in their one to ones.

Are Hospice services for adults effective?

Good

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

There was a holistic approach to assessing, planning and delivering care and treatment to people who used services. The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff holistically assessed people's physical, mental health and social needs, and delivered care and treatment in line with legislation, standards and evidence-based guidance.

The hospice consistently employed a variety of measures to assure effective high-quality care was provided across the hospice. These included workforce monitoring, National Institute for Health and Care Excellence (NICE) guidance, audits and central alerting system (CAS) and The Medicines and Healthcare products Regulatory Agency (MHRA) alert monitoring.

End of life care was carried out in line with NICE QS144 'Care of dying adults in the last days of life' (2017), NICE NG31 'Care of dying adults in the last days of life' (2015) and NICE QS13 'End of life care for adults' (2011).

The hospice had completed a clinical guideline review of NICE QS13 in September 2021 with the aim of improving care for end of life patients. The review found the hospice to be compliant with the guidance; managers made sure hospice policies referenced NICE guidance.

Staff held NICE Action and other Group (NAG) meetings. The meeting looked at different NICE guidance and if the hospice was compliant. We looked at the minutes for September 2021 and saw staff discussed various NICE guidelines, these included guidelines on dementia, safeguarding adults in care homes, venous thromboembolism in adults: diagnosis and management, decision making and mental capacity, COVID-19 and vitamin D.

Patients had clear personalised care plans in place which reflected any complex needs and were up to date. The hospice had policies and procedures in place, with links to guidance and legislation.

The hospice delivered care in the last days and hours of life in line with the five priorities of care of the dying person. The five priorities originated from the one chance to get it right document by the leadership alliance for the Care of Dying People (2014). The hospice delivered the priorities in a variety of ways such as through the provision of palliative study days, patient survey results, embedding of the Karnofsky performance status assessment tool scale and information provision for families and service design. We saw posters displaying information on the five priorities of care of the dying person.

The hospice was taking action to implement the 'Ambitions for Palliative and End of Life Care' A national framework for local action 2021-2026 (2021) We reviewed the hospice ambitions framework action plan; the action plan referred to the ambitions framework and how staff were achieving this. For example, ensuring community access to bereavement support was clearly identified, work programme needed to be developed in supporting the agreed strategy and ensuring shareholders understood the strands of supporting compassionate communities.

Staff assessed patients and completed individualised care plans that detailed any emotional, spiritual and social needs. Staff regularly updated care plans to reflect activities of daily living. Recommended Summary Plans for Emergency Care and Treatment (ReSPECT) documents were in place and completed appropriately. The ReSPECT process creates a summary of personalised recommendations for a person's clinical care in a future emergency in which they do not have capacity to make or express choices.

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, particularly those with specialist nutrition and hydration needs. Staff completed nutritional care plans which detailed any specific nutritional needs. Patients told us staff gave them enough to eat and drink and they were happy with the food provided. We saw one patient had a care plan in place for both enteral feeding and diabetes.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff completed diet and fluid charts and kept them on the patient's file. Staff recorded details of the patient's fluid and dietary requirements on the patient information handover document.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. A catering team was on site seven days a week. Kitchen staff recorded any specific dietary on a board in the kitchen area. Staff told us they would refer patients to the community dietitians if more they needed any additional dietary advice or support.

Staff alerted kitchen staff to any dietary needs and completed a daily catering sheet. Patients told us how staff brought them cups of tea, how they could ask for anything and how staff offered them an alternative if they did not like what was on the menu. Staff offered patients and their family's cake and tea in the afternoons.

Drinking water was readily available to staff, patients and their visitors. In the morning patients could have a choice of what they would like to eat.

There was a nutritional information board displayed on the inpatient unit. The board had details of dysphasia, kitchen operation times, menus, snacks available out of hours and nutritional supplements. There was a seven-day menu in place, patients could request anything they liked if they did not want what was on the menu. Staff told us if they did not have it in stock someone would go out and purchase it. We saw information charts in patients' folders the charts had details of different religions and what foods were forbidden.

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.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff used pain tools appropriately, the Abbey pain scale was readily available if needed. The Abbey pain scale is a tool designed to assist in the assessment of pain in patients who are unable to articulate their needs for example if they had any communication issues. Staff recorded information around patients' pain in a pain care plan when needed.

Patients received pain relief soon after requesting it. Patients and their families told us nursing staff administered pain medicine on time, staff recognised when their loved ones needed additional pain relief and how the correct medicines had been sought to provide good pain relief.

Staff prescribed, administered and recorded pain relief accurately. Staff prescribed anticipatory medicines appropriately in people identified as approaching end of life. We reviewed a copy of the most recent pain management tool dated July 2021 and found the overall compliance rates for various subtopics were between 77% and 85%. The tool considered documented evidence to identify areas to improve and covered three sub topics; areas identified for improvement included what non-pharmacological interventions had worked in the past, the spiritual aspect of pain and the psychological aspects of pain. Areas where the hospice performed better included the possible causes of pain and relieving factors.

Patient outcomes

Opportunities to participate in benchmarking were proactively pursued. Outcomes for people who used the service were positive, consistent and regularly exceeded expectations. Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits. The hospice took part in local and national audits and benchmarking. They benchmarked themselves against other hospices, through a data-based decision-making tool and Executive Clinical Leads in Hospice and Palliative Care (ECLiHP) audits. Areas of benchmarking included bed occupancy, admissions from hospital, average length of stay, inpatient unit deaths, pressure ulcers and slips, trips and falls.

The hospice used patient feedback tools to measure patient outcomes to highlight areas that needed to improve. Patient feedback champions were in post with responsibility for encouraging colleagues to engage with patients and families on the importance of completing surveys to help and shape services.

Outcome data used in reporting to the local clinical commissioning group (CCG) included average length of stay, hospice at home visits completed, specialist care clinical nurse's specialist visits, therapy activity, bereavement, information on advance care planning.

The hospice completed a Hospice UK inpatient submission on a quarterly basis via an online portal. The data submitted looked at severity of incidents, number of incidents and covered falls, beds, pressure ulcers and medications incidents.

