Sue Ryder

Sue Ryder - Thorpe Hall

Inspection report

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

Ratings

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

Summary of findings

Overall summary

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- The medicines policy did not reflect current working practices and ensure accountability for medicines reconciliation and how this will be monitored.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	Good 	Our rating of this service went down. We rated it as good. See the summary above for details.

Summary of findings

Contents

Summary of this inspection

Background to Sue Ryder - Thorpe Hall

Sue Ryder Thorpe Hall is operated by Sue Ryder, a national charitable organisation which specialises in providing palliative and neurological care to people living with life-limiting conditions. The hospice is located in Longthorpe, Peterborough. It primarily serves the communities of Cambridgeshire, Peterborough and South Lincolnshire. The hospice has 20 inpatient beds. At the time of the inspection the hospice was caring for seven patients on the inpatient unit.

Facilities include an inpatient unit, hospice at home service, day services and family and bereavement support services. The head of clinical services was the registered manager.

The service is registered with the CQC to provide:

Treatment of disease, disorder and injury

Diagnostic and screening procedures

Transport services, triage and medical advice provided remotely.

How we carried out this inspection

We visited the inpatient unit and spoke with staff delivering hospice at home, bereavement and virtual day services. We held interviews with service leads. We spoke with 17 staff including nurses, health care assistants, doctors, day service staff, bereavement staff, catering staff, reception and non-clinical staff. We also spoke with two patients and their relatives who had experienced support from hospice staff. We observed care and treatment provided in the inpatient unit, reviewed data about the service and reviewed patient care records.

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Outstanding practice

We found the following outstanding practice:

- The service was responsive to the needs of patients. This included expanding the use of the hospice at home service to provide care for patients requiring rapid discharge to be cared for in their own home at the end of life.
- A virtual day service had been created, providing support to patients with neurological conditions. Staff created innovative ways to deliver the service remotely. Feedback from patients included describing the service as life changing.

Areas for improvement

Action the service SHOULD take to improve:

Summary of this inspection

- Review the medicines policy to reflect current working practices and ensure accountability for medicines reconciliation and how this will be monitored.
- The service should ensure that it is clear that homely remedies have been reviewed as appropriate for administration on an individual basis.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Hospice services for adults

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

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 and made sure everyone completed it.

Staff received and kept up to date with their mandatory training. The hospice aimed for mandatory training compliance of 95%. Where compliance fell below 95% this was identified as part of the monthly integrated quality and performance report. This involved identified courses and actions to improve compliance on a monthly basis.

Managers monitored mandatory training and alerted staff when they needed to update their training. The practice educator worked with managers to increase uptake. Compliance with mandatory training overall was 95% at the time of inspection.

Mandatory training was comprehensive and met the needs of patients and staff. Training needs were role specific. For example, senior staff completed modules such as verification of expected death and post incident management training in addition to other modules. More widely across staff teams, completed training modules included basic life support, infection control, fire safety and managing medical gases.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. They received human rights 'what matters to me' training, to focus on ensuring human rights when delivering care at the end of life. Staff completed online learning modules on learning disabilities, autism and dementia.

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. Nurses completed safeguarding level two training for both children and adults' safeguarding training. Compliance was at 94% for each. Medical staff and safeguarding leads had been trained to safeguarding level three.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff had received training in equality and diversity and issues around human rights at the end of life.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff demonstrated an understanding of types of abuse and action required to address these. One of the safeguarding leads had produced information cards for staff to reference, which included a prompt about the types of abuse that could occur and contact information for local safeguarding teams.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There was clear safeguarding leadership on the unit, including one for adults and one for children. Staff had access to safeguarding policies and knew how to access safeguarding support or make a referral. Safeguarding leads reviewed safeguarding reports to identify learning and changes to practice. Safeguarding data was included in monthly integrated quality and performance reports.

Cleanliness, infection control and hygiene

Staff used infection control measures when visiting patients on the inpatient unit.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. A monthly audit of the environment, nursing practices and COVID-19 considerations was carried out. The service performed consistently well. We observed clinical staff adopting good hand hygiene practices.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Enhanced cleaning was in place due to COVID-19 including frequent cleaning of high touch areas.

Staff followed infection control principles including the use of personal protective equipment (PPE). There was high compliance with infection control training with an achievement of 94% at the time of inspection. There were clear signs on the inpatient unit about the need for PPE. There were PPE 'grab bags' for use when entering patient's rooms and clear procedures for the type of PPE depending on the status of the patient and the activities undertaken. Visitors were required to wear PPE, including a face mask at all times. Staff reported breaches in the use of PPE on the electronic incident reporting system and these were reviewed alongside other incidents. Actions included providing clearer guidance to visitors and staff.

COVID-19 risk assessments had been carried out in relation to the environment and for individual staff members to identify risks. Action to minimise risks had been taken in line with national guidance. This included the creation of a separate wing within the inpatient unit to cohort any patient who had tested positive, the use of PPE, regular testing for staff and patients. Arrangements for visitors included regular testing and use of PPE, plus screening for symptoms on arrival on the unit.

Data for 2021/22 showed no MRSA or *Clostridioides difficile* ***(C.difficile)*** infections to date. COVID-19 infections were reported, this included 13 in 2020/21 and one in 2021/22.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. There was no onsite mortuary, however, it was possible for visitors to spend time with patients in their room after death. A cold blanket was in use which was checked every two hours to ensure it was maintaining the correct temperature.

Good

Hospice services for adults

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. Staff answered bells promptly, and staff told us it was everyone's responsibility to respond to bells. The hospice leads had invested in pendant call bells (worn by the patient so that they are always in reach) as part of their plans to reduce the risk of falls.

The design of the environment followed national guidance. Patients were cared for in single rooms with en-suite facilities. Rooms were kitted out to provide comfort and safety.

Staff carried out daily safety checks of specialist equipment. Clinical equipment, including beds, hoists and assisted baths were regularly maintained. Calibration of medical devices was carried out annually. Equipment that was faulty was repaired or replaced. Equipment used for emergency situations was appropriate and accessible for staff when needed. We saw this was logged as checked daily and single use equipment was within 'use by' dates.

