The Shakespeare Hospice

# The Shakespeare Hospice

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| 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? | Outstanding |

# Summary of findings

## Overall summary

This inspection took place on 6 and 8 April 2016 and was announced.

The Shakespeare Hospice is a registered charity providing 24 hour nursing and personal care services to people who are suffering from a life limiting or terminal illness. The hospice at home service supports people with a terminal illness who choose to die at home. The service provides treatment and care for the physical symptoms during people's final weeks of life and supports their emotional, spiritual and social wellbeing. They also provide support to families and carers during this period and following bereavement. The hospice provides a day service from its building in Stratford upon Avon. The services provided include counselling and bereavement support for adults and children, occupational therapy, physiotherapy, complementary therapies and chaplaincy. There is a specialist transitional service for young people moving between children's and adult's hospices.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. The registered manager was also the chief executive and is referred to as that in our report.

The provider had a vision that put people at the heart of the service offered. This vision was shared by the staff team who were enthusiastic and motivated to provide high quality care in a compassionate way. Staff ensured people were at the centre of everything they did and made to feel they mattered. Staff gave people and their relatives time to discuss their feelings and listened to what they had to say. Staff were responsive to requests for support outside scheduled visits and stayed with people to support them and their families during a crisis or as they approached death.

People and their relatives spoke highly of the kindness of staff who advocated on their behalf whilst leaving them empowered to make their own decisions. Staff supported families to retain their role in providing care, stepping back and allowing relatives to respond to their family member's care needs when they wished to.

There was a holistic approach to providing care and support which involved the service's occupational therapist, physiotherapist and complementary therapists. The hospice at home team worked closely with other organisations to provide care that was responsive to people's needs. Collaborative working ensured people received the support they required and kept them pain free. Staff worked flexibly and people and their relatives told us they received support when they needed it from staff who knew them well.

Staff understood their responsibilities to protect people from harm and were encouraged and supported to raise any concerns. Staff worked with their partner organisations to identify and manage risks associated with people's health and care needs. The service had policies and procedures for the safe management of medicines.

People received care from a multi-disciplinary staff team who were qualified, supported and trained to meet their needs. Staff knowledge was shared in clinical education meetings so people received effective care based on up to date practice. Staff had formal and informal opportunities for reflective practice to discuss the demands of their role and their training and developmental needs. Staff told us they were extremely well supported by the management team and each other and had the resources required to carry out their roles.

The Mental Capacity Act 2005 (MCA) provides legal safeguards for people who may be unable to make decisions about their care. Staff demonstrated a clear awareness of the importance of supporting people to decide for themselves about their care and treatment. People and their families were supported to talk about their wishes and that these were constantly reviewed as part of care delivery. Staff understood the importance of asking for consent to care and waiting for a response.

The chief executive and senior managers had the responsibility for running the service with direction and support from a Board of Trustees. The trustees and senior managers worked closely together so there was an open and transparent system which reviewed all aspects of the service provided. Staff were aware of the roles of the management team and knew who to go to for support and where to seek advice.

People and their relatives were asked for their views which were used as a source of information to provide a service that was founded on what was important to the people who used it. The provider monitored the quality of the service which included checks of medicines management, clinical notes and documentation. Accidents, incidents and complaints were investigated and actions taken to minimise the risks of re-occurrence. The provider shared learning with staff to improve care provision.

There was a strong emphasis on continually striving to recognise, promote and implement innovative systems to improve the service in response to the changing needs of the local community. The provider had researched and identified areas where there were gaps in service provision for palliative and end of life care locally and acted to fill those gaps. The provider was a member of several good practice initiatives where they worked in partnership with other organisations to make sure they were following current best practice and providing high quality care through the sharing of knowledge. People from the community were encouraged to visit the hospice, work as volunteers and be involved in its on-going development. The hospice had received various recognition of good practice awards during the last 12 months, for the quality of care and support provided for people using the service.

The provider was aware of the importance of forward planning to meet the needs of the community and ensure the quality of service they provided could continue to develop. Staff were involved in formulating the strategic plan and committed to developing the service so people could receive the support they needed at the end of their life.

## 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.

People were protected from the risks of abuse because staff understood their responsibility to report any concerns about people's safety or wellbeing. The provider had plans in place to cover staff absence and to support staff in working flexibly to meet people's needs. The provider checked staff's suitability for their role before they started working for the service. Staff handled people's medicines safely.

### Is the service effective?

Good

The service was effective.

People and their relatives received care from staff who were knowledgeable and skilled in their roles. There was a proactive support system to support staff to develop and deliver very high quality care. The provider was committed to the personal and professional development of staff. People's healthcare needs were discussed with people and those closest to them. The provider worked closely and in partnership with other healthcare professionals and providers of care for people with terminal or life limiting conditions.

### Is the service caring?

Good

The service was caring.

People told us all the staff were kind and caring and showed them empathy. Staff were motivated and committed to providing quality end of life care in a compassionate way. Staff gave people and their relatives time to discuss their feelings and listened to what they had to say. Staff acted as an advocate for families whilst leaving them empowered to make their own decisions.

