

KEMP Hospice

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Inspection report

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Ratings

Overall rating for this service

Good ●

Is the service safe?

Good ●

Is the service effective?

Good ●

Is the service caring?

Good ●

Is the service responsive?

Good ●

Is the service well-led?

Good ●

Summary of findings

Overall summary

This inspection took place on 15 June 2016 and was announced.

The provider for Kemp Hospice provides personal care to older people with life threatening and life limiting conditions at the later stages of their lives who live in their own homes in the Wyre Forest and surrounding area. The provider also provides a day hospice service within the same building as the home care service. This service is not regulated by the Care Quality Commission [CQC]. At the time of our inspection two people were using the hospice at home service.

There was a manager who was also known as the head of care and was currently applying to become the registered manager at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Potential risks to people and staff were assessed with preventative measures put in place. This was done in consultation with people and health professionals who were already involved in providing care to people who live in their own homes. Staff knew how to recognise and report any concerns to keep people safe from harm. People who needed staff assistance to take their medicines were supported by staff who had received training to do this safely.

Staffing resources were managed with care to make sure people received the support at the right time and in the right way for them. Arrangements were in place to ensure potential new staff were only recruited once essential background checks had been completed to show they were suitable to provide care to people who lived in their own homes. Staff had the knowledge, skills and experience required to meet people's individual end of life care needs effectively and were actively supported with on-going updates to meet people's specialist needs. The manager provided staff with supervision and support including gaining feedback from people who used the service around staff member's practices in delivering the care people required to promote best practice.

People were at the heart of the service as staff worked closely with other professionals to promote people's wellbeing and enable people's wishes to die at home to be fulfilled. Staff saw themselves as part of the community palliative care team which supported people in receiving a seamless service at the end of their lives. People were actively involved in deciding upon their choices and preferences which were detailed in their advance care plans so people received effective care and support as they wished. Relatives told us the care and support they received provided them and their relatives with the opportunity to realise their wish to receive their end of life care at home.

Staff promoted people's wellbeing by working in close partnership with health professionals so where required they could effectively respond to people's eating and drinking needs. Staff shared information

when they had supported people with district nurses to make sure people's changing needs, symptom and pain management was responded to.

Staff showed they cared about people they supported and felt privileged to be part of people's lives at such an important time. Relatives consistently felt staff were there for them and showed kindness when they required comfort as well as their family members. Staff were proud of their caring roles and treated people respectfully and promoted their dignity. The provider sought people's opinions on the quality of the service and encouraged people to raise any concerns or suggestions.

The leadership team showed they were committed to continual focus upon improvements to make sure the services offered reflected the needs of people who lived in the local community. A five year action plan was in place which showed the areas for improvements and what had been achieved to enrich the end of life care people received.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

Staff knew how to recognise and report any concerns to keep people safe from harm.

The provider assessed any potential risks to people and staff and put preventive measures in place where these were required.

Staffing resources were managed with care to ensure people's individual needs were met at the right time and in the right way for them.

Background checks were completed to make sure staff were suitable to work with people who used the service in their own homes.

People who needed staff assistance to take their medicines were supported by safely by staff who knew their responsibilities in this aspect of people's care.

Is the service effective?

Good ●

The service was effective.

People were supported by staff who had the specialist knowledge, skills and experience required to meet their individual end of life care needs.

Staff worked very well with local healthcare services and supported people to access any specialist support they needed.

People were supported to make their own decisions and choices about their care and treatment. Their consent was sought by staff.

People's eating and drinking needs were known by staff so they could support people if this was required.

Is the service caring?

Good ●

The service was caring.

People were provided with care and support which took account of each person's personal needs and preferences.

People were supported to have choice and control over all aspects of their care and treatment.

People were treated with dignity and respect and their diverse needs were met.

Staff supported the emotional wellbeing of people and their relatives. End of life care was provided with sensitivity and bereavement support offered.

Is the service responsive?

Good ●

The service was responsive.

People received personalised care which was responsive to their changing needs.

People were actively involved in devising their own advance care plans which described the care and support needed together with people's aspirations.

People knew how to raise concerns and complaints, any received would be reflected upon to gain future learning opportunities.

Is the service well-led?

Good ●

The service was well led.

People who used the service and their relatives had opportunities to comment and influence the quality of the service provided.