The service had suitable facilities to meet the needs of patients' families. During the pandemic families could visit or stay with patients in their rooms. They were encouraged to wear personal protective equipment in line with guidance. Families were offered refreshments. Ordinarily, there was a family area that could accommodate overnight stays; however, this was not in use during the pandemic.

The service had enough suitable equipment to help them to safely care for patients. Syringe pumps were available in line with recommended guidelines and were appropriately checked during administration.

Staff disposed of clinical waste safely. Clinical waste bins were locked. Sharps bins were correctly labelled and disposed of within the appropriate timeline in line with national guidance.

Patient environment surveys were conducted, asking patients a range of questions about their rooms, staff hand washing, cleanliness and whether the patient felt safe in the care of the hospice. We viewed a range of survey reports and saw that these consistently scored 100%.

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. We saw the national early warning score (NEWS2) in use to monitor and record physiological observations such as blood pressure and temperature. There was an escalation protocol for patients who became unexpectedly unwell outside of normal working hours. An acute illness management plan was completed along with a NEWS2 calculation score. The plan included contacting the out of hours doctor to assess for active treatment and in some cases a transfer to the accident and emergency department.

Staff completed risk assessments for each patient on admission using a recognised tool, and reviewed this regularly, including after any incident. Routine risk assessments were undertaken including those relating to the risk of falls, pressure ulcers, malnutrition and moving and handling. Risks associated with the use of bed rails were identified and

action taken to minimise identified risks. All risk assessments were regularly reviewed in line with changes to a patient's condition, routine reviews of risk assessments were carried out during admission. Review timelines were identified as part of ongoing assessment processes. The plan helped staff to differentiate between expected deterioration and other red flag scenarios such as uncontrolled acute bleeding or seizures or sepsis.

Staff knew about and dealt with any specific risk issues. There was a nationally recognised sepsis screening tool in use, providing clear escalation guidance in the event of a patient with clinical signs of sepsis. Patients were screened on admission for infections and these were reported as part of the monthly integrated quality and performance report.

Personalised care rounding documents were in use. These were red, amber, green (RAG) rated with different assessment tools used based on the dependency of care needs for individual patients. This included regular two hourly position changes for patients requiring full assistance. Patients requiring some assistance were reminded to change position every four to six hours. Those requiring minimal assistance had their pressure areas checked or asked about daily.

Patients were assessed for the risk of falls. The hospice had introduced a huddle up for safer healthcare (HUSH) programme. This involved a daily meeting where members of the multidisciplinary team met to discuss patients at higher risk. Discussions included identifying patients likely to fall and involved a team approach to monitor this and reduce the risk.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health. Assessment processes included aspects of the patient's psychological wellbeing. Internal support services were in place including from psychotherapists.

Staff shared key information to keep patients safe when handing over their care to others. A handover record form was completed at each shift and included current risks or concerns, relevant medication and their escalation status. The handover form was developed as part of an improvement project following a serious incident investigation, led by the senior nursing team. This included whether a patient wished to be treated in hospital if their condition deteriorated. Recommendations about changes to care were included and input from the multidisciplinary team recorded. Shift changes and handovers included all necessary key information to keep patients safe.

Nurse staffing

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

The service had enough nursing and support staff to keep patients safe. Managers accurately calculated and reviewed the number and grade of nurses and nursing assistants needed for each shift in accordance with national guidance. The hospice was participating in a safer staffing national project coordinated by the provider. This included triangulating data, outcomes and professional judgements to identify safe staffing levels. The first phase of the project involved piloting a validated acuity and dependency tool from the 1st April 2021. The second phase was in progress at the time of the inspection and included gathering views from patients and staff. The project was supported by an external (NHS Improvement) consultant.

The number of nurses and nursing assistants matched the planned numbers. Staffing establishment shortfalls were reported monthly along with sickness levels and use of agency. The registered nursing shortfall on the inpatient unit had reduced over time from 7 whole time equivalent (WTE) in November/December 2020 to 5.62 WTE in June 2021 and 3.98 WTE in August 2021. Improvements had been made due to targeted recruitment in the local community including radio advertising, social media promotion and working with the hospice marketing team to raise the profile of the Hospice.

The managers could adjust staffing levels daily according to the needs of patients. This included aligning staffing with patient dependency. Managers reported that although bed occupancy was lower than establishment the dependency was high, therefore staff were adjusted based on this rather than on the number of occupied beds.

Registered nurse hospice at home staffing levels were above the establishment. For example, in August 2021 there was one WTE additional registered nurse in post. There was a shortfall of four WTE nursing assistants and these vacant posts were covered by bank and agency staff.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers utilised permanent staff and their own nursing bank to cover shifts before requesting agency staff. Managers made sure all bank and agency staff had a full induction and understood the service. Regular bank and agency nurses worked on the inpatient unit and were provided with specific induction, training and supervisory support. The hospice had an arrangement in place with a local nursing agency to provide regular nurses who had some experience with palliative / end of life care.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep patients safe. The service always had a consultant on call during evenings and weekends. There was consultant cover two days a week on site and on call consultant cover outside of these times. In addition, there was a specialist palliative registrar and four part time specialist palliative care doctors, providing medical cover Monday to Friday. The medical team provided on call cover until 7 pm Monday to Friday and between 9am and 5pm Saturday and Sunday. Daily ward rounds were undertaken seven days a week.

Out of hours medical cover for the inpatient unit was provided between 7pm and 8am seven days a week through the NHS 111 service, with a dedicated healthcare professional line ensuring prompt cover. There was an on-call palliative medicine consultant on call covering out of hours for further advice. Patients had a clearly documented plan for escalation of care out of hours, which was reviewed daily by the medical team and signed by both the doctor and nurse in charge each day.

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. Nursing notes were recorded on an electronic patient record system aligned with NHS providers in the locality. Medical records were paper based. This dual record system was identified as a risk on the service's risk register. Action to address the risks associated with this included the

development of a working group that included nursing and medical representation. Service leads told us they had recently renewed efforts to align medical and nursing notes on the electronic system. There were plans in place for the working group to take forward and resolve the associated risks within a reasonable timeframe, to be completed within the current year. Plans had been reviewed and agreed by the quality improvement group.