### Is the service responsive?

Good

The service was responsive.

Staff understood people's individual needs and were responsive

to any requests for support. Staff responded quickly when people needed them outside their scheduled visits. People had no complaints but were able to discuss any concerns with staff. Feedback about the service was used to change and make improvements for the benefit of people and their relatives.

## Is the service well-led?

**Outstanding** ☆

The service was well-led.

The provider had a person centred vision and values staff understood that put people at the heart of the service. Staff praised the provider and the management team and felt motivated to maintain high standards of care. There was an open and transparent system of governance which reviewed all aspects of the service provided to ensure quality of care and best practice were achieved and maintained. There was a strong emphasis on continually striving to improve the service in response to the changing needs of the local community. The provider was a member of several good practice initiatives to share learning and best practice. The provider worked with other healthcare professionals and national organisations to develop and influence care for people and their families. The provider had a consistent track record of delivering high quality care and managing improvements.

# The Shakespeare 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 function. 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 6 and 8 April 2016. The provider was given 48 hours notice of our visit. This was because we needed to be sure that the appropriate people would be available when we visited.

The inspection team consisted of two inspectors, a pharmacy inspector, a specialist advisor with experience of palliative and end of life care (palliative care is specialised medical care focusing on providing people with relief from symptoms and stress of a serious illness) and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who has used this type of service.

Before our inspection visit we asked the provider to complete a Provide Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We found the information in the PIR was an accurate assessment of how the service operated. The provider also sent us a list of people who used the service, their relatives, community professionals and care staff. We sent questionnaires to a selection of those people to find out what they thought of the service provided. We looked at the information people had shared when responding to our questionnaires.

We reviewed other information we held about the service. We looked at information received from relatives and other statutory notifications the manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We spoke with local health authority commissioners responsible for contracting or monitoring people's care at the hospice.

At our inspection visit we spoke with a range of people about the service. They included five people and four relatives. We spoke with the Chair of the Board of Trustees, registered manager, human resources manager, medical officer and the head of clinical services. We also spoke with nine members of staff which included nursing staff, health care assistants, therapists and a counsellor. We also spoke with one volunteer. We

looked at three people's care plans to see how their support was planned and delivered. We looked at a selection of medication documents to check medicines were managed safely. We accompanied a nurse and health care assistant on two visits and spent time observing them interacting with people and their relatives. We looked at policies and procedures and the service's governance structure. We reviewed management records of the checks made to assure people received a quality service.

Good

# Is the service safe?

## Our findings

People and relatives told us they felt safe with staff and confident any risks associated with their health conditions were managed. One relative told us, "It's a safe service as they make sure my relative comes to no harm while carrying out the jobs they have to do." One person visiting the day hospice explained, "I feel safe and able to share my feelings in a safe and comfortable environment." One hundred percent of people and their relatives who responded to our questionnaire told us they felt safe with the staff providing their care and support. A healthcare professional responded, "Generally a good, safe, accessible service provided for patients and their families."

People were protected from the risks of abuse. Staff and volunteers were provided with guidance and training so they understood their role in protecting people from harm. Staff understood their responsibilities for keeping people safe and what they should do if they had concerns about someone's safety. For example when asked how they would deal with an abusive situation, one staff member told us, "I would report it to my manager and if I was not happy with the response, I would tell the CQC and the local authority. We have a safeguarding and whistleblowing policy both on line and in hard copy." Another said, "I would report it to the manager and they then tell the local safeguarding team." Information about important contact numbers for the multi-disciplinary child and adult safeguarding teams was available for all staff to refer to. A community professional who responded to our questionnaire wrote, "They (staff) recently handled a potential safeguarding issue with sensitivity and discretion." A safeguarding lead supported staff who had any safeguarding concerns.

There were sufficient staff to keep people safe. Staff worked flexibly so people received support when they needed it from staff who knew them well. One relative told us, "All the staff have a working knowledge of my relative which enables the care to be provided with continuity." Another relative whose family member had received support from the service in the last few days of their life said, "Mainly it was always the same staff who treated my relative." The provider had a 'bank' of nursing staff to provide cover for planned or unexpected absence and in the event a nurse had to stay with a patient due to deterioration in their condition. The registered manager acknowledged that a lot of their support for people and their families was provided in partnership with other organisations. They explained, "We liaise with Marie Curie, McMillan and the district nurses to make sure people get the support they need even though we can't do all the calls ourselves." The provider had plans to recruit another healthcare assistant to provide additional support to the nurses during the evening.

Some staff when responding to our questionnaire told us they sometimes had to work alone at night which could make them feel vulnerable. We discussed this with the registered manager who told us the provider had a lone workers policy and an on call system so staff could get support and help in difficult situations. The registered manager told us, "They do have personal alarms and there is a 24 hour senior manager on call so if there was an issue they could call on that manager. If it was a clinical issue, they can call the on call palliative care consultant." The human resources manager explained that 'keeping safe' was part of the induction when new staff started work. One member of nursing staff told us how changes had recently been made to support their safety at night. As people knew the nurses who would be coming, it was felt the

nurses did not have to wear uniform as this made them obvious; however, they had to wear their identification badges.