Outcomes for patients were positive, consistent and met expectations, such as national standards. Quality and outcome information showed that the needs of people were being met by the service. For example, staff monitored and reported patients preferred place of death through the clinical governance committee. Results showed the percentage of patients who had achieved their preferred place of death was consistently high for example, October (96%), November (98%) and December (98%). Referrers were able to document the patients preferred place of death on the referral form.

Hospice services for adults

We reviewed the hospice quarterly integrated quality assurance report October to December 2021 and noted 100% of service users had an advance care plan in place at the time of death, 100% of patients had expressed a preferred place of death within their advance care. Referrers were able to document if a specific advance care planning document was in use on the referral form.

We reviewed the Hospice at Home end to end report clinical audit report dated March 2021 and saw compliance with the Integrated Palliative Care Outcome Scale (IPOS) was audited. Results showed the IPOS completion rate was 100%.

The hospice was a member of the executive clinical leads in hospice and palliative care (ECLiHP). The forum was for all executive and aspiring executive clinical leaders engaged in the strategic planning and operational delivery of contemporary hospice care regardless of discipline.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The hospice had an annual audit programme, staff reported compliance and results quarterly to the clinical governance committee. Departmental managers monitored and managed action plans any noncompliance escalated and discussed at the clinical governance committee. The audit group agreed a programme of audits annually at the audit group and reported to the clinical governance committee.

Managers used information from the audits to improve care and treatment. The hospice had numerous groups which reported into the board and were imperative in improving patient outcomes. The groups included a clinical audit group, mortality group, medicines management group, patient safety group, neurodiversity group, research and education and a NICE guidelines group. There was a clinical nurse specialist referral audit three-month evaluation report in place (January 2022). The audit was set up as the managerial team were keen to understand the data behind the referrals to the community teams, especially those deemed inappropriate and the reasons these were occurring. The audit report identified discussion points around referrals, the populations, diagnosis codes, ethnicity. As a result of the audit the hospice were able to implement an action plan to improve with actions including continuing to encourage referrals from hard to reach services, setting up clinics in areas of hard to reach groups with independent interpreters and ensuring the environment was suitable for an increasing elderly population. The next audit report was due to take place in April 2022.

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. However, at the time of the inspection appraisal rates were low due to the impact of the COVID-19 pandemic.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff completed training appropriate to their role. This included additional training such as syringe driver training, suction, cannulation, drug calculations and train the trainer courses. The hospice had clinical nurse specialists who supported patients in their home environment.

The specialist pharmacist in palliative care had delivered specialist training courses around medicines including Olanzapine for the treatment of nausea/vomiting in palliative care and symptom management.

Staff told us how managers had encouraged them to develop within the service; for example, two health care assistants were completing a nursing associate course. We heard of examples where staff had been trained to carry out different roles due to the pandemic.

All new nursing staff received a supernumerary induction period of four weeks and worked through competencies during their first 12 months of employment. The hospice supported newly qualified nurses with a mentor for 12 months, and specific competencies such as drug administration.

Managers gave all new staff a full induction tailored to their role before they started work. There was a structured induction programme in place which all staff completed when they started work. There was a John Taylor Hospice Induction pack in place, the pack provided staff with useful information and included checklists which required a manager sign off.

Managers supported staff to develop through yearly, constructive appraisals of their work. At the time of the inspection only 68% of staff had completed their yearly appraisal. Managers told us this was due to priority changes by the management team due to COVID-19 and they had concentrated instead on daily/weekly check ins with staff alongside team meetings. Following the merger with another hospice, leaders were designing a new appraisal process and plan with a view to being launched in September 2022.

Managers supported staff to develop through regular, constructive clinical supervision of their work. Staff were able to access clinical supervision and provided positive feedback around this such as it is brilliant. We reviewed the clinical supervision summary report from June 2021 to December 2021; the report identified 22 staff regularly attended supervision sessions once. Annual appraisals included a section on any training identified.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We heard several examples of excellent multidisciplinary working, for example how the occupational therapist and physiotherapist had worked as part of a multidisciplinary team, with clinical nurse specialists and pharmacists to complete home visits.

We also heard an example of how staff had worked together to arrange a discharge home for an end of life patient within three hours. Working together in this way had ensured patients got their wish to return home, or to have families visiting them at home when they may not have been able to otherwise.

The multi-disciplinary team were based within close proximity to one another which worked very well. This included the social care team, physiotherapists, occupational therapists, management, information technology, governance, the referral team and the Hospices of Birmingham and Solihull (HoBS). Managers held a multidisciplinary team meeting every Tuesday via an online conference where staff discussed the patients.

Hospices of Birmingham and Solihull (HoBS) weekday bed meetings took place with representation from hospices, local trusts, community hospital, palliative care teams. Staff attended several external/multidisciplinary meetings including the integrated operational management hub that met weekly to discuss end of life patients in beds across the community health landscape. Staff also took part in the wound care network with representatives from across the West Midlands sharing practices, which the local trust ran and an end of life collaboration system steering group in collaboration with a local clinical commissioning group (CCG).

Seven-day services

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

Patients could access the inpatient unit 24 hours a day, seven days a week if needed.

The hospice at home team of nurse and health care assistants provided care at home from 8am to 8.30pm seven days a week.

HoBS operated between 8am to 8pm seven days a week. Outside of these hours the clinical nurse specialist handed over to the inpatient unit who would provide any support remotely overnight.

Housekeeping staff were on site seven days a week.

Pharmacists, physiotherapy and occupational therapy services were available were available to patients in the hospice and the community from Monday to Friday.

There was medical and nurse support 24 hours a day seven days a week as an on-call rota was in place.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on units. The hospice used personal health budgets to identify what was the most important to patients their health and wellbeing.

The hospice team provided patients with complementary therapies suitable for patients suffering from a wide variety of symptoms such as pain, anxiety and nausea.