Staff enjoyed their work and were proud in supporting people at the end of their lives so their wishes to die at home could be realised.

There was an effective quality assurance system to monitor the service people received. There was a five year plan in place which reflected the areas for improvement and what had been achieved with the impact very much centred on people who used the services.

The manager was committed to continually improve services to make sure they reflected the needs of the local community.

KEMP Hospice

Detailed findings

Background to this inspection

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

This inspection visit took place on 15 June 2016 and was announced. One inspector carried out this inspection.

The provider was given 48 hours' notice because the location provides a hospice at home care service and we needed to be sure that someone would be in.

We looked at the information we held about the service and the provider including statutory notifications. Statutory notifications include information about important events which the provider is required to send us.

We sought information about the quality of service from the local authority and the clinical commissioning group. In addition to this we received information from Healthwatch who are an independent consumer champion who promote the views and experiences of people who use health and social care. We used this information to help us plan this inspection.

We were unable to talk with the two people who were currently provided with a service as we needed to be mindful and respectful of the fact the service was provided to people who were very near the end of their lives. With this in mind we used a number of methods to gain people's views and experiences of the service they received which included talking with people's relatives. We spoke with the representative of one person who was receiving a service and five relatives of people who had been provided with a service before they died.

We also spoke with the manager and two staff. We looked at the forms used to record the individual details and support needs of two people, staff recruitment files and quality assurance arrangements. We also looked at the information about the quality of the service people received from the provider's compliments

and surveys. The manager also sent us some further information.

Is the service safe?

Our findings

All of the relatives we spoke with told us they felt their family member was safe and secure with the staff who came to provide support in their own homes. One relative told us, "The lady was very pleasant and kind which made us both feel safe and secure through the dark hours of the night." Another relative said, "They (staff) put us both at ease and I instantly felt safe and reassured by their caring attitude." A further person said, "It was good to know [person's name] they would be safe and well cared for. [Person's name] really wanted to die at home which is what they were able to do with all the care they needed to keep them safe."

Staff we spoke with knew what action they would take if they saw any signs a person was at risk of harm or abuse in their own homes. We heard consistent examples of staff showing they had the knowledge of recognising and reporting abuse so people were safe from harm. Staff had received training in how to keep people safe and there were up to date policies and procedures in place to guide staff in this area. Although no concerns had been raised the manager showed their awareness of how to work with other agencies should any concerns be raised. This included how concerns would be investigated with actions taken as necessary to keep people safe from harm or abuse.

There were specific arrangements in place to assist staff in supporting people to manage risks to their safety and wellbeing which had been well developed over the years. These were personalised to the nature of the service provided to ensure people's end of life care needs could be met, when they were very near to dying and often at short notice. For example, when people required additional pain relief and or had difficulties in moving staff contacted the district nurses who would take the required action so risks to the person were mitigated. Staff told us close partnerships had been formed with district nurses who had already developed assessments of people's individual care needs and identified risks. Each person's care records were in their homes for staff to refer to and follow. The manager also told us when people were referred for support at home they would provide staff with details about people's identified needs and any possible risks to their health and wellbeing. Staff we spoke with told us they felt the sharing of people's individual needs and identified risks worked well and supported them in assisting people to remain as safe as possible in their own homes.

Staff told us they felt their training alongside the skills and knowledge they had developed over the years supported them in their role of reducing risks to people's wellbeing and safety. This included using specialist equipment to assist people to move safely. Although staff told us people may not require anything during the night other than reassurance and to know support was close at hand if they should require anything. One staff member told us, "It's all about people's comfort in what could be their final hours of life. Knowing when to provide touch appropriately or how to respond when someone is fearful about dying. People would be at risk emotionally if you did not know how to meet people's needs."

Staff understood what their responsibilities were at times of unforeseen emergencies so people's safety and wellbeing was not compromised. For example, staff described to us how they would contact the district nurses if the person experienced additional feelings of pain. The district nurses would visit the person to assess their levels of pain so they were provided with the required pain relief to ease their feelings of

discomfort. Another example which highlighted staff knew what to do in an emergency was if a person accidentally fell they would contact the emergency services. These practices enabled each person to have their needs assessed and receive any treatment they required.