The provider's recruitment process ensured risks to people's safety were minimised and that staff with the right skills, knowledge and values were recruited to work for the service. References were obtained and a Disclosure and Barring Service (DBS) check completed before staff were allowed to start work. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with people who use services. Checks were made to ensure nurses were registered with their professional body and fit to practice. Staff we spoke with confirmed all the checks were in place before they were allowed to start working with people.

Staff worked with their partner organisations to identify and manage risks associated with people's health and care needs. The registered manager explained, "The keyworker is always the district nurse and they liaise with the hospice at home nurses." Where risks had been identified, people could be referred to the physiotherapist or occupational therapist for an assessment for specialist equipment to manage that risk. Staff we spoke with understood the need to be aware of any risks in the home environment which could compromise people's safety such as trip hazards.

The provider had a system for learning from adverse incidents and monitoring safety. Incident reporting was covered as part of mandatory training and there was a no-blame culture with staff encouraged to report any accidents, incidents or near misses. Learning from incidents was an integral part of the service's culture and shared with staff at team meetings. The registered manager told us the service was required to comply with the same guidance as NHS Trusts and follow the NHS 'Duty of Candour' requirements. The Duty of Candour is a legal duty on NHS Trusts to inform and apologise to patients following incidents which resulted in moderate or significant harm.

The provider received alerts about people's safety in respect of medical products, equipment or medicines. The alerts were managed by the head of clinical services who ensured that the nurses were made aware of these so they could take appropriate action where necessary.

The service had policies and procedures for the safe management of medicines. Medicines for people who used the service had been prescribed by their own GP's, out of hours doctors or by the palliative care team. Only the registered nurses were involved in administering medicines to patients in their own homes and only when an administration sheet prepared by the district nurses or other community nurses was in place. Medicines were kept in the person's own home and remained their property. Risk assessments were undertaken to identify any potential risks associated with particular medicines or situations. A hospice at home nurse we spoke with was able to provide an example where additional measures had been put in place to keep the patient and their relatives safe.

A recent significant event involving a syringe driver highlighted concerns regarding the paperwork used to record syringe driver prescriptions and doses of 'as necessary' medicines. A syringe driver helps control symptoms by delivering a steady flow of medicines through a continuous injection under the skin. The paperwork was not produced by the hospice so these concerns were raised with the Clinical Commissioning Group End of Life Lead and this was being followed up by the Medical Officer for the hospice. Learning from this significant event was shared within the hospice at home nurse team and also discussed with the community nurses to reduce the risk of recurrence.

A medicines management audit had been undertaken recently and an action plan produced which had resulted in the medicines management policy covering the hospice at home service being updated. A

competency framework was in place and being used by the registered nurses which included clinical competencies associated with medicine use as well as medicine administration and recording.

We visited two people at home with one of the registered nurses. Medication needs were discussed with both families. Medicines were checked and documented and issues identified regarding drug types, suitability and routes of admission. We later heard the nurse discuss these issues with the district nurse and GP to ensure the person continued to receive their medicine in the most appropriate form to manage their pain relief.

Good

# Is the service effective?

## Our findings

People and their relatives told us they received support from staff who were knowledgeable and skilled in their roles. One relative told us, "They are well trained, competent and treat my relative with compassion." One person told us, "The staff all have different skills so they complement each other. If I ask for any information, if they don't know the answer they go and find out straightaway."

People received care from a multi-disciplinary staff team who were qualified, supported and trained to meet their needs. The PIR stated: "The hospice is committed to delivering high quality palliative care which is based on best practice. The clinical staff are encouraged to read the hospice bulletins that are mailed out weekly which provide up to date news on what is topical in palliative care. When new guidelines are published, for example, NICE guidelines on care of dying adults in the last days of live, the link to these guidelines are circulated to clinical staff to facilitate self-directed learning." This ensured people received effective care based on up to date knowledge.

Staff told us they received regular training that gave them the skills to undertake their role safely and effectively. The clinical update programme covered additional training for clinical staff with regards to nursing procedures and tasks. One nurse we spoke with described a recent training session in PEG feeding and medicines administration. (PEG feeding is a system by which people who are unable to take food or fluid by mouth receive supplements via a tube directly into their stomach.) This training had improved their confidence in caring for patients with PEGs in-situ. Other clinical staff told us they had received specialist training in areas such as managing symptoms of nausea and vomiting, chemotherapy, radiotherapy, listening skills and nutrition for people at end of life.

The provider had recently introduced clinical education meetings that occurred alternate months and were led by the head of clinical services and the medical officer. The meetings were based on learning needs identified by the clinical staff who shared their specific expertise and knowledge. For example, the occupational therapist led on neurological conditions and had delivered training and support in that area. One member of the clinical staff explained, "I will request specialist nurses to come and give updates on their role and care they provide. We can ask for training and I can also share my knowledge with staff." The meetings were open to non-clinical staff, volunteers and also community nursing staff.