Information boards displayed information relevant to health such as information around nutrition and how to care for your skin; the hospice ran a wellbeing service

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff understood the relevant consent and decision-making requirements of legislation and guidance around the Mental Capacity Act 2005.

We reviewed the minutes from the patient safety group dated September 2021 and saw staff discussed examples of best interest meetings and when staff had put deprivation of liberty safeguards (DoLS) in place had been to keep patients safe. We also saw staff discussed an example when staff closed a DoLS when a patient was reassessed and regained mental capacity.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We reviewed patient records and noted staff obtained and recorded consent. The hospice consent to treatment policy included details such as definitions of consent, mental capacity to give consent, types of consent and refusal of treatment.

Outstanding ☆

Hospice services for adults

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Eighty percent of staff had completed Mental Capacity Act and Deprivation of liberty training. We reviewed the clinical services annual report 2020 to 2021 and saw there had been seven deprivation of liberty Safeguards (DoLS) made over the reporting period and these included both urgent and standard authorisations.

Are Hospice services for adults caring?

Outstanding ☆

Our rating of caring improved. We rated it as outstanding.

Compassionate care

Feedback from people who used the service and those close to them was continually positive and staff went the extra mile. Patients emotional and social needs were as important as their physical needs. Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff treating patients with respect. Staff recorded patient's wishes in handover documents, for example we reviewed a handover document which noted how the patients liked to have their beard groomed. One staff member told us how they had sat with a patient holding their hand as they had wanted to have company.

Feedback from people who used the service and those who were close to them was consistently positive about the way staff treated people. Patients felt really cared for and that they mattered; patients and their families told us staff listened to them, "*were golden*", made them comfortable and took the time to talk to them. They felt staff helped them feel relaxed and calm and how they felt they were always there for them when needed. One patient's family member told us how staff treated them as part of the John Taylor family and how at a difficult time it was a wonderful experience; another told us they would score them 11 out of 10.

We heard many examples of how staff had gone the extra mile to provide patients at the end of their life with care and support that exceeded their expectations. Staff gave examples of where the service had showed a particularly caring approach to the person approaching the end of life and their family. Examples included staff turning an area of the hospice into a beach so the patient could have their wish to take their child to the seaside.

Staff spoke of how they had arranged for sand, ice creams, fish and chips, deckchairs and a photographer for keepsake photographs. Other examples of going above and beyond included arranging afternoon teas, supporting with special Afro Caribbean hair and skin routines, arranging a Halloween party, making memory boxes for children, giving keepsake bears some with voice recordings, hand casts, bringing in lambs, ducks, donkeys, arranging for a patient to hold a bird of prey and arranging of trips to theme parks for patients and their families. We also heard how staff had got together to discuss how they could facilitate a patient's love of music without disturbing any other patients. Staff took time to interact with people who used the service and those close to them in a respectful and considerate way.

Managers understood the importance of patient stories in showing the caring aspects of what they did. However, due to COVID-19 limitations patient stories were not evident in the most recent board reports we reviewed; it was hoped these could resume again shortly.

Staff were highly motivated and inspired to offer care that was kind and promoted peoples' dignity. Relationships between the people who used the service, those close to them and staff were strong, caring respectful and supportive. The relationships were highly valued by staff and promoted by leaders.

Staff followed policy to keep patient care and treatment confidential. Patients told us staff respected their privacy and confidentiality at all times. We saw staff knocking on patient doors before they entered and closing doors behind them.

People's emotional and social needs were seen as being as important as their physical needs. Staff told us how they had recognised when a patient needed some company and how they sat and held their hand; they expressed the importance of having the time for patients and to give them comfort.

Staff provided families of the deceased with practical information on funeral arrangements, registering the death, benefits and grants. The booklet "What do I do now; a guide to help with practical and emotional issues around death", also had contacts for emotional support.

There was a care after death policy in place. The policy described how staff should maintain the privacy and dignity of the deceased at all times, through actions such as moving the patient and drawing curtains and closing doors when transferring the deceased to the cold room. There was a cold body storage area which had access to the outside where funeral directors could collect the body of the deceased.

The hospice had a tissue donation policy and procedure in place. The purpose of the document was to ensure staff considered tissue donation in all appropriate situations and to maximise the overall number of tissue donations through better support to potential donors and their families. The policy detailed the procedure prior to a patient's death, after a patient's death, donation for research, medical schools and specific tissue donation.

Emotional support

Staff recognised and respected the totality of people's needs. Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs and found innovative ways to meet them.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff provided patients with emotional support; the hospice had a pre and post bereavement service provided by their on-site well being team, there was no time limit on how long after a bereavement people could access the service.

The hospice living well centre offered a 12-week therapeutic programme designed to help address symptom control and provide support for physical, emotional and spiritual needs. The service also had a counselling service patients, relatives and staff could access. However, at the time of the inspection managers had closed the living well centre due to the pandemic. The living well team continued to support patients by doorstep visits, weekly telephone calls, virtual one to ones and a monthly newsletter.

The service provided services to help minimise patients' distress. This included complementary therapy in the patient's room or in the complementary therapy room. The complementary therapy room had relaxing music and lighting.

Staff recognised and respected the totality of people's needs. They always took people's personal, cultural, social and religious needs into account, and found innovative ways to meet them. Staff understood and respected the personal, cultural, social and religious needs of people and how these may relate to care needs and spoke of additional training they had received such as being taught about Mecca. We noted staff had recorded when a patient's catholic priest had visited.

Staff had made a poster for a patient with photographs of their family who lived in another country and were unable to visit, so they could see them every day. We heard examples of staff arranging beads for a patient's prayer. Contact details for advice on religious or secular services were available in the hospice information document "What do I do now?" Patient folders had specific information around different religious diets. Managers told us how John Taylor Hospice had access to a wide variety of faith representatives and how they had recently recruited a chaplain as a spiritual care coordinator who was due to take up the post in February 2022.

We reviewed seven patients' care records and found staff had clearly documented the patient's religion. Staff made reference within records of the patient's preferred name.