Relatives we spoke with consistently told us it was important for them and their family members to know they were in "safe hands." One relative told us, "I was able to get some sleep if only for a couple of hours knowing [person's name] was safe and had the support they needed. This was worth more than anything else to me at the time." Another relative said, "I knew deep down I needed some sleep but how could I when [person's name] needed me both day and night. They wanted to be at home; it was their last wish but without the support they would have been at risk."

The staffing arrangements the manager described to us reflected a personalised and flexible approach was taken to make sure people's specific needs were met at the right time for them. For example a person could be referred to the service on the day they required the support to meet their particular needs for that night. Staff told us there were no issues about rushing people or only being with people for a few hours as the support centred around what each person needed. Reflecting upon staffing arrangements both relatives and staff told us the arrangements helped to reduce the risks of people not being able to fulfil their wishes to die at home and relatives becoming exhausted.

Staff spoken with told us they had all provided evidence of their identities and references from former employees as part of the provider's recruitment procedures. The staff recruitment files we looked at confirmed this. We saw staff did not begin supporting people until this evidence had been received. Police checks had also been made to show whether potential staff were of good character and suitable to support people who lived in their own homes. One relative told us they would feel unsafe if people came into their home without their background being checked by their employer. They went on to confirm, "People are most vulnerable when living in their own homes and they are so poorly, it is important to be confident in the employer."

People had their medicines prescribed to them by health professionals who were involved in their medical care and either independently took their own medicines or had assistance from their relatives. Staff had received training to support people where this was required, so they were able as much as possible to continue to take their own prescribed medicines.

Is the service effective?

Our findings

Everyone spoken with were positive about staff member's knowledge around meeting people's specific end of life care needs. This was reflected in the care and support staff provided people. One relative told us, "Wonderful support, the lady helped me to cope with what was happening, I could tell they knew their subject area very well as I asked questions and they were able to answer these." Another relative said, "More than pleased with how they (staff) cared for [person's name], they knew a lot and were very professional."

The manager and staff we spoke with told us about the induction and training opportunities they had experienced when they first came into post. Staff told us they had worked in the day hospice alongside other more experienced staff before they supported people in their own homes. One staff member told us new staff would spend the first two hours of the night with them when they supported people in their own homes. This helped new staff gain an insight into the work they would be doing. These arrangements also helped staff to get to know their colleagues, the manager and gain an insight into the organisation they were now working for. Staff felt supported in their roles by their colleagues and the manager. One staff member said, "There is plenty of support and training" and, "There are regular opportunities to share any issues we have and if we need any additional training."

There was a small, stable staff team who told us they had previous experience and knowledge of working with people in social and health care roles for many years. Staff spoken with told us the training opportunities provided were excellent and relevant to their specific roles. The manager told us staff who provided support to people in their own homes were very much part of the wider staffing team. They told us this meant they were included in the range of training and education development opportunities the same as staff who provided support in the day hospice. Staff were also provided with bespoke training and educational updates to ensure staff had the skills and knowledge necessary to support people. For example, as part of the staff team's on-going learning the palliative care consultant shared any updates relevant to the staff member's specific areas of practice.

Staff told us the provider's systematic approach to training had been effective in helping them increase and update their skills and knowledge. Reflecting on some training, staff provided us with examples of how effective communication was important in their roles when supporting people. One staff member told us how people may be anxious about their illness and needed reassurance. They said, "It is important to know when to listen and just be there for the person." One relative told us, "The lady who came really did listen, I was not in a good way but they instinctively knew what to say and were very professional." Another relative said, "They (staff) knew exactly what to say and how to say it, this was so helpful to me at the time as emotionally I was not in a good place but they were not fazed by this. This must be down to the skills they have."

The manager provided staff with supervision to ensure they had the knowledge and skills to do their role effectively and in line with the provider's values and ethos. This included checking with people and family members about the quality of support they had received and how they felt it had benefited them. They also used surveys as another method of making sure the care and support staff provided was effective in meeting

each person's end of life care needs. We saw some of the compliments people had made in writing about staff who had provided support. One person commented, 'I could not have coped at home without the specialist care of you all at Worcester Palliative care team, you were exceptional. During the night a lovely lady named [staff members name] would sit with him, enabling me to have a reasonable night's sleep.' Another person had written, 'The service provided was first rate and the carers did a brilliant job under very trying physical and emotional circumstances.'