Records were stored securely. Electronic records were password protected. Paper records were stored in a locked filing cabinet. The audit showed a score of 99.5%. This reflected compliance with storage, record completion and identifiable entries. An area identified for improvement was for records indicating information and information leaflets being given to patients needed to be completed more consistently. Action to address this included reminding staff at handovers of the requirement to complete the relevant documentation. Information leaflets for the prevention of falls and pressure ulcers were discussed with patients and those close to them, with a view to involving them in the approach to prevention. Audits in June and September 2021 showed that 100% of patients had received the information and had this discussed with them.

Medicines

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

Staff followed safe systems and processes when prescribing, administering, recording and storing medicines. Medicines were supplied by a local NHS trust and a pharmacist visited once a week for two hours to review prescriptions. Pharmacists were contactable for advice the rest of the time but did not provide support with stock management.

Medical staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Prescribing was clear, safe and appropriate to be able to respond to symptoms that patients may experience during their stay. Emergency medicines were available should they be required. There was evidence of medicines being appropriately titrated to respond to patients' symptoms which included prompt and adequate pain relief. People receiving medicines by syringe pumps (medicines delivered through the skin) were regularly monitored. At discharge the patients were provided with a list of their medicines and how to take them.

People were routinely able to get homely remedies should they require them as they were pre-printed onto the prescriptions which meant there was no delay in getting medicines to treat minor ailments. It was not always clear from the documentation that these were reviewed on a patient specific basis although it was highlighted at handover and staff told us these were reviewed daily by medical staff. None of the unsuitable medicines had been administered and the issues around suitability had been highlighted at handover.

No information was available to inform people about using unlicensed medicines within a palliative care setting, but we did see all medicines were being used within current national palliative care guidance.

Staff stored and managed medicines and prescribing documents in line with national guidance, , however, the medicines management policy contained out of date guidance. The Sue Ryder corporate policy which was in use, was out of date and was under review to ensure the policy reflected current practice. Staff told us that an external audit of the medicines management policy was being undertaken by the provider.

Staff followed current national practice to check patients had the correct medicines, although there was no data available to see if this check (medicine reconciliation) was carried out in a timely manner. The policy did not mention whose responsibility it was to complete medicine reconciliation or who was accountable for this process. After our inspection, the provider told us that it was the responsibility of medical staff to complete medicine reconciliation. The

medicines policy referred to Nursing and Midwifery Council standards which were withdrawn in January 2019. The professional standards referenced were subsequently updated following our inspection. There was a procedure in place to allow people to self-administer their own medicines if they wished and we saw that one person was partially doing this. The facilities within patient's rooms were designed so they could keep their medicines safely with them.

The service had systems in place to ensure staff knew about safety alerts and incidents, so patients received their medicines safely, however not all correct actions for National safety alerts had been identified, which caused a delay in compliance for one alert. This was in relation to a specific alert about steroid prescribing where the alert had been reviewed but the action not completed. Managers told us there had been a misunderstanding about the action required and that this would be actioned. Following the inspection, managers sent us information to demonstrate action taken to ensure compliance with the safety alert.

Staff reported medication incidents and near misses. Incidents were then reviewed at appropriate clinical governance meetings, including medicines management and quality improvement groups. There was no pharmacist representation at these meetings. There was evidence that actions had been completed and learning had been shared with hospice staff.

The service conducted audits to assess compliance against the medicines policy including the management of Controlled Drugs. There was evidence that issues identified were addressed and learning shared.

All relevant staff had received medicines training and were assessed for competency every two years.

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. Staff raised concerns and reported incidents and near misses in line with the provider's policy. Staff understood how to report incidents and near misses on the electronic reporting system. The system provided shortcut processes for staff to report the most commonly occurring incidents such as falls and pressure ulcers. Incidents were recorded and reviewed regularly by senior staff. We reviewed monthly reports and saw that incidents were rated according to the level of harm caused.

Incidents were investigated and contributary factors were identified. Action was taken to address the issues, including falls prevention work, improving assessment methods for identifying drops in blood pressure when mobilising and improving seizure monitoring. A falls prevention plan included the use of safety huddles where staff worked together to identify and manage the risk of falls in individual patients.

Staff met to discuss the feedback and look at improvements to patient care. There was evidence that changes had been made as a result of feedback. Incidents were discussed at quality improvement meetings and actions reviewed. Staff were informed of incidents and involved in learning discussions at handovers and regular internal study days. Actions included physiotherapy developed resources to help reduce the risk of falls, as well as other falls prevention strategies. Actions relating to medicine errors included staff completing reflective statements and where appropriate having repeat competency assessments.

Good

Hospice services for adults

Staff understood duty of candour and this was applied appropriately following a fall resulting in harm. They were open and transparent and gave patients and families a full explanation when things went wrong. Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We viewed incident reports that included informing patients and their family members. An apology was given, and they were kept informed of investigations and subsequent outcomes and actions.

Safety thermometer

The service used monitoring results well to improve safety. Managers collected safety information and shared it with staff, patients and visitors.

The service continually monitored safety performance. This included monthly reports relating to medicines and other incidents, falls, pressure ulcers, staffing and patient feedback.

Safety information showed the service had reduced the incidence of harm within the reporting period. Staff used the data to further improve services. At the time of inspection there had been 103 consecutive harm free days which was an improvement on previous months. Results relating to harm free care were displayed within the hospice for patients, families and visitors to see. The improvement in harm free care was as a result of Huddle up to safer care (HUSH) initiatives that had been implemented as a result of an increase in falls within the hospice.

Are Hospice services for adults effective?

Good

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

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Organisational and care policies took account of relevant national guidance, for example NICE Quality Standard 13 End of life care for adults and NICE guidance 31 Care of Dying Adults in the Last Days of Life. Patients had personalised care plans and assessments took account of people's emotional, spiritual and social needs. Care in the last days and hours of life delivered the Five Priorities for Care of the Dying Person.

Care plans were developed with input from the patient and those close to them. They included support for patient's psychological and spiritual support needs. Recommended summary plans for emergency care (ReSPECT) forms were completed in line with national guidance. They included 'what matters to me' decisions in relation to treatment and care in an emergency, including balancing living for as long as possible with quality of life issues.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Handover and multidisciplinary records reflected discussions about all aspects of the wellbeing of patients and those close to them. Handovers were held at shift changes and included personalised discussions about patient's needs including emotional and spiritual needs.