The provider was committed to the personal and professional development of staff to promote good practice and encouraged them to undertake additional training and gain appropriate palliative care qualifications. The medical officer had commenced the Cardiff University Palliative Medicine Diploma and funding had been agreed for two members of nursing staff each year to obtain the European Certificate in Essential Palliative Care.

New staff had an in-depth induction when they started working at the service. The head of clinical services worked with the human resources manager to plan an individual induction programme for each new member of staff. The induction included working alongside more experienced members of staff and the opportunity to shadow staff from other teams so they had a good understanding of the whole service. The

human resources manager explained, "The induction programme will not conclude until they are happy. We have had occasions when a nurse has asked for an additional week's induction. It is important they are happy. They would always be allocated a mentor and will be given an opportunity to shadow everyone in the team." New staff had regular feedback and meetings with their mentor to assess their progress in their new role.

Health care assistants completed the Care Certificate as part of their induction and training. The Care Certificate is a set of standards for care workers that will help them develop and demonstrate key skills, knowledge, values and behaviours, enabling them to provide people with safe, effective, compassionate, high quality care. One new health care assistant told us they felt well supported in their role saying, "I did a lot of shadowing with a registered nurse and I spent time in the day hospice. I had a few follow ups with [head of clinical services] to see how I was getting on."

There was a proactive support system to support staff to develop and deliver very high quality care. Staff told us they had regular opportunities to discuss their practice and any concerns at clinical and management one-to-one and group supervision meetings. One staff member told us, "We get regular supervision and I feel incredibly valued, there is always a good flow of information from managers." There was a system for providing staff with annual appraisals of their work and training needs. Discussions during these meetings formulated individual development plans that fed into the overall training plan for the service.

Staff told us they had formal and informal opportunities for reflective practice to discuss the demands of their role and their experiences and feelings about caring for people and their families. One member of staff explained, "The hospice at home team is only a small team and if it is a difficult visit or a difficult situation, we tend to reflect a lot together. We have clinical support meetings so it is a set time to discuss any difficult experiences you have had."

Volunteers received induction and training which enabled them to support people effectively. One volunteer told us they also had "monthly counsellor supervisions with one-to-one support" to provide them with emotional support for their role.

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. The application procedures for this in hospices are called the Deprivation of Liberty safeguards (DoLS).

Nursing and care staff understood the role of the MCA and the importance of considering people's ability to make informed decisions about their care and treatment. They had a clear awareness of the importance of supporting people to make their own decisions where possible. Where people had a mental health condition that meant they had difficulty making a decision, staff understood they needed to act in the person's best interests. Staff followed the code of conduct of the Act and understood the importance of asking for consent to care and waiting for a response. One staff member explained, "I always explain what I am going to do and ask first. If someone lacks capacity I would discuss things with the carer or the family." Another said, "I would discuss with the family or advocate if a person lacked capacity. We do complete a mental capacity assessment form. We always ask for consent." A relative told us, "The staff always chat away to my relative saying what they want to do and is that okay even though they find it hard to communicate."

Nutritional assessments were carried out by the district nurse as part of their care planning for people and the two services worked together to monitor and evaluate nutritional needs. Staff supported people and their families to understand the place of nutrition at the end of life.

The provider worked closely and in partnership with other healthcare professionals and providers of care for people with terminal or life limiting conditions. We observed a nurse discussing with a member of the local McMillan team how they were going to support one person over the weekend. This joint approach ensured the person received the appropriate frequency of visits and the support they required to meet their medical needs and keep them pain free.  One member of staff confirmed there was very good collaborative working with other professionals and said, "We have a great communication and will do joint visits together to see patients." Clinical staff attended multi-disciplinary meetings with GPs, district nurses and other clinicians to discuss and plan how people's needs were to be met. One staff member told us, "Joint working creates effective care. You learn from a multi-disciplinary skill mix."

Good

# Is the service caring?

## Our findings

People told us all the staff showed them compassion and empathy. One person told us, "The staff are very caring and compassionate…..nothing is too much trouble for them and the volunteers are the same." One relative explained to us, "They cared for my relative with such love and compassion and care, I don't know what I would have done without them. Not only did they care for my relative, they supported all the family as well." Another relative said, "They are more like friends than nurses and carers. I have a lovely working relationship with them and can talk about anything so they give me great support as well."

One hundred percent of people and relatives who responded to our questionnaire confirmed that staff were caring and kind. One relative had recorded, "I will always be thankful for all the care and wonderful support that [person] received at home during the last week of his life. The team of nurses were absolutely wonderful."

A recurring theme was that staff gave people and their relatives time to discuss their feelings and listened to what they had to say. During our inspection visit we observed people being listened to with patience and interest and encouraged to share concerns. We heard professional and supportive dialogue and humour. Communication was sensitive and issues important to the person were discussed with candour and honesty. One relative told us, "Today I just couldn't cope. I called the hospice and they were here within 30 minutes. They cleaned up my relative, changed the bed linen, chatted away with my relative, made sure everything was okay then they sat and chatted to me – wonderful people they are. When staff have completed all the jobs that have to be done they sit and listen to me and how I'm feeling, it's a great support to me."