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA and applications must be made to the Court of Protection. We checked whether the service was working within the principles of the MCA and discussions with staff showed that they were aware of the principles. Due to the bespoke nature of this service any best interest decisions would already have been made where required with other agencies who were the primary lead in people's care. Staff told us they would follow these when they were related to the care and support they provided.

Staff spoke with us about how they sought people's consent when they provided any care and support to people. This was also confirmed to us by relatives we spoke with. One relative told us, "The carers always included [person's name] in all of the support provided. They never did anything without checking out if this was what we needed." Another relative said, "We provided our consent to the carer coming into our home. Nothing is taken for granted; it was all on our terms."

When staff supported people they were made aware of people's eating and drinking needs which would have already been identified by other healthcare professionals. One staff member told us because they mainly supported people during the night the person's dietary needs were managed independently in their own homes with healthcare professionals and relatives support. One relative told us, "When [person's name] needed a drink of water during the night, [staff member's name] helped them."

Staff worked closely with a range of local healthcare professionals including, doctors, district nurses and MacMillan nurses. We heard many examples from relatives and staff about how people were provided with seamless palliative care and treatment because of the close relationships formed by health professionals. Relatives felt this had a positive impact on their family member's end of life care as it made them feel confident and assured that all the health professionals were knowledgeable about their family members specific health conditions. One relative told us, "I could not have coped without the team, right from the district nurses to the lovely lady from Kemp who sat through the night. It is reassuring to know they all brought their knowledge and worked together in order to help me and [person's name] cope." Staff provided us with examples of how their relationship with the district nurses had built up professional trust over a number of years. This had meant they very much worked closely together to complement the service people received to monitor and meet their health needs. One example provided was when people's symptoms changed. Staff contacted the district nurses so people's needs could be reviewed and any treatment they needed was provided.

Is the service caring?

Our findings

Relatives told us their family members were supported with care and kindness which was shown to them as well by the staff who provided support. One relative said, "It doesn't matter what you want, they say don't worry we're here for you". Another relative told us, "The carers supported me and my family as well as [person's name]. This is kindness for you."

The care and kindness shown by staff towards people was also a consistent theme in the positive written comments received from relatives. One relative's comment read, 'My family and I cannot praise you angels enough for your dedication and compassion at one of the worst times of my life.' Another relative had written, 'A very good service with very kind, professional caring people.'

The manager and staff spoken with showed compassion for the people they supported. They shared a strong sense of how the support they provided helped people to fulfil their wishes and preferences to die at home. An example of this was described to us by one person's friend who told us without the support from staff the person would not have been able to remain living at home as they lived alone. They said it was a positive outcome for them as the person was supported to meet their wish of dying at home.

Relatives told us their family members were treated with respect and staff maintained their privacy and dignity. One relative told us how staff ensured their family member was as comfortable as possible during the final hours of their life which included talking through any support even if their family member was not always responsive due to their health condition. The relative told us, "They (staff) treated [person's name] with so much dignity, I can't stress enough how good they were." Another relative described to us how staff asked where their family member would like them to be when they provided support during the night and did not just presume their family member wanted them to sit by their bed. This approach provided people with choice and control over their lives as relatives told us staff always asked their family member for their views around how they would like to receive their support. One staff member said they always checked with people to make sure, before they provided support, people were happy to receive this. They also described to us how they made sure people were warm enough, comfortable and were covered up to respect their dignity.

Relatives we spoke with consistently described to us their family members received their end of life care in accordance with their care preferences. One relative shared with us how their family member had been supported to achieve their care preferences due to the team of professionals who supported them throughout their care journey. They told us the staff from, "Kemp have been an important part of the team of people who helped to support us in our time of need with such valued care. It all helped [person's name] to achieve their wishes." One staff member told us, "We offer holistic, individualised end of life care". This was reflected in the different examples of care and support people told us they received. For example, one relative described to us how they were able to sleep with the confidence if their family member needed some care they would be provided with this through the night. They told us, "The lady was so nice and friendly and they had real knowledge of the care needed. I was able to confidently get some much needed sleep with peace of mind. I knew if [person's name] needed a drink or just a chat this was provided. I would

say this is all round good care for both me and [person's name]."

We heard from relatives and staff spoken with about the arrangements in place which aimed for people to experience comfortable and pain free end of life care. If people received their end of life care at home the medicines required to achieve this were put into place in advance so they could be used when the person required them. One relative told us, "They have made [person's name] comfortable, they have been superb."