Good

Hospice services for adults

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. Catering staff provided a wide variety of meals. Patients were offered menu choices and alternatives were available.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Food and fluid intake were recorded and monitored. There were assessment processes for the appropriate use of clinically assisted hydration.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. In addition, a comprehensive nutrition assessment was completed. This included assessing patients' ability to tolerate food, special dietary needs and their likes and dislikes. They identified causes of reduced food intake and planned patients' care to address issues identified.

Specialist support from staff such as dietitians and speech and language therapists were available through referral processes. Clinical staff had received training in dysphagia and swallowing assessments, in total 82% of relevant staff had completed this training. Meal supplements were available for patients requiring them. Catering staff were experienced in providing high calorie high fat foods to those patients with additional nutrition needs.

All patients had a mouthcare record screening tool and care plan that was updated daily. Staff followed national guidelines on providing effective oral care and had access to the Royal Marsden online on the inpatient unit. They followed Royal College of Nursing guidance - Mouthcare Matters in End of Life Care published in September 2021 which was shared with the clinical team through routine clinical updates.

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 visual and numerical scores to assess pain. We viewed pain assessment charts and care plans and saw that these were completed appropriately.

Patients received pain relief soon after requesting it. We observed staff responding promptly to requests for pain relief.

Staff prescribed, administered and recorded pain relief accurately. The effectiveness of pain relief was reviewed, and the multidisciplinary team routinely assessed pain daily and more frequently if required. Patient experience feedback reports included positive comments about patients feeling better able to manage their pain because of the care and treatment received. Feedback included improvements in quality of life as result.

Patient outcomes

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

Service leads received monthly integrated quality and performance reports. These included benchmarking against other Sue Ryder hospices. They also took part in the Hospice UK patient safety benchmarking project which included data on pressure ulcers, patient falls and medicine errors. In addition, the service was in the process of commencing work with Marie Curie on benchmarking across the hospices of both organisations.

Outcomes for patients were positive, consistent and met expectations, such as national standards. The Australian-modified Karnofsky performance scale (AkPs) phase of illness score. Use of the scale helped staff to illustrate changes in the patient's condition, assessing patients' overall status and ability to carry out everyday activities. This scale was discussed during patient handovers and multidisciplinary meetings with involvement from medical staff, therapy staff, nurses and nursing assistants. Managers and staff used the tool to plan treatment and care, support the needs of patients and evaluate their health outcomes.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. This included audits of falls risks, infections, incidents and pressure ulcers. Action was taken to improve and there were continuous evaluation processes in place. Audit results were shared with staff who were encouraged to participate in improvement activities.

Preferred place of care at the end of life was recorded and the service audited achievement of preferred place of death. For example, 97% of patients who wanted to be cared for at home had achieved this.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers gave all new staff a full induction tailored to their role before they started work. A five-day initial induction programme had been in place for new staff and was amended during the pandemic to allow for restrictions on face to face training. At the time of the inspection a two day induction with additional tailored time for new staff on an individual basis was in place. Training included an introduction to care plans and pathway, audit reports, safety huddles, handovers and having courageous conversations. We viewed staff files and found relevant information on staff competency assessments, induction and appraisal.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff we spoke with confirmed they received regular appraisals and had development plans in place. New staff received specific training to their roles and had probationary reviews. Managers monitored appraisal rates to ensure that staff consistently received appraisals on an annual basis. At the time of our inspection 90% of eligible clinical staff had received an appraisal in the previous 12 months which was in line with the hospice target.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. A weekly bulletin was sent to all staff, including the inpatient unit staff by the inpatient unit manager. These contained up to date information on practice issues and were shared with the corporate quality team. Regular study days were held where information about incidents, safety and changes to practice were discussed with staff. These were combined study days with registered nurses and nursing assistants, with the staff team split into study day groups to support building rapport and creating a safe space for staff to learn.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Regular study days were held for staff groups within the hospice. These included training in specific areas such as recognising sepsis and deteriorating patients. Training included quizzes to test knowledge and evaluate learning. Staff evaluations of the study days were positive.

The practice educator supported the learning and development needs of staff. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. For example, new starters discussed training needs with their line manager as part of their probationary review. The hospice practice educator worked actively with managers and staff to address training issues. For example, in relation to sourcing materials to support staff in caring for patients with neurological conditions.

Managers made sure staff received any specialist training for their role. At the time of our inspection 62% of staff had completed an online end of life public access course, with other staff working through modules as part of their induction. Members of the senior management team had completed university modules in palliative and end of life care. Speciality doctors had completed post graduate training in palliative care. Staff had received training in advanced communication and advance care planning to support patients in making decisions about their end of life care.

Managers identified poor staff performance promptly and supported staff to improve. Managers worked with Sue Ryder corporate staff to support performance management issues. We saw that these were addressed promptly, and action taken to ensure staff performance was consistent and of a high level.

Managers recruited, trained and supported volunteers to support patients in the service. Some volunteers had recently been brought back into the service since the start of the pandemic and had received relevant refresher training. They were receiving a full induction back into the ward environment having had over a year away and were buddied up with a nursing assistant for their first few weeks back for additional support.

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. These were held weekly on the inpatient unit and involved medical, nursing, allied health professionals and psychological support staff. Individual patients and their ongoing care needs were discussed in detail. Handovers and safety huddles had involvement from the multidisciplinary team including physiotherapist support in areas such as falls prevention.

Staff worked across health care disciplines and with other agencies when required to care for patients. Inpatient unit staff had a good understanding of the support available from other agencies and there were referral processes in place. Hospice at home staff worked in partnership with other health and care providers to meet the needs of patients. There were open discussions between professionals to support patients transitioning between services.

Seven-day services

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

Consultants and speciality doctors led daily ward rounds, including weekends. There was medical and senior nurse support for the inpatient unit 24 hours a day through the on-call system.

The hospice at home service was available seven days a week.