Staff we spoke with were motivated and committed to providing quality end of life care in a compassionate way. One member of staff told us, "Delivering care in people's own homes so they can die where they want to be is a great privilege." Another said, "We want people to be as comfortable as they can be at the end of life. It is a privilege to make somebody more comfortable." Staff however, were aware that people's wishes may change and they could decide that being at home was no longer where they wanted to be. A member of nursing staff explained they would support people with those decisions saying, "It is about being where the patient and family are."

Staff told us that one aspect of their roles they valued most was that they could give people time and there was no necessity to rush between visits. They told us that if they arrived and a person was approaching death or there was a crisis, they stayed with that family. Colleagues and 'bank staff' picked up any of their other scheduled visits. One member of staff explained, "That is one thing I love. We can go out to a patient for hours. We do have other visits but there is always someone else to cover those visits."

Staff told us people and their families were supported to talk about their wishes and that these were constantly reviewed as part of care delivery. We were invited to join a 'Planning Ahead' workshop facilitated by the hospice. This was led by the occupational therapist and provided people with an opportunity to discuss their plans for their future care. People were supported to discuss very personal issues such as

where they would like to be cared for as they approached the end of their life. The occupational therapist told us the workshop ensured people could make informed choices and was useful for the start of the pathway to the hospice at home service. People were given the time and space to speak freely without being interrupted. One person told us, "I think the staff listen to me and respect my views, that it is dignified and compassionate."

One nurse explained that an important aspect of their role was to facilitate conversations between people and those closest to them. We read in one person's notes that the previous day they and their nearest relative were given an opportunity to explore their feelings around the person's approaching death. The nurse facilitated this delicate and sensitive discussion and left the room thereby allowing the couple time to discuss their fears, anxieties, regrets and future plans. The relative was grateful for what had unfolded and said it gave them an insight into what their family member was experiencing.

Staff supported people with dignity and respect. One relative told us, "I can call them anytime and when they do things for my relative they make sure the tasks are done with dignity, in privacy and in a safe manner with competence and care."

During our visits we observed staff acted with kindness and compassion as an advocate for the families whilst leaving them empowered to make their own decisions. Staff allowed people to lead on the care they required and gave them choices. Personal care was given in a timely person centred manner with praise and encouragement for tasks achieved by the person throughout. When responding to our questionnaire one community professional recorded, "All staff are very caring and strong advocates for their patients."

Staff demonstrated an awareness they were often supporting relatives who wanted to remain the primary carer in their family member's life. We observed staff stepping back and sensitively allowing relatives to respond to their family member's care needs. Relatives we spoke with told us they felt involved and informed and their views were considered when care and treatment was planned. One relative explained, "I can discuss my views so I feel listened to and respected for what I'm saying. This way I can contribute to the care planning in a positive way."

Relatives and friends could attend the day service for support. The provider had also implemented a 'sitting service' to enable relatives to take breaks from their caring responsibilities. One relative when responding to our questionnaire wrote, "I appreciate the opportunity to visit the hospice on carers' days which gives me the chance to discuss and share my concerns. I now look on this as my respite from the day to day mentally exhausting situation in which I find myself…….the sitting service has helped me recently and allowed me to make a visit when I have had a problem leaving [person] with a friend or paid sitter."

People had access to services which provided support and counselling with regards to their religious and spiritual needs. A chaplain led a team who could support people on their spiritual journey either within a faith setting or not. The chaplaincy was available to relatives, friends and staff.

The hospice provided a counselling and bereavement service to support people and their relatives before, during and after death. This provided people with both emotional and practical support. A social work service provided support which included signposting people to local mediation and advocacy services where they could receive benefits support and advice. The facilities were provided at the day service but transport was organised for people and their relatives who received hospice at home support.

A children's and young person's counsellor provided counselling support to children who had lost a sibling, parent or grandparent. The service was provided by experienced practitioners and trained volunteers who

had an in-depth knowledge of the effects of bereavement on children. Children and young people were supported to share their experiences and make sense of what was happening by using many different creative activities.

The provider had explored ways to ensure that bereavement support carried on for people after the death of their family member. One relative told us, "A few weeks after my relative passed away the staff came and visited me to see how I was and was there anymore that they could do for me." The chief executive explained that as a result of feedback from the staff forum a coffee club had been set up. They explained, "It is for people who have been bereaved for some time but feel lonely or socially isolated. They may have been discharged from our service some time ago, but still need our support."

Staff spoke positively about the caring support they received from the team at the hospice. One staff member told us, "The managers will ask me if I am okay; recently I dealt with a very difficult situation and team members supported me through that." Other comments from staff included: "I couldn't ask for better, all the nurses are a joy to work with and the other professionals. It is a very supportive team," and, "As a team I feel well supported, we can share things with each other. We are close knit and recognise when something is worrying a person."

Good

# Is the service responsive?

## Our findings

People received individualised care based on their own specific needs and preferences. People and their relatives told us staff understood their needs and were responsive to any requests for support. One person said, "If I'm at home and have any concerns, I can call the centre and they support me in that way." Comments from relatives included: "I only have to call the hospice and they respond straight away, I just can't fault the service they provide."