The hospice offered relatives the opportunity for the bereaved to have an engraved keepsake in their name to remember their loved ones. They had also arranged for hand casts, teddies and voice recordings. Teddies called filled with love had been stuffed, gift wrapped and given to patients. Staff gave the teddies to patients on the inpatient unit to give to families and neighbours.

Understanding and involvement of patients and those close to them

People were treated with dignity, they felt cared for and that they mattered. People valued their relationships with the staff team and felt they went the extra mile for them when providing care and support. Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment. Peoples' individual preferences and needs were reflected in how care was delivered.

People were always treated with dignity by all those involved in their care, treatment and support. Patients and their families told us staff explained information to them, they felt involved and not overlooked and that doctors kept them updated about their care and treatment. Patients told us how the doctors were always honest with them.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Communication aids were available if needed to help people to become partners in their own care and treatment. There were communication tools on the inpatient unit, including tools for assessing pain in patients who were unable to communicate. The hospice had a communications team who helped to ensure they made appropriate messaging available to patients, visitors and staff.

People and their families felt really cared for and that they mattered. They told us they had never known care like it, how staff did not rush and took the time to talk to them. They told us how staff were always there if they needed them, were encouraging and how they had made a big difference.

People valued their relationships with the staff team and felt they often went the extra mile for them when providing care and support. One relative told us how they treated their family member the way they would treat their own family and how staff were friendly, caring, personable and kept their spirits up. Another told us how they would like to work at the hospice if they could.

Outstanding ☆

Hospice services for adults

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Managers displayed "you said, we did" posters showing staff had made changes in response to feedback received. For example, therapy staff had replaced equipment over beds with teaching and assisting patients how to reposition in bed.

Patients gave positive feedback about the service Each patient received an information pack which included a patient survey. All new patients referred into the hospice community teams received a survey after three or four contacts to allow them sufficient contact with the member of staff for them to make an informed opinion.

Patient survey results and feedback were positive with respondents strongly agreeing with the likelihood of recommending the hospice services to family and friends in need of similar care and support.

Staff included patient experience in the quarterly integrated quality assurance report; they shared comments alongside any recommendations for future improvement on the survey. We reviewed the notes from the report dated October to December 2021 and saw actions were identified including continuing to encourage patients/carers and relatives to complete questionnaires, using electronic systems to enhance survey reporting.

Peoples' individual preferences and needs were always reflected in how care was delivered. Staff supported patients to make advanced decisions about their care. Processes were in place to enable staff to support patients with an advance care plan. The hospice had an advance care template they could use if this was the patient's choice. The hospice provided patients with education sessions on advance care planning and future wishes.

We reviewed the slides from a scenario and staff training session on advance care planning; the slides contained information such as advanced decisions to refuse treatment, mental capacity, skills needed to help patients to plan ahead, different documents and national guidance to support. Audits for achieving advance care planning from September 2021 to November 2021 was 100%.

Are Hospice services for adults responsive?

Outstanding ☆

Our rating of responsive improved. We rated it as outstanding.

Service delivery to meet the needs of local people

Peoples individual needs and preferences were central to the delivery of tailored services. There were innovative approaches that involved other service providers. The service was flexible and planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers particularly for people with complex and multiple needs. The hospice inpatient unit provided 24-hour care for specialist palliative care patients and Sandwell and West Birmingham home from home patients. Specialist admissions could be for symptom control or end of life care.

The service was flexible to ensure continuity of care. Managers identified gaps in services and addressed the gaps. Hospices of Birmingham and Solihull (HoBS) was set up at the beginning of April 2020 response to the COVID-19

pandemic. This was a collaboration between John Taylor Hospice and three other providers with direct pathways to local ambulance and hospital trusts and as a result had achieved a collective and responsive palliative care service for end of life patients across Birmingham and Solihull. The service was utilised by patients, their families and professionals in need of advice.

The HoBS service had implemented a central bed management, referral and triage point for patients requiring end of life care linked to the provision of a rapid response service to prevent hospital admissions and care for patients in the community, had supported with crisis management of patients within the community. The rapid response visits provided short term interventions during a patient or carer crisis to try to avoid hospital admission for patients whose preferred place of death was home or hospice. Staff provided us with examples of when the service had prevented hospital admissions. From October to December 2021, one HoBS responder alone had provided telephone advice and support to over 120 people and face to face contact to over 40 people.

The hospice also provided a service for patients in the community, the hospice at home team consisted of nurse and health care assistants and provided up to three calls a day to patients approaching the end of their lives. The hospice employed community clinical nurse specialists the team provided psychological support and specialist symptom control advice in patients' homes seven days a week.

The hospice identified gaps in the service and took action to try to address the gaps. For example, the clinical nurse specialist referral audit report three-month evaluation (January 2022) noted future plans as completing an depth analysis of hard to reach groups, gathering data on protected characteristics and understanding areas of high deprivation and engagement with services.

The hospice had reviewed and updated the clinical services strategy due to the COVID-19 pandemic. Service improvements identified included in reach services for acute hospitals, personal health budgets, hospices of Birmingham and Solihull (HoBS) and through the development of the wellbeing service. The aim was to continue to work in collaboration with other health and social care providers to redesign and deliver series.

The service took action to ensure staff delivered care to people from equality groups and people who may be vulnerable because of circumstances. In November 2021 staff had set up a new forum to raise awareness around neurodiversity and learning disability. The aim of the forum was to improve patients' care and family support and to offer staff support who feel they have personal experience to bring. The group had started to gather information to put on the shared drive around extra training and strategies from the local learning disability teams for improving care and information such as this is me documents and hospital passports, the group was also keen to grow and engage with patients and their families. We reviewed the meeting minutes from November 2021 and saw the group had an update on Learning from Lives and Deaths People with a Learning Disability and autistic people (LeDeR).

The hospice engaged with people and their families in the design and running of the services. We reviewed the carers support needs assessment tool (CNAST) audit and results dated July 2021. The audit had helped to find the most common carers concerns and themes including having time to themselves, dealing with feelings and worries and knowing who to contact at night. This helped the hospice to show how they could develop community palliative care and hospice services based on the requirements of the caring population. We heard an example of how a family had been invited to be involved in ongoing work around improving services for patients with a learning disability following a complaint.