Good

Hospice services for adults

Health promotion

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

The service had relevant information promoting health and wellbeing. This included advice and support on nutrition, pain control, emotional and spiritual needs. Staff cared for patients with a holistic approach and regularly monitored patients' wellbeing.

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. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They had received training in the mental capacity act (2005) and assessments of capacity were routinely carried out. Best interest decisions were made with input from family members when patients did not have mental capacity to make decisions.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. This included consent to share information internally and with other relevant service providers who were involved in the patients' treatment and care. A June 2021 audit of consent recorded within patient records showed 100% compliance.

Managers monitored the use of Deprivation of Liberty Safeguards (DoLS) and made sure staff knew how to complete them. DoLS applications were completed appropriately and monitored by service leads through monthly performance metrics and a patient dashboard. Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. The medical team regularly assessed patients for confusion or delirium, using nationally recognised assessment tools. All clinical staff used a mental capacity assessment form when a formal assessment of capacity for a required decision was made.

Patients were supported to develop advance care plans and recommended summary plans for emergency care and treatment (ReSPECT) forms were in use. Do not attempt cardiopulmonary resuscitations were appropriately recorded and there was evidence of decisions being made with involvement of the patient and those close to them.

Are Hospice services for adults caring?

Good

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

Compassionate care

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

Staff were 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. Patients told us that staff introduced themselves by name and consistently knocked before entering their room, asking for consent to enter.

Patients said staff treated them well and with kindness. One patient described staff as 'brilliant', saying 'nothing is a chore, they are always happy to speak with me'. The family member of a patient who had died on the inpatient unit described the staff as 'fantastic'. Feedback from a patient using the virtual neurological day service described staff as bringing out the best in them and changing their life. We observed staff taking time to interact with patients and treating them with respect and compassion.

Staff worked together to support patients' individual needs. They supported them to celebrate special occasions, for example, children's birthdays. There was a whole team approach to organising a wedding for a patient wishing to marry their long-term partner before they died. Catering staff provided food and a wedding cake and housekeeping staff organised decorations. A day service patient had been supported by staff to fulfil a wish to go sailing. A member of the hospice at home team got in touch with a patient's favourite football team who provided memorabilia for the patient as a surprise.

Staff followed policy to keep patient care and treatment confidential. Paper records were locked away and patients were cared for in individual rooms. We observed staff taking care to ensure that conversations were confidential and not overheard.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Chaplaincy support was available. Patients told us they were supported by the chaplain irrespective of their chosen faith or none. Assessment processes included all aspects of the patient's cultural, social and religious needs. Aspects of social, psychological and spiritual care were incorporated into multidisciplinary meetings. Staff had been trained in equality and diversity and study days included training on meeting a variety of needs. Patients were consistently asked about what mattered to them and staff endeavoured to meet those needs.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients consistently provided positive feedback on their experience of care. We reviewed patient experience reports that showed over 90% of feedback scored 100% in terms of patient's care experience. All patient experience reports had a score of over 90%. Patients stated they felt listened to, that staff were friendly and helpful and consistently described the care they received as excellent.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. All staff had received training on having courageous conversations and enhanced communication skills. We saw that developing supportive and empathic communication was central to the ethos of the service. Study days for nursing and support staff consistently included sessions on developing communication skills to support patients and their families.

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. We heard of examples of staff going out of their way to support the wellbeing of patients and their families. This included preparing a special meal for a patient's wife on their anniversary, organising flowers with a local florist for a patient's family member and contacting a film producer to organise a pre-release film that a patient wanted to see.

Staff made the hospice welcoming and supportive to those close to patients. They understood the difficulties experienced by families during the pandemic and offered additional support to help them visit despite some restrictions. Staff helped patients and their loved ones create memory boxes. Family support staff were visible on the inpatient unit, providing support. For example, with daily visits to the inpatient unit to support people to come to terms with their situation when nearing the end of life.

The hospice memorial service had been cancelled due to the pandemic; however, a spiritual care volunteer arranged a virtual service providing an order of service for families to reflect at home. Positive feedback and cards were received following these services.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Involvement of patients and those close to them was central to decision making and the culture of the service. Staff consistently found ways to support patients to make decisions within the framework of 'what matters to me'. Information leaflets were available to support discussions and patients were given time to fully understand their options.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff used picture cards when communicating with patients who were not able to express themselves verbally. This helped them to communicate how they were feeling, allowing staff to better understand and support them. Patients and family members consistently stated they had enough time to communicate with staff and did not feel rushed.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. There were several feedback mechanisms in place, including friends and family test, patient experience feedback and bereavement support feedback. Patients and their families were consistently positive about the care received. Feedback was included in monthly integrated quality and performance reports and was regularly shared with staff.

Staff supported patients to make advance decisions about their care. All staff had received training in advance care planning. Asking patients about their treatment and care wishes was central to admission and ongoing assessment processes.

Staff supported patients to make informed decisions about their care. 'What matters to me' records provided a framework for including patient's wishes. These included helping patients to identify their priorities, favourite things to do and goals they'd like to achieve. Patient feedback included that staff consistently involved patients in decisions, listened to their concerns and supported them to make decisions focused on quality of life issues.

Patients gave positive feedback about the service. Feedback from patients and their families on the inpatient unit was consistently positive about their experience of treatment and care. Overall positive feedback was above 90%, with most friends and family test and patient experience feedback at 100%.

Feedback about hospice at home services included that staff were helpful and helped to reduce the worries of the patient's family. Staff were described as caring and thoughtful, professional and caring. Families described the impact of the service in terms of the support providing relief. One relative stated that the support provided enabled them to be the patient's wife and not just their carer.

Good

Hospice services for adults

Feedback about bereavement and family services included that staff were good at listening, focused on general wellbeing and helped service users to develop coping strategies and better deal with their bereavement.

Are Hospice services for adults responsive?

Good

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

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. The service provided inpatient and hospice at home palliative and end of life care. Managers had increased the hospice at home provision in response to more people wishing to be cared for at home. This was aligned with plans to continue to increase the hospice at home care provision in the long term. The service also provided a day service for patients living with long term conditions. The face to face day service had paused during the pandemic and had been developed into a virtual group. Activities included discussion groups, complementary therapies, chair-based exercise, art and relaxation. Family support services provided one to one support in preparation for and following bereavement.