Staff responded quickly when people needed them outside their scheduled visits. We listened to a support call from a carer to one of the hospice at home nurses. The nurse was supportive and identified the continued support that could be provided. They ensured other agencies involved in the person's care were aware of a change in the person's circumstances and confirmed the carer had support until the next scheduled visit. The nurse explained this visit would have been brought forward if necessary. A district nurse contacted the team because a family member had become distressed coping with the needs of their dying relative and needed extra support. The nurse arranged to visit the person that day.

People's care needs were identified and recorded in a shared record with the district nursing service. The hospice at home staff followed the district nursing care plan. Staff made detailed recordings in people's care plans so all the agencies involved in the person's care had the information they needed to respond to changes in health. They also listened to relatives to ensure they captured all relevant information. One relative told us, "I tell them what has happened since their last visit and they update their information."

Records showed that people and their relatives were involved in planning and managing the care people wanted as they neared the end of life. Relatives told us they were kept informed. One relative told us, "Staff talk to me about my relative's changing needs so I know what's happening."

There was a holistic approach to providing care and support which looked at people's physical, psychological and spiritual needs and involved the service's occupational therapist, physiotherapist and complementary therapists. Therapists linked to the day hospice responded to requests to visit people in their own home when a need was identified. For example, the physiotherapist told us they were often asked to assess people around moving and handling issues to make them more comfortable. Support was also given around breathing techniques, effective coughing and fatigue management to assist people and their families to cope with symptoms associated with illness. We were told the aim was to control symptoms and thus improve the quality of life. One therapist told us, "I am proud we are very responsive to people's needs and we get equipment quickly. People tell us they are pleased about that." A complementary therapist told us, "Touch is important; some people welcome it and tell us they think others shy away from them because of their illness….People say things like 'I'm floating on air' and you can see people are often calmer and more relaxed." When responding to our questionnaire, a community professional wrote, "Excellent occupational therapy and physiotherapy makes a real difference to empowering patients to stay at home and especially good at managing breathlessness."

The day service provided a range of facilities and equipment to support people living with a diagnosis of a

life limiting illness. Specialist nurses, therapists and counsellors offered people, their carers and family members physical, emotional and practical support to manage their diagnosis. The day service provided an opportunity for people to obtain help and advice in an informal setting. Some people had asked about how they could access information in a different way about their health conditions. In response the provider was introducing a virtual library which would contain valid, current and reliable information. The chief executive explained, "It is an information system for patients. They often ask questions about their diagnosis so we are uploading information which could help answer their questions."

People we spoke with had no complaints about the service. They told us they were able to discuss concerns about people's needs with staff and if they had a complaint, would report it to the manager. Comments from relatives included: "Staff were available to talk through any issues or concerns that I had and the care was always to my satisfaction, I didn't need to complain but could talk to the manager if needed." One person said, "If I had any concerns or needed to complain, I'd see the manager who is really good at her job."

The service had received two complaints in the previous 12 months. These had been dealt with under the complaints policy and procedure. One complaint had been as a result of inappropriately timed correspondence. The chief executive explained, "We only have one chance to get it right for people. It was an issue with the data base which was cleansed and our letter templates have been reviewed." The other complaint had involved raising the awareness of the provision of funeral directors out of hours.

The service had received 62 compliments in the previous 12 months. The themes identified from the compliments were that people felt supported, safe and that staff consistently demonstrated kindness and compassion. A typical comment was: "Thank you so much for the care you gave to our friend. It couldn't have been better and you made her wish to die at home in her own bed a reality."

Outstanding ☆

# Is the service well-led?

## Our findings

The open and positive leadership of the hospice meant people received high quality care from committed staff. One relative told us, "The quality of care is 100% and there's nothing they won't do for us both." Another said, "I have no concerns or complaints because it is a brilliant service that they provide."

The provider had a person centred vision and mission statement that put people at the heart of the service. This was displayed on the hospice website and within the hospice building. We found staff had a clear understanding of the key principles, vision and focus of the service. Staff were proud of the service people received and enthusiastic and motivated to provide high quality care. One staff member told us, "We are a small service and provide excellent care." Another staff member said, "There is a great ethos here about getting everything right." During our visit we observed staff ensured people were at the centre of everything they did and made to feel they mattered. Staff were kind, compassionate and had the time to facilitate opportunities for people and their relatives to explore their feelings. Comments from staff included, "The best part of this job is making a difference," and "It's okay to sit and spend time with patients, including their families. I don't have to justify myself. It is such a privilege to work with patients." The provider had received a number of compliments which demonstrated a high satisfaction with the care people received. A typical compliment was: "It was such a wonderful feeling when our first nurses arrived and instantly Mum and I knew we were not alone anymore as we cared for Dad. You are an amazing team and the impact you have on families' lives when they are at their most fragile state is invaluable."

There was a strong emphasis on continually striving to recognise, promote and implement innovative systems to improve the service in response to the changing needs of the local community. The provider had researched and identified areas where there were gaps in service provision for palliative and end of life care locally. The research had identified there was limited specialist nursing care in Kenilworth and Southam for people who chose to stay at home in their last few weeks of life. The provider had extended their service to cover these areas. The introduction of the Twilight Service enabled 24/7 support from the hospice at home team. The service provided cover for the evening period which was previously a difficult time for people and their carers to access 24 hour specialist palliative care in Warwickshire.