Relatives could access bereavement support by staff signposting them to resources. Guidance was available for people about support services which provided people with life limiting and life threatening conditions with bereavement, spiritual, advocacy and counselling help. The manager told us relatives were contacted and offered bereavement support after a period of time following the death of their family member. There was a bereavement service for adults, young people and children.

Is the service responsive?

Our findings

We consistently heard from relatives spoken with how they had greatly appreciated staff support. They said the support was responsive to their family members needs, often at times when their health had rapidly deteriorated. One family member told us, "More than pleased with the support they (staff) gave to [person's name] not to mention the reassurance this gave to me." Another family member said, "I could not have coped without their (staff) support, they were really great at knowing what was needed."

The written comments we saw also reflected how relatives valued the service at their times of need. One relative commented, 'Both myself and my family found the services offered extremely helpful and we would not have coped without the help of Kemp.' Another person had written, 'I cannot thank you enough for the help you gave me, without it I would not have been able to care for my husband at home.'

The manager and staff we spoke with told us they were proud of how the care and support they provided was flexible and responsive to people's individual needs often at very short notice. We heard examples of how people's needs were responded to at very short notice. This included providing care and support to people due to the rapid deterioration of their needs and in times of crisis when a relative may be struggling to enable people to remain living in their own homes as they wished. One staff member told us it was a privilege to support people at the very end of their lives so they were able to achieve their goals to remain living in their own homes. Another staff member said everybody deserved good palliative care and support which included providing comfort and reassurance in a person's final hours of life.

Staff spoken with told us they had sufficient information about people's care and support needs as this had been provided by the manager. They also had access to each person's care records which were kept in their homes. Staff said they listened to people who used the service and their relatives to establish the support they would like at the time of their visit and their preferences. One staff member said, "We observe and listen to people as they are the experts in their own needs. We try our very best to respond in the right way and at the right time for them."

Relatives we spoke with provided examples of how through staff's practices their family member's specific needs and preferences had been responded to. One relative described how staff had taken the time to be with their family member and followed their lead in how they wanted their care and support needs to be met. This included recognising when to provide comfort and when their family member just needed to rest. Another relative reflected upon their experiences of how staff had also responded to their needs by providing them with another person to talk through their anxieties with and to make them feel at ease. They said, "She showed such empathy when supporting me and I knew she would be with me for as long as I needed her. Such values are hard to find."

The manager described to us how over the years through the methods of assessing people's individual needs they had built up strong and trusting relationships with health professionals, such as the district nursing team. The district nurses had care records in people's homes for staff to refer to. Any changes during the support staff provided would be noted in these so people's needs were responded to in the right way for

them. One example staff provided was when it could be unsafe for a person to eat or drink due to their deteriorating health. Staff told us people needs would be reviewed by the district nurses and the outcome of their assessment would be reflected in the care they provided. One staff member said, "People's needs may change rapidly and the district nurses guidance helps us to make sure our care is right for the person." Staff also described to us when people experienced a lot of pain they would contact the district nurses who would visit to do an assessment of each person's needs. Staff told us people experienced pain differently and even when people were not able to fully communicate their pain they would observe the person's facial expressions and body language. This gave them clues about how pain and symptom free a person was and showed they cared about people's quality of life.

The manager told us they always checked whether people had made decisions in relation to their resuscitation known as Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR). This was because it was important for staff who provided support, very often overnight, to have this information. This made sure actions taken by staff in the event of a person's health deteriorating were responsive to their DNACPR decisions. Staff confirmed they had received training in resuscitation and felt competent to respond effectively to changes in people's needs.

The manager told us they used a number of ways to make sure the service provided continued to be responsive to people using the service. One example was by continually monitoring the feedback they received from people. This helped the manager to focus on whether the staffing arrangement's continued to meet the needs of people in the local community at times they needed it. Another example was the offer of complementary therapy for people who received a service in their own homes so people were not disadvantaged from receiving therapies. Complementary therapies, such as body massages, relaxation sessions and aromatherapy would help to support and respond to people's symptoms or side effects or help people to feel better emotionally.