A project had recently been set up to increase inpatient bed occupancy. Work was planned to explore referral routes into the hospice, obstacles for referrers and internal processes around admissions. The aim of this project was to improve patient access and outcomes.

The hospice had expanded their hospice at home services in collaboration with the local clinical commissioning group (CCG) and a partner hospice. The service was designed to support patients requiring rapid discharge from hospital to be cared for in their preferred place of death, for example, their own home.

During the COVID-19 pandemic the hospice neurological day service had stopped. This was then redesigned as a virtual service where patients could access hour long virtual sessions for support in their own homes. Group activities included complementary therapies where patients and their family were taught interventions such as massage and reflexology. Other virtual interventions included physiotherapy, occupational therapy and psychological support as well as social interaction.

Facilities and premises were appropriate for the services being delivered. Patient rooms were spacious and had direct access to the garden. There was communal space for patients and their families, however, this was not in use during the pandemic. Visiting arrangements took account of COVID-19 risk assessments and visitors were able to access rooms directly from the garden. Patients were supported to see their family and people close to them. Visiting was arranged through a booking system so that staff could ensure patients, visitors and staff were safe and appropriate safety measures were in place. Visitors were encouraged to stay in patient rooms rather than spend time in communal areas, and were provided with refreshments as required. There were no restrictions on the amount or timing of visitors when patients were approaching the end of life. When restrictions to visiting were in place during the pandemic, staff supported patients to connect with those close to them using virtual methods.

Good

Hospice services for adults

The service had systems to help care for patients in need of additional support or specialist intervention. Staff had received training to meet the needs of patients with additional needs. This included training in understanding the needs of patients with learning disabilities or dementia. They had a good understanding of the services available to support these patients and worked collaboratively to meet their needs. Psychological support services were available within the hospice.

Meeting people's individual needs

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

Staff made sure patients living with mental health conditions, learning disabilities and dementia, received the necessary care to meet their needs. There were dementia champions working within the hospice. Staff used 'what matters to me' documentation to identify individual patient needs. The day service hosted a drop-in service to support people living with dementia and their carers, although this had paused during the pandemic. The hospice environment was dementia friendly with clear signage and staff used recognised symbols to identify patients with dementia so that all staff were aware of their additional needs.

Managers made sure staff, and patients, loved ones and carers could access interpreters or signers when needed. Staff told us they were able to access interpreting services when they needed them. Services were available via telephone or face to face when required.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Catering staff took time to understand the wishes of individuals and adapted individual menus to meet those needs.

Staff had access to communication aids to help patients become partners in their care and treatment. The 'what matters to me' process included information displayed on a white board in patients' rooms. This ensured that patients wishes were visible to all staff involved in treatment and care, irrespective of the patient's ability to communicate verbally. Information about what mattered to patients was obtained through initial and ongoing assessment and discussion with family and those close to the patient.

Staff understood the needs of different groups of people including people living in vulnerable circumstances. There were dementia champions working in the hospice and outside of the pandemic the hospice had run a dementia café for drop-in support for people living with dementia and their carers. The hospice had reached out to traveller communities to inform them about the services available. Staff had received training in meeting the needs of people from different communities and there was a religious guidance document, detailing different practices and traditions in end of life care.

Care after death was managed sensitively and staff respected the wishes of the deceased person and their families. There were effective arrangements with funeral directors and staff told us that collection was arranged promptly once the needs of the deceased and their relatives had been met. Religious resources were available for patients, families and staff.

The hospice's family support team provided virtual and telephone support during the pandemic to ensure patients families and friends continued to be supported whilst restrictions were in place for accessing the hospice.

Good

Hospice services for adults

Access and flow

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

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The average wait for an inpatient bed between June and August 2021 was five days. There were effective processes for managing inpatient admissions. Referrals were generally made by patient's GPs, hospital and community teams. Referral meetings were held twice a day and patients were triaged and admitted based on their individual needs, incorporating acuity and capacity on the inpatient unit. Referrals data was collected and reported through the monthly integrated quality and performance report that was shared with senior managers and team leaders.

Managers collected information about referrals, including those that had not resulted in admission. Data was regularly reviewed as part of quality improvement meetings. Reasons for not admitting someone included where patients were unable to be transferred due to declining health, personal choice and where there was insufficient capacity on the inpatient unit.

Where patients were unable to be admitted immediately, the hospice assessed individual needs and where appropriate provided support to patients at home through the hospice at home services. In this situation patients generally had a first contact with a member of the hospice at home team within a few hours. Data showed that between June and August 2021 first contact was made, on average, within three and a half hours.

The hospice at home service worked with other services in the community and provided nursing care, psychological and emotional support and symptom management. The service was provided by registered nurses and nursing assistants. The hospice at home caseload had increased from an average of six patients in 2020/21 to 14 patients in 2021/22. The service had a fast track contract with the local clinical commissioning group (CCG), providing support to patients wishing to die at home. Nursing assistants provided personal care and registered nurses provided support to district nurses with symptom control. Data showed that 97% of patients referred died in their preferred place of care.

Managers and staff worked to ensure discharge planning was started as early as possible. Discharge plans were commenced at the point of admission to the inpatient unit, with assessments of discharge needs carried out. Staff worked with other local services to support prompt discharge. The hospice at home service provided a dedicated rapid discharge service for patients whose preferred place of care was in their own home. There was more consistent recording of preferred place of care following the hospice's previous inspection.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. There was a multidisciplinary approach to discharge planning. Staff referred patients appropriately to other services to support their discharge.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. Staff encouraged patients and those close to them to raise concerns so these could be addressed. There were processes to deal with complaints promptly. Where issues were not able to be addressed immediately people were supported to go through the formal complaints process.

Good

Hospice services for adults

Managers investigated complaints and identified themes. They acknowledged complaints immediately and offered meetings with complainants to understand the issues and find solutions. Three complaints had been received in the six months prior to our inspection. Issues included communication and concerns about aspects of care during COVID-19 relating to restrictions on visiting in line with government guidance. These were addressed promptly by senior staff and feedback was given to staff involved.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Information about complaints was reported as part of the integrated quality and performance report and reviewed regularly by the quality improvement group. Action to address issues was shared as part of this process. Staff could give examples of how they used patient feedback to improve daily practice. When concerns were raised as part of routine feedback processes these were also addressed promptly. For example, where patients commented on issues such as a dripping tap.