Another area where the provider's research had identified a gap in service provision was around services for children and young people. The "Young People's Hub" had been established to support young people with life limiting conditions during the transitional period between children's and adults hospices. The Shakespeare Hospice was the only adult hospice to have developed this transitional service in the UK. The provider's work in this area had been positively acknowledged by organisations such as Hospice UK and Together for Short Lives. The provider planned to disseminate and publish this development in service provision. One community professional when responding to our questionnaire wrote, "They are inspirational and have excellent clinical leadership and working with interdisciplinary respect."

The hospice had received various recognition or good practice awards during the last 12 months, for the quality of care and support provided for people using the service. The hospice had recently been successful in winning a GSK IMPACT Award, a national award run in partnership with The Kings Fund that recognises

excellence in charities improving health and wellbeing in their communities. The hospice had been picked from more than 400 organisations to win the accolade following a rigorous assessment. The award was for leadership, quality, diversity and innovative development of all services, in particular the children and young person's service and included £30,000.00 in unrestricted funding and access to training and further leadership development. The hospice had also achieved the Fundraising Standards Board accreditation. The provider had a consistent track record of delivering high quality care and managing improvements.

The provider recognised that partnership working was essential in delivering a high quality service in response to an identified increase in demand for end of life and palliative care. The provider worked in partnership with the local Foundation Trust to support care provision and development in these areas. The local community hospital was undergoing refurbishment to include a new oncology unit and the Trust had approached the provider to develop supportive therapies in the new unit. The model of support was under development with a target to become operational in March 2017. The chief executive explained that collaborative working improved access to the services offered by the hospice. The provider also worked closely with other organisations such as McMillan and Marie Curie and other local hospices to ensure people received the support they required when they needed it.

The provider was also a member of several good practice initiatives where they worked in partnership with other organisations to make sure they were following current best practice and providing high quality care through the sharing of knowledge. Members of the senior management team attended meetings of a number of local partnership groups looking at wider quality and service development in end of life care.

The hospice team had strong links to the local community, many of whom were involved in events to raise funds for the service. The provider recognised that one way of encouraging awareness of what the hospice did was to invite more people into the building and to encourage people to regard it as a community resource. The chief executive explained, "We are saying to the community, it is your hospice so come and use it. I like to think of us as a hub and resource for all the community. Raising the profile is helping more people and helping to raise funds so we can help even more people." People from the community were encouraged to visit the hospice, work as volunteers and be involved in its on-going development. One volunteer told us, "It's a freely given commitment …..I feel a valued member of the team."

There were strong links with the younger members of the local community. The provider worked closely with schools and youth groups to offer work experience and volunteering opportunities for young people. One community professional wrote on our questionnaire, "The [youth] co-ordinator has been consistently very effective in developing customized projects for our students." Following requests from a number of local schools, the chief executive had developed a training programme for teachers and teaching assistants on how to communicate with children facing loss or bereavement. The training was delivered by the chief executive and staff from the hospice provided practical support within the school setting.

There was a strong management structure with senior staff who reported directly to the chief executive who was also the registered manager. The chief executive had been in post for eight years, was open and transparent and had the required experience and competencies for their role. The chief executive had a clear understanding of the focus of the service and the values they wished to promote. They had a positive sense of direction and worked to continuously improve end of life care for people and those closest to them. One person told us, "We all know the managers and team leaders beside the care staff because they involve themselves in our care."

The provider had arranged bespoke training for senior staff to equip them with the skills and knowledge they needed to be successful in their managerial role. Staff we spoke with were aware of the roles of the

management team and told us managers were approachable and had a regular presence in the hospice. Staff knew who to go to for support and where to seek advice. There was always an 'on call' telephone number staff could call outside office hours to speak with a manager if they needed to. This showed leadership advice was present 24 hours a day to manage and address any concerns raised.

Staff told us they felt valued and were extremely well supported by the management team and each other which motivated them to maintain high standards of care. They told us they were supported through training and personal development and had the resources required to carry out their roles effectively and respond to changes in people's needs. Staff were provided with opportunities to share their views at regular staff meetings and told us their ideas were welcomed and listened to. One staff member told us, "I feel very supported to carry out my role, they are superb managers and they listen to my ideas." A member of the therapy team told us, "The managers make us feel part of the team, it's a credit to the organisation how they view complementary therapy. I am very happy here, this is a dream job and I am recognised for what I do." Another member of staff said, "I feel very supported by the management; they are 100% behind me. I love working here; we are very supportive of each other." The human resources manager told us they monitored sickness and absence to promote the wellbeing of staff and explained, "That is where human resources is very closely involved with staff. If there are any issues we identify it so we can offer support straightaway."