People we spoke with told us they had had no reason to make any complaints or raise any concerns about the service they had received at home. Information about how to make a complaint was included within the information provided to people when they commenced using the hospice at home service. We saw a range of compliments from people which showed they were happy with the support they received. Surveys had been completed by relatives whose family members had received the hospice at home service, which showed the manager sought people's feedback. We saw the manager responded to people's feedback to ensure continual development of the service. For example the manager was focusing on promoting the service further in the local community to make sure people and professionals were knowledgeable about the support which was offered. This was responsive to people's feedback as we saw one person had commented, 'Until we actually received a service, organised by the surgery, we didn't know it was available and were immensely grateful, so perhaps wider knowledge among the patient base would help others.'

Is the service well-led?

Our findings

Relatives spoken with told us how highly they thought of the hospice at home service, staff and the care and support offered to their family members at the end of the lives. One relative said, "I would highly recommend the service as it helped us to get through a very difficult time." Another relative said, "Kemp helped me out, the support was wonderful from the carer."

We found that there was a positive culture which was inclusive and supportive to both people and staff which enabled them to provide their feedback and suggestions about the service. For example, regular surveys were carried out which asked for feedback about the service provided to people in their own homes. We found the surveys gave very positive feedback to the provider. We noted the comments people and relatives gave about the service used words like, 'invaluable', 'excellent', 'absolutely brilliant' and 'extremely helpful'.

The manager of the hospice at home service had changed since our last inspection. The current manager showed us they were committed and passionate about their role in developing the service provided to people who lived in their own homes. For example they talked about plans to ensure the service provided to people enabled their wishes around their preferred place of death to be met. In doing so the manager was forming closer links with professionals who worked in settings, such as hospitals to ensure the hospice at home service was further promoted. They told us they felt supported by the management structure within the wider organisation, such as the chief executive officer and the board of trustees. We spoke with the chief executive officer who talked enthusiastically about their dedication to ensuring the services offered to people met the needs of the local community.

Throughout our inspection, the manager showed an open management style and strong values-based leadership of her staff team. The manager told us the, "Last few days are what people remember." She also said the staff, "Will do above and beyond. We are very lucky they are all conscientious and all very professional. I have a great team and never ask anyone to do anything I wouldn't do myself. Quite happy for them to come into my house." The manager's approach was clearly appreciated by staff. One staff member said, "We can talk to [manager's name] anytime as they are approachable and will listen." Staff knew about the provider's whistle blowing procedure and said they would not hesitate to use it if they had concerns about the running of the service which could not be addressed internally.

We heard from staff they worked as a small team and were motivated by strong values about the care and support they provided enabling people's wishes to remain at home to die to be realised. We heard many examples where staff had a strong sense of placing people at the heart of the service. One example was the partnership working which had enabled them to contact the district nurses when people needed immediate support with their symptoms and pain. Another example was how they supported relatives when their family members were very near to the end of their lives and when they had died if staff were at people's homes at the time. Staff had a sense of how they could contribute to the overall end of life care people received.

Quality checks were undertaken to review and measure the performance of the hospice services people received. The audit checks were seen by all the management team and staff and reported to the board of trustees. Planning ahead was in place for the next five years to ensure the hospice services continued to be developed to meet the needs of people in the community and improve services for the future. This included consultation with people, relatives and other professionals. The manager showed their enthusiasm to ensure future planning, developments and ongoing improvements to the hospice services were driven by the experiences of people. This included factors such as developing and expanding the service offered to more people by exploring gaps in the community service provision for people at the end of their lives taking into account chronic health conditions and best practices.

The manager attended meetings with other hospice managers as a support mechanism and to share practices. The manager told us support was provided to staff in care homes to develop their skills around developing people's advance plans. This helped to promote people's choices around their end of life care. They also told us they had provided hospice staff to people who lived in care homes so the staff member could support a person at the end of their lives on a one to one basis overnight. The manager showed they were passionate about working with other agencies to promote good practice in palliative and end of life care. This enabled the leadership team to continually improve the quality of end of life care people received in different community settings.

The manager told us they used a number of different ways in which to ensure the quality of the service people received was benchmarked with national guidance and other hospices. For example, the provider was a member of 'Hospice UK' where policies and best practices were shared. This helps the spread of knowledge and good practice to enhance the support and care people received at the end of their lives. This reflected the vision of, 'Access, quality and choice in palliative and end of life care and bereavement support for everyone in the Wyre Forest and surrounding areas.'