The hospice pharmacy team accepted community referrals for home visits to patients with specialist needs, the team offered support and advice in areas such as drug choice and anticipatory medicine.

Hospice services for adults

The specialist respiratory service involved the management and support of a caseload of patients with chronic life limiting respiratory disease who had complex symptoms that were unresolved with basic measures. The respiratory specialist nurse liaised with case managers, GPs, and specialist teams in the community to ensure patients were comfortable from a symptom perspective and also to ensure completion of advance care planning where possible.

The hospice had a wellbeing team which offered patients psychological and spiritual support. The service was available for hospice patients and their families both pre and post death including children and young people, individuals, families and groups.

There was a living well centre on site. The living well team offered a 12-week therapeutic programme designed to help address symptom control and provide support for physical, emotional and spiritual needs.

The on-site complementary therapist offered a variety of therapies to patients and staff including Reiki and aromatherapy massage, aroma sticks and meditation. The therapist had a room where they could see people, or they would go to the patients on the inpatient unit if more appropriate. We reviewed the complementary therapy service report 2020 to 2021 and saw the service had treated 1196 patients, families and staff. The complementary therapist had been shortlisted by a professional association for complementary, beauty and sports therapists as a finalist for its excellence awards 2021. The complementary therapist also won the inspirational therapist award in a national competition in March 2022.

The bereavement service referred families for complementary therapy to work alongside their treatment plan. The service had made 703 telephone contacts and carried out 131 virtual sessions.

The hospice had a team of physiotherapists who provided holistic assessment of symptoms and collaborative treatment plans to palliative patients within the hospice or at home. The techniques used aimed to provide palliative rehabilitation to improve physical symptoms such as reduced functional ability muscle strength and mobility, pain, dyspnoea and fatigue.

The hospice had implemented a fatigue, anxiety and breathlessness programme, the hospice occupational therapist, physiotherapist and respiratory nurse ran the nine-week programme; the specialist course included education, advice and self-management techniques. The aim of the programme was to educate and equip patients with respiratory disease to self-manage their condition and consequent symptoms and prevent hospital admissions. Session topics included stress, anxiety and breathlessness, sleep management, nutrition and dietary advice, social support and advance care planning, breathing techniques and medicines management. The programme took a multidisciplinary approach.

The support at home service provided social and emotional support to families and carers of individuals with life limiting illness. Support included short breaks, social support, practical support and signposting. The hospice launched the telephone service in 2021 where volunteers telephoned the patient on a weekly basis for a general chat which may be around hobbies, what book they were reading, what TV programmes they were watching to the weather.

Patients' families were able to order a meal from the kitchen if they wished. There was a visitor's area for families to make themselves something to eat and drink; however, at the time of the inspection the hospice had limited access due to COVID-19. Staff offered visitors refreshments and there was drinking water available on the inpatient unit. There was access to drinks and snacks in the reception area.

Hospice services for adults

The hospice HuB social team offered patients a variety of support including continuing healthcare referrals for packages of care, referrals to external agencies for day sits, cleaning and shopping, arranging key safe access, telephone shopping, attendance at multi-disciplinary meetings, and referrals for young carer support. The team was set up during the pandemic and had arranged 471 packages of care to help avoid hospital admissions and had provided over 150 referrals to external teams and services.

The hospice had set up a palliative support register. The aim of the register was recognised as a way to enable key information about the individual's preferences for care at the end of life to be recorded and accessed by a range of services, The aim of holding the register was to improve coordination of care so end of life care could be more proactive and patient's wishes could be better adhered to with more patients being able to die in the place of their choosing with their preferred care package and not be admitted to hospital . The register was set up in 2021 with key benefits including promotion of a seamless service, fewer hospital admissions, less family distress, key advice and support regarding patient's diagnosis and prognosis to external professional teams out of hours.

There was a visitor information board on the inpatient unit. The board had information had information on carer support, personal health budgets, opioids, caring for skin and thromboprophylaxis as well as have your say leaflets. There was also an information board on admission to the inpatient unit with the details and photographs of the staff on duty that day.

Facilities and premises were appropriate for the services being delivered. At the time of the inspection managers had reduced bed occupancy due to COVID-19 and staff cared for patients in their own rooms. The hospice had a car park with disabled parking available; corridors were wide and there was a spacious new lift in situ.

Meeting people's individual needs

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

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. There was a shared drive in place which had information for people living with dementia including the this is me booklet, dementia support, educational resources 'and a link to national guidance. The hospice had made some changes to help meet the needs of patients living with a cognitive impairment such as dementia; for example, staff had put up directional signs and painted doors.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff had access to a hearing loop and communication tools to aid in communication.

The service had information leaflets available in languages spoken by the patients and local community. The John Taylor welcome sign carried eight languages spoken by communities across the city including English, Irish, Polish, Urdu, Bengali, Hindi, Punjabi and Arabic.

Patient televisions could access different channels to meet their diverse requirements with languages including English, Hindi, Tamil and Punjabi. In November staff had created a special Diwali card and sent it out to patients. Some staff spoke a variety of languages with the Wellbeing Service being available in English, Urdu, Hindi and Punjabi.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff were able to access translations services when a patient's first language was not English. The hospice had a counsellor who was able to speak several languages.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Staff documented and made other staff aware of any religious needs, for example we saw it documented a patient was Muslim and required a halal diet. Staff working on the inpatient unit provided kitchen staff with information on any specific diets to meet cultural and religious preferences.

Access and flow

Patients could access services and appointments in a way and time that suited them. Access the specialist palliative care service when they needed it. Waiting times from referral to achievement of preferred place of care and death were in line with good practice.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. The hospice referral form clearly identified the criteria. There was a clinical dashboard in place which detailed the referral figures and contact times for the service. Staff discussed the admission list each morning, the bed manager, clinical nurse specialist and staff from another hospice attended the meeting.