Managers shared feedback from complaints with staff and learning was used to improve the service. Complaints were discussed as part of regular staff study days and reflective practice was encouraged. In addition, compliments were shared with staff regularly. There were a significant number of compliments. We viewed a collated log of 259 compliments received between April 2020 and October 2021. Compliments were routinely shared with staff.

Are Hospice services for adults well-led?

Good

Our rating of well-led went down. We rated it as good.

Leadership

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

There was a clear leadership and management structure. The day to day management was the responsibility of the service director, head of operations, head of clinical services, head of fundraising and service manager. They were supported by the medical team, managers and team leads of each department. The senior management team reported to the Sue Ryder executive leadership team who were responsible to the board of trustees.

Leaders recognised the priorities and challenges faced by the hospice and acted to address these. For example, they took action to prioritise patient safety and quality of care. During COVID-19 they addressed issues as they arose and followed government guidelines to keep patients, visitors, volunteers and staff safe.

Leaders were visible and approachable, and staff told us they felt supported. Leadership development opportunities were available to staff, with additional training opportunities available to support this. This was incorporated into the Sue Ryder organisational strategy.

Good

Hospice services for adults

Vision and Strategy

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

There was a clear vision and a set of values, with quality and sustainability as the top priorities. The hospice vision and strategy were those of Sue Ryder, with strategic aims to provide care and support for more people and influence new models of care across the UK. The 2018 – 2023 five-year strategy focused on eight work streams including strengthening brand and culture, expanding community services, developing buildings, investing in education, enhancing use of technology, influencing care delivery and growing online support. From January 2021 the strategic change programme had been revised in order to provide more focus as a result of the pandemic. This included impacting the growth of palliative and bereavement services and new healthcare models; financial stability; brand and culture; and, technology and data, including growth in virtual care.

The strategy was developed in collaboration with staff, service users and external partners. It was aligned to national recommendations for palliative and end of life care. The strategy took account of the needs of a growing and ageing population and an increase in people being cared for in the community rather than inpatient settings. The revised strategy incorporated learning from the pandemic, for example, through a focus on creating more virtual care models.

The hospice had worked to develop services in line with the strategy. This included the expansion of the hospice at home service and the development of a virtual day service for people with neurological conditions. Progress against delivering the strategy and local plans was monitored and reviewed.

Culture

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

Staff we spoke with were passionate about providing high quality palliative and end of life care. They were proud to work at the hospice and they worked well together as a team. The senior management team were approachable and visible, and staff generally felt valued. Staff were surveyed anonymously by leaders and this included aspects of management and leadership that influence culture within the service. This survey included asking staff if they felt valued by their immediate line manager and responses to this were positive. The highest scoring question in the most recent staff survey related to staff feeling motivated to help Sue Ryder provide more care to more people.

Equality, diversity and inclusion were promoted within the service. A Sue Ryder cultural development programme had been launched in February 2020. This included identified and agreed values and behaviours across the organisation. The values were identified as supportive, connected and impactful. Each value incorporated defined behaviours that included respect, communication, collaboration, challenge and improve. The values and behaviours work were influenced by survey results from both staff and volunteers, service user feedback and working groups that involved representation across the services.

A 2018/19 corporate culture audit identified gaps in equality, diversity and inclusion. A steering group was established as a result and a strategy developed in 2020 with special interest networks set up. These were black, Asian and minority

ethnic communities; people with disabilities; lesbian, gay, bisexual, transgender and queer/questioning+ (LGBTQ+) communities; and, women & non-binary individuals. Action to date included valuing difference training, a review of recruitment processes, strategic investment, a review of policies and an agreed target date for inclusive employer accreditation.

There were opportunities for career development. Staff we spoke with told us they were aware of the opportunities and we saw examples of staff who had been supported to develop into senior roles. Staff survey results showed that not all staff felt there were enough development opportunities. A survey action plan included raising the profile of education and training to support staff development within the service.

There was an emphasis on the safety and wellbeing of staff. There were lone working protocols such as risk assessments and buddy systems. Community staff were piloting the use of lone worker devices where they could easily raise the alarm if in danger in the community. There was a whistleblowing policy in place. Staff could raise concerns with line and senior managers or through a staff helpline. Advice was given to staff on raising concerns externally and who to report these to. Staff told us they felt able to raise concerns with their line managers. Mind care sessions were provided for staff to support their wellbeing and there were trained mental health first aiders working at the hospice. There were systems in place to recognise the achievements of staff and volunteers, including colleague nominated recognition for staff and long service recognition for volunteers.

Patients and those close to them told us they could raise concerns, and these were addressed. We saw evidence of this in response to feedback processes.

Governance

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

There were effective governance structures, processes and systems of accountability to support the delivery of quality services and high standards of care. The service had a governance structure that aligned safety, quality assurance and quality improvement. The Sue Ryder executive leadership team reported to the council of trustees. There were three sub committees; health and social care; audit, risk and commercial; and, people and remuneration. A health governance group had oversight of groups such as research and governance, learning and development, medical devices, and, professional forums for palliative and neurological services. There were clear lines of reporting, governance and accountability between the hospice senior leadership team, the quality improvement groups and other governance structures within Sue Ryder.

Quality and risk information was reviewed from hospice through to board level governance. Monthly integrated and quality performance reports used collated data and feedback to inform management discussions and decisions. Monthly quality improvement group meetings were held. The agenda was aligned to the Care Quality Commission (CQC) key questions of safe, effective, caring, responsive and well-led. We reviewed meeting minutes from March to August 2021 which demonstrated governance issues such as risks, incidents, complaints, staffing, feedback, audits and training compliance were reviewed and discussed. Information was fed from the relevant corporate groups into the health governance committee, the health and social care sub-committee and the council of trustees.

Staff were clear about their roles and accountabilities. Reporting structures were embedded within the services. There was a high incident reporting culture and staff were actively involved in quality and safety improvement mechanisms, for example, the huddle up for safer care (HUSH) programme.