The chief executive and senior managers had the responsibility for running the service under the direction of the Board of Trustees. The Board comprised people with clinical skills and people with expertise in other areas such as finance and fundraising to support the governance of the hospice. Members of the Board had specific responsibilities under a committee structure that covered areas such as audit and finance, income strategy and clinical governance. Committees met every two months and discussed strategy and implementation plans for the service. The hospice website provided information about the Board of Trustees and their role. Staff told us the Board supported and encouraged the development of the hospice. One staff member told us, "The trustees have visions and are keen to identify needs and fulfil them."

The Chairman of the Board demonstrated a clear understanding of their role and legal responsibilities as a trustee. They were responsive to changes in legislation and were aware of the outcome of a recent review which had implications on fundraising within the charity sector. A workshop had been arranged for all trustees to ensure they understood how changes in the care and charity sectors impacted on service provision.

Through the committee structure, trustees worked closely with senior managers who were also members of committees. For example, the medical officer and hospice clinical lead were members of the Clinical Governance Committee. The chief executive had regular meetings with the Chairman of the Board and each year there was a trustees and senior management 'away day' where objectives and plans were reviewed and discussed. This collaborative working promoted good governance as there was an open and transparent system which reviewed all aspects of the service provided. The registered manager explained, "It is a good working relationship. They (Board of Trustees) listen to me, they support the vision for the hospice, they are a critical friend." The Chairman of the Board confirmed, "We are constantly looking for the inspiration [chief executive] gives us as to the direction the hospice wishes to go in."

The provider's quality assurance system involved asking people and their relatives about their experience of the service. This was through questionnaires and a service user forum. The forum provided people with an opportunity to share their views and ideas and was a source of information to ensure the development of the service was founded on what was important to the people who used it. A relative of a person who had used the hospice at home service had been invited to join the Board of Trustees and there was a patient representative on the Clinical Governance Committee. This meant that people had an active involvement in

monitoring the quality of care and in influencing the growth and future direction of the hospice and the services it provided.

There was a system of clinical audits and checks in areas such as medicines management, clinical notes and documentation to check that quality of care and best practice were maintained. The findings from these audits were evaluated and put into action plans for improvements where a need was identified. For example, following a medicines audit a new medicines policy had been implemented. A patient experience and audit group' was being established to review the results of audits and monitor the progress of any resulting action plans. The Clinical Governance Committee monitored the service to ensure clinical services were compliant with statutory requirements and met the required standards.

The Board of Trustees monitored the quality of the service through regular visits. These included inspections by clinical members of the Board in line with five key areas of safe, effective, caring, responsive and well led. The results of the visits were fed back to staff during clinical and staff meetings to drive improvement in service delivery.

The Chairman of the Board of Trustees and the chief executive were consistent when talking about the challenges facing the service. They both told us, "The one big challenge which still remains is about promoting the Shakespeare Hospice and what it has to offer to patients, carers and families." The chief executive told us that 50% of people who completed the most recent satisfaction survey would have liked an earlier referral to the service by their doctors and consultants. As a result of this feedback an audit of referrals was being undertaken to identify the reasons for late referrals so action could be taken. In the meantime, the service was acting proactively to share information with primary care trusts and GPs so they understood what services the hospice could deliver and the referral criteria. The chief executive, explained, "We forever invite clinicians and other healthcare professionals over the threshold so they can see what we do." Some local charitable groups had been invited to use the hospice for their meetings, such as the South Warwickshire Prostate Cancer Support Group and Warwickshire Young Carers, which again raised awareness of what the hospice had to offer.

The provider was aware of the importance of forward planning to meet the needs of the community and ensure the quality of service they provided could continue to develop. The provider's strategic plan for 2015-2020 set out service objectives reflected against known challenges such as an increase in the incidence of people diagnosed with life limiting illness, complexities of care and increased competition for funding. The strategy included objectives to review the skill mix of the hospice at home team and operational policies to improve the efficiency and quality and continued expansion of the service. Due to an increase in demand for the service, there were plans to identify a satellite location to support staff so travel time was reduced. A five year development timeframe set yearly objectives for achieving the strategic plan to ensure the service could reach more people who required hospice support within their own homes. The chief executive explained, "Because we haven't got to fund beds, we can be creative in how we provide the hospice at home service."

The provider demonstrated an awareness that staff needed to be involved in the development of the strategic plan to be committed to it. The chief executive told us that senior managers consulted their teams and explained, "When we developed our strategy that didn't come from the top down, staff are engaged in the process of where we are heading. Staff have contributed to that. We have an annual staff communications day where we update them on strategic planning. They are involved in the five year plan and they have looked at the words in the mission statement and they buy into it. I could write all sorts of things, but if the staff don't believe it, what is the point." One member of staff confirmed, "The whole of the service are involved in the development of the vision and values. It is discussed with staff – what is our core

business, what is our mission, what are our values."

Shakespeare Hospice produced an annual quality account which provided information as to the services priorities for the next twelve months, along with a progress report on the previous year's priorities. The report included information provided by people and their relatives who had used the service, audits, clinical care reviews, and interrogation of data. The report was shared with the local clinical commissioning group and displayed on the hospice website. This demonstrated transparency and an open culture. There was also a regular newsletter which provided information about new staff, different aspects of the service and what had been achieved in the previous months.