People did not have to wait long to access the service. We reviewed the data for October 2021 to December 2021. The hospice achieved 100% in relation to timely access to inpatient admissions, hospice at home, the clinical nurse's specialist service and the wellbeing service.

People with the most urgent needs had their care and treatment prioritised. There were urgent and non-urgent referral processes in place, this meant people with the most urgent needs were prioritised. Professionals were able to record the urgency of the referral on the referral form. For those identifying an urgent referral the referrer needed to follow the form up with a telephone call for immediate advice.

Referrals came into the hospice via HoBS and administration support staff shared these with three other hospices. Staff inputted the information and any attachments were added into the system. Administration staff sent a task alert to the clinical nurse specialist to alert to the referral. The clinical nurse specialist triaged the referrals to see if they could accept the patient and followed up if they needed further information.

The hospice used technology to support timely access to care and treatment. Each referral was colour coded depending on which hospice was the most appropriate; this meant all hospices were aware of the patients waiting and the waiting times of each hospice meaning patients were more likely to find a bed quicker.

Managers and staff worked to make sure that they started discharge planning as early as possible. The hospice had a discharge facilitator based on the inpatient unit that supported with patient discharges. They worked with patients and their families and linked in with the on-site social work team to arrange any care packages and to ensure a safe discharge home. The discharge facilitator also linked in with the bed manager to discuss any patients for discharge. The hospice benchmarked themselves against other hospices in relation to average length of stay.

Staff supported patients when they were referred or transferred between services. The discharge facilitator ensured a safe discharge by linking with other professionals such as social workers, district nurses and community teams.

Outstanding ☆

Hospice services for adults

Learning from complaints and concerns

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

Staff understood the policy on complaints and knew how to handle them. Staff were able to tell us the process when someone made a complaint and about their right to appeal. Information was available to patients and their families on how to make a complaint.

Staff documented complaints on the hospice electronic recording system. A complaints' policy was in place which detailed any timescales and the role of the Health and Parliamentary Ombudsman (PHSO). The service was not a member of the Independent Complaints Advocacy Service (ICAS).

Managers investigated complaints and identified themes. We reviewed two complaint responses and saw managers had investigated complaints, offered patients families the opportunity to meet, apologised and told them what to do if they were not happy with the outcome of the complaint. We saw the hospice took appropriate actions when patients or their families made complaints.

The hospice had received five formal complaints between 2020 and 2021 and there were no common themes. Managers reported on any complaints, themes and learning in the hospice clinical services annual report 2020 to 2021.

Managers shared feedback from complaints with staff and learning was used to improve the service. We reviewed the minutes from the patient safety group dated September 2021 and noted staff discussed complaints. Mangers also shared learning from complaint investigations such as communication training for staff; managers shared details of complaints in staff meetings.

We reviewed the clinical services annual report 2020 to 2021 and saw examples of when changes to practice had occurred following complaints these changes included installing additional phone lines and mobile handsets and further education around medicines.

Are Hospice services for adults well-led?

Outstanding ☆

Our rating of well-led improved. We rated it as outstanding.

Leadership

There was compassionate, inclusive and effective leadership at all levels. Leaders had the skills and abilities to run the service. They had a deep understanding of issues, challenges and priorities in their service and beyond. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

There was a clear management structure in place. The executive management team included a chief executive officer (CEO), a director of finance, income generation, medical director, director of clinical services, of people and culture and an executive assistant of governance. The hospice also had a board of trustees which met every quarter. All trustees held the post in a voluntary capacity and had varying skills and expertise.

The hospice had faced several challenges over the previous year, this included the merger of the hospice with another hospice to become the Hospice Charity Partnership in August 2021 which involved an often-complex programme of realignment. The hospice was in the process of making changes to the leadership team. The hospice had various committees and groups which ensured any information was discussed, shared and cascaded to the relevant people.

Leaders had the skills, knowledge, experience and integrity they needed to provide effective leadership. They worked with other organisations to address any issues and manage their priorities. All staff we spoke with felt leaders were visible and approachable and provided consistent positive feedback on the leadership team; managers and staff told us there was no feeling of hierarchy and a no blame culture. The chief executive (CEO) was based at the hospice and described as an excellent, pragmatic leader who cared about patients and staff.

Leaders were able to demonstrate a clear understanding of the challenges they faced, and the actions needed to address them. We spoke with two trustees and found they had a good understanding of the positive work done by the hospice, the challenges the service faced and what managers needed to do to take the service forward.

Vision and Strategy

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

The hospice had a clear vision and a set of values with quality and sustainability as top priorities. At the time of the inspection the hospice had just launched its future hospice care shaped by our community's strategy for 2022 to 2027. The strategy adopted the principles of build, grow and refresh. Actions from the strategy included growing the collective understanding of the needs of Birmingham's diverse communities, increasing supporters to grow a sustainable voluntary income, adapting services to meet the needs of the community and refurbishment of the hospice site.

We reviewed the slides from a senior clinical lead away day in June 2021, which focussed on the merger journey. The slides discussed new roles, plans of action, challenges, and the new world of the Hospice Charity Partnership. We also viewed some slides named next steps, which detailed how the hospice was looking to the future as they agreed future plans, built new services, found balance and built trust and dared to be different.

All staff had been involved in defining the new values which were due to be launched in March 2022, the values would underpin and shape the organisations culture going forward.

The hospice had identified that although the current approach met the needs of many people there were groups within communities that did not access the current specialist palliative care and end of life offering, the hospice had planned to work with the wider health system to understand why.

The service strategy considered what the hospice must do for stakeholders to be successful. Actions included co designing services with partners and stakeholders that reflected the diverse needs of communities. A strategic goal was increasing work alongside communities and partners shaping palliative and end of life services in the future.

The hospice mission was to provide specialist care for people living with a terminal illness and their families and our vision is a compassionate and dignified death for all. Values included caring for all, seeing the person, be right first time and simplifying the complex.

