

The Primrose Hospice Limited

# Primrose Hospice

## Inspection