There were arrangements for managing and monitoring contracts and service level agreements. For example, we saw that arrangements for pharmacy provision were under review.

Management of risk, issues and performance

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

There were clear processes for identifying and mitigating risks. There was a local hospice risk register. Risks included that patient records were recorded electronically and on paper, recruitment and retention of medical staff and registered nurses, and, the risk of COVID-19. The potential hazard from each risk was identified with a RAG (red, amber, green) rating which was reviewed once mitigating actions had been implemented.

Actions to mitigate the risk of COVID-19 included reducing the footfall within the hospice and other risk management strategies in line with national guidance such as social distancing, testing, vaccination and use of personal protective equipment (PPE). The risk rating for COVID-19 had reduced from 25 to 16 with mitigating actions.

Individual risk assessments were carried out for each patient on admission and reviewed regularly during admission. Risks from falls and pressure ulcers were mitigated with appropriate measures such as huddle meetings and the use of pressure relieving equipment.

Environmental risk assessments were undertaken by internal facilities staff and external contractors. There were effective arrangements in place to mitigate the risks from fire, legionella and slips, trips and falls.

Current and future performance was monitored through a range of information and we saw evidence of this in the integrated quality and performance reports. Information included safety measures, feedback and performance against key performance indicators. This information was shared with commissioners as part of ongoing performance monitoring.

Information Management

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

There was a comprehensive understanding of performance. Information on quality, operations and finances were collated, along with people's views of the services. The monthly integrated quality and performance reports were produced with sufficient information and analysis to inform leaders and staff of performance and quality indicators. Reports included data on a range of indicators including incidents, staffing, complaints, service user feedback and other activity metrics. Performance was tracked over time and benchmarked against other hospices managed by the provider. Performance was highlighted and used to drive improvement.

Statutory notifications were submitted to external bodies as in line with requirements. Quality data was reviewed by the quality improvement group, the executive leadership team, board of trustees and shared with the clinical commissioning group.

Staff had access to up-to-date and comprehensive information about patients' care and treatment. The electronic patient record system was aligned with record systems used by GPs and community services. Information was shared with appropriate consent. Information was kept secure with electronic devices encrypted and password protected.

Medical notes were in paper form despite there being the facility for these within the electronic system. Leaders recognised that this was a risk and it was identified on the service risk register. A working group had been created with involvement of key staff including members of the medical team. The aim of the group was to integrate the patient records onto the electronic system effectively and ensure medical staff training was completed for the use of the system. Issues had been identified following a serious incident review, where communication between medical and nursing staff had been impacted by the two-system approach to the management of patient information.

At our inspection in 2019 we identified that not all patients had their preferred place of care identified on the electronic system. The service had taken action to address this and we saw that preferred place of care was consistently recorded. We saw that 91% of patients had their preferred place of care recorded.

Engagement

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

People's views and experiences were gathered and acted on to improve services and patients' experience. There were a range of feedback surveys, including inpatient experience, friends and family test, mealtime and environment surveys. These enabled patients and those close to them to provide regular feedback on different aspects of the inpatient service. Hospice at home, day service and bereavement services were also subject to regular service user surveys. Feedback from patients was overwhelmingly positive. Where concerns were raised these were acted on promptly and improvements evaluated by the integrated quality and performance group.

Engagement processes were integrated into the hospice governance framework. The hospice had a service user group with people whose lives had been affected by a life limiting condition. This included both patients and family members. The group facilitated improvements in people's care and influencing the development of future hospice services. The objective of the group was to establish open communication for patients and their families to influence services and highlight issues. The group had met monthly prior to the pandemic and was in the process of restarting at the time of the inspection. The group was represented on the hospice's quality improvement group.

The views of staff were sought and acted on. A staff survey had been conducted in April/May 2021. Results were benchmarked against Sue Ryder as a whole and hospice services specifically. Thorpe Hall results were similar to other hospices. For example, overall hospice survey results scored 7.5 and Thorpe Hall scored 7.4. Questions were focused on themes such as support, communication, collaboration and improvements. Additional questions relating to the COVID-19 response were included in the most recent survey. Lower scoring areas were incorporated into an action plan. For example, Sue Ryder were reviewing pay inequalities, raising the profile of development opportunities and were organising service level visits by the executive leadership team to increase visibility.

There were collaborations with partner organisations and commissioners to develop services. This was evident within the hospice at home service in order to expand the service to meet the needs of patients cared for at the end of life in the community. Leaders regularly engaged with other services, equality groups and commissioners. They were involved in community groups such as the Dementia Action Alliance.

Good

Hospice services for adults

Learning, continuous improvement and innovation

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.

Leaders and staff strive for continuous learning and improvement. Standardised improvement tools and measures were in place. There were systems to support improvement and innovation work. These included the use of clinical audit, investigations and pilot processes to test effective solutions. Examples of improvement included actions following a serious patient fall. There was a collaborative approach to the investigation, learning and improvement with staff involved from across the hospice. Nursing staff implemented the huddle up for safer care (HUSH) programme, physiotherapists developed resources and the practice educator delivered specific training to staff.

As part of the hospice at home expansion project the hospice worked collaboratively with the regional palliative and end of life care board, other providers and commissioners to provide services for local patients requiring fast track discharge from hospital to receive end of life care in their own homes. This helped to achieve preferred place of care for patients wishing to die at home.

After the neurological day service had ceased in March 2020 due to the pandemic, staff continued to speak with the members of the group weekly. Following these discussions staff developed a model to restart the group virtually so as to be complaint with COVID-19 restrictions. The new model of service delivery allowed virtual working with another Sue Ryder hospice and greater opportunity for people to experience a wider range of sessions.

The practice educator worked collaboratively with another hospice to set up virtual study days for care home staff to teach about end of life care, advance care planning, bereavement support and staff wellbeing and support during the pandemic.

A transition coordinator started at the end of 2019, working across Thorpe Hall and other regional hospices. This enabled Thorpe Hall to make and build links with children services within Peterborough in order to get to know young people and their families before they turn 18 and move to adult services. A coffee morning was planned for November 2021 to start to meet some of these families.