Outstanding ☆

Hospice services for adults

Culture

Leaders had an inspiring shared purpose and strived to deliver and motivate staff to succeed. There were high levels of satisfaction across all staff. There was a strong organisational commitment towards ensuring there was equality and inclusion across the workforce. The service promoted equality and diversity in daily work and provided opportunities for career development. Staff at all levels were actively encouraged to speak up and raise concerns. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff felt supported, respected and valued; they consistently spoke about the service in a positive manner and were proud to work for the organisation**.** The team philosophy of providing a welcoming caring environment in which to deliver safe, effective care via a friendly approach was displayed on the visitor information board. Managers displayed values in action posters on the inpatient unit and incorporated values into yearly appraisals. Leaders thanked staff for all their hard work in staff meetings and displayed above and beyond award posters on the inpatient unit.

The hospice strived to be a fully inclusive service, in which every person in the community could fully access and benefit from the specialist care the hospice provided. The hospice had an equality, diversity and inclusion group who met to drive forward policies and procedures. They also looked at ways to improve; hospice policies contained a diversity statement. Trustees recognised the need for a board that was more representative of the local populations.

The Equality and diversity group had proposed to the people committee that they formulated one action plan for the hospice charity partnership. They also proposed they worked towards investors in diversity accreditation in 2023. The hospice had gone out to recruitment for an equality and diversity business partner. The idea was this additional resource would help to provide momentum to drive forward any actions. Engagement with the National Centre for Diversity had already taken place.

There was a strong emphasis on wellbeing within the hospice, with managers strongly advocating the importance of this. Staff could access clinical supervision, the well-being service, have holistic therapies and counselling. Managers and trustees were able to give examples of when staff wellbeing had been compromised. There was a focus on improving health outcomes embedded in the hospice culture. This was clear within the hospice services, their programme of audit and the governance systems in place. Staff one to one forms had a section on wellbeing and a list of mental health first aiders was on displayed in the hospice.

There was a buddy system in place for staff working in the community, staff were able to record on the electronic recording system where they were going in time order; this meant others knew where they were. Staff could also access a safety application on their mobile phones when lone working in the community.

Mechanisms were in place to support staff with the development they needed including appraisals and career development conversations. Annual appraisals including conversations on career and personal objectives in addition to a performance summary.

Governance

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

There were effective structures, processes and systems of accountability to support the delivery of the hospice strategy. The hospice had a clinical governance lead and various groups that fed into the board. For example, there was a patient safety group attended by the multidisciplinary team who discussed incidents, safeguarding, deprivation of liberty, complaints, medicines management, patient safety alerts and policies. This group fed into the hospital clinical governance committee, the quality governance committee and then the board. Reports to clinical governance looked at analysis of themes, background assessments and made recommendations.

The hospice held Medicines' Management committee meetings which included policy updates, details on the audit programme, accountable officer updates, incidents, themes, national guidelines, flu vaccines, pharmacy team updates and patient safety drug alerts. There was a clinical dashboard in place which detailed specific data such as incidents complaints, pressure ulcers, duty of candour, preferred place of death, national guidance and audit results.

All levels of governance and management functioned effectively and interacted with each other appropriately. Groups that fed into the board included a clinical audit group, a neurodiversity group, a patient safety group, a mortality group and a health and safety forum the National Institute for Health and Care Excellence (NICE) guidance action group looked at compliance with NICE guidance and was attended by consultant in palliative medicines, clinical governance manager, palliative care social worker, clinical education lead, advanced nurse practitioner, governance officer.

There was a systematic programme of clinical and internal audit to check quality and systems to identify where staff should be taking action. Staff recorded audit results in the quarterly integrated quality assurance report and inputted into the hospice clinical dashboard. There was an audit calendar in place, staff attached any learning to the individual audits results as well as an action plan tracker. The service benchmarked themselves against other hospices and submitted data to the local clinical commissioning groups.

The hospice produced an Integrated quality assurance report. We reviewed the report dated October to December 2021. The report collated important information such as incident types and themes with each theme broken down further, for example medicine incidents were mainly ordering issues. Safeguarding incidents were detailed including the type of abuse and the outcome, for example if they had been reported to the local authority, what referrals were made, if the patient had been moved to another location; patient experience, advance care planning and preferred place of death were also included.

Arrangements with partners and third-party providers were governed and managed effectively. We saw service level agreements were in place and leaders attended contract group meetings; the hospice provided commissioners with required information.

The training information provided was difficult to interpret, managers told us training figures had been difficult to accurately collate for several reasons such as the merging of two hospice education approaches leading to a review of what type of training was required to each role. A full review of internal and external training was underway and full alignment across both sites was forming part of the work.

Management of risk, issues and performance

There was a demonstrated commitment to best practice performance and risk management systems and processes. Leaders and teams used systems to manage performance effectively. They identified and addressed problems quickly and openly and 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.

The board reviewed quality and risk information. For example, we reviewed the last two board meeting minutes dated September and November 2021 and noted the board looked at various reports from the sub committees including the audit committee report, clinical assurance, quality governance, they also discussed the risk register and the recent merger. Managers had done a lot of work to align the two hospices following the merger with plans and changes continuing at the time of the inspection.

There were clear processes for identifying and mitigating risk. Managers ensured staff recorded risks on the hospice electronic risk management system, alongside the hospice risk register. We reviewed the latest risk register and found it was colour coded and risks aligned with what managers told us. The hospice was in the process of developing a board assurance framework (BAF). Business cases were completed when a need was identified; for example, a business case had been put forward for the purchase of a piece of equipment to move patients back to their beds following a fall. The business case clearly identified the reasons the equipment was needed, the key outcomes and success criteria, costs and provided reference from NICE.

Management of risk was embedded throughout the organisation from floor to board, staff completed risk assessments for patients, groups were set up to discuss and address risks such as falls, COVID-19 and mortality. Staff disseminated risks up to board through various subgroups. Managers followed up safeguarding referrals and shared with members of the multidisciplinary team. There were processes in place to ensure staff reported safeguarding incidents and staff discusses, resolved, and learnt from them.

Information Management

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

Staff recorded information governance incidents in the quarterly integrated quality assurance report. We reviewed the October to December 2021 report and found there had been seven information governance incidents in this period. Managers had graded the incidents and they were low or no harm; they also investigated each incident individually to identify any learning.

The hospice was aligning a lot of their information management systems due to the recent merger with another hospice. The hospice had invested in a new risk management system, training systems, electronic patient records as well as technology for hospice at home staff.

Staff were able to access computers and the hospice intranet and shared drives. Computers were password protected and staff locked them when they were not in use.

The hospice submitted data to external organisations as required. There was an information governance steering group and a database user group that fed into committees and the board.

Engagement

There were consistently high levels of constructive engagement with staff and people who used services. They collaborated with partner organisations to help improve services for patients.

The hospice worked in partnership with other services to ensure they effectively met peoples' needs. For example, they worked with the local NHS trusts, clinical commissioning groups, other hospices and palliative care teams as could be evidence by the work completed as part of the Hospices of Birmingham and Solihull (HoBS) service.

The hospice gathered and acted upon people's views and experiences, they were acted upon to shape and improve services and culture including people in equality groups. Staff had the opportunity to discuss issues important to them at board meetings and had been invited to join groups such as the learning disability and neurodiversity group.

Managers used feedback from people who used services to inform improvements and learning. Complaints were discussed in staff meetings and patient stories and surveys were discussed in different forums. The inpatient unit displayed information such as how may pressure areas and how many falls they had.

Arrangements were in place to ensure staff could raise concerns safely; there were whistleblowing and disciplinary policies in place. The hospice was committed to Freedom to speak up and had a freedom to speak up guardian in post.

We heard an example of how managers had invited a staff member to a board meeting in October 2020 to speak about work they had completed around equality, diversity and inclusion with reference to both patients and staff. The staff member represented ethnically diverse staff and shared how they felt in the workplace and was able to make suggestions as to how staff could be better represented.

Managers sought and acted upon the views of staff in the service. Staff had the opportunity to complete a people survey in November 2021 which showed a varied response to questions asked. Questions included if staff felt positive about the future, if they felt their work was valued, if they had a voice and if they would recommend the hospice as a great place to work. Staff had completed the survey. Staff completed the survey following the merger, so it did not reflect John Taylor hospice. An action planning meeting and implementation of any quick win actions were due to take place throughout January and February 2022.

Learning, continuous improvement and innovation

There was a fully embedded and systematic approach to improvement. Safe innovation was celebrated. All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The hospice had a mortality group that reported into the clinical governance committee. The meeting took place via teams during the pandemic and had representation from the inpatient unit, living well centre, hospice at home, the medical and wellbeing team, pharmacy and the medical team. We reviewed the mortality review dated December 2021 and saw staff discussed individual cases, identified learning, and that staff were given the opportunity to reflect. Staff also looked at the number of deaths and if the patients had achieved their preferred place of death.

Since the last CQC inspection in 2016, the pharmacist had implemented stringent checks to ensure any medicines were not out of date.

The hospice showed significant improvement in relation to the patients' preferred place of death. Results in 2019/2020 showed the average amount of patients dying where they wished was 57%, this improved to 98% by December 2021. Staff reiterated the importance of gaining this information in the monthly mortality review meetings and felt that this had helped to drive improvement.

Hospice services for adults

The hospice had contributed in the area of research and studies and had a research steering group in place. Areas of research the hospice staff had been involved in included meeting patient needs during the COVID-19 pandemic (day hospice), The impact and implications of COVID-19 on the relational, social and healthcare experiences of hospice care in the West Midlands and The Medicines Management Challenges of injectable Controlled Drugs Prescribed for Anticipatory Symptom Control at the End of Life in conjunction with a local university. The complementary therapy service submitted their first poster to the supportive and palliative care virtual showcase event, 280 people accessed the poster gallery.

The hospice personal health budget team were shortlisted for a national award in 2021. The project supported 155 patients across Birmingham with support ranging from household chores, to providing beds and linen so people could die at home in comfort and with dignity surrounded by their loved ones. The hospice had undertaken presentations and shared how to refer patients for the government initiative with many external professional teams. Feedback from families included thank you for finding the dog walker, the afternoon tea was lovely, and you don't know how much this means to me.

The hospice provided a range of learning opportunities to support different specialities in students' development. The hospice provided teaching, mentoring and support to both postgraduate and undergraduate medical students and post graduate speciality trainees. This included tutoring and training students in holistic palliative care to consolidate their learning. They also welcomed physiotherapist and occupational therapists' students from local universities to gain an insight into their role in palliative and end of life care. The hospice had achieved the placement of excellence gold leaf certificate in August 2019 for exceptional student evaluation feedback.

To keep up with the changes due to COVID-19 pandemic, the complementary therapy service adapted to include a postal service, phone meditations, complementary videos and virtual sessions. The hospice launched the support at home telephone service in 2021 where volunteers telephoned the patient on a weekly basis.

The complementary therapist had been shortlisted by a professional association for complementary, beauty and sports therapists as a finalist for its excellence awards 2021. The complementary therapist also won the inspirational therapist award in a national competition in March 2022.

The specialist respiratory service involved the management and support of a caseload of patients with chronic life limiting respiratory disease who had complex symptoms that were unresolved with basic measures.

Hospices of Birmingham and Solihull (HoBS) was set up at the beginning of April 2020 response to the COVID-19 pandemic. This was a collaboration between John Taylor Hospice and three other providers with direct pathways to local ambulance and hospital trusts and as a result had achieved a collective and responsive palliative care service for end of life patients across Birmingham and Solihull.

The hospice occupational therapist, physiotherapist and respiratory nurse ran a fatigue, anxiety and breathlessness' programme. The specialist course included education, advice and self-management techniques. We spoke to one hospice at home patient who had completed the course, they told us the course was fabulous and how it really helped with their breathing.

The hospice had set up a palliative support register. The aim of the register was recognised as a way to enable key information about the individual's preferences for care at the end of life to be recorded and accessed by a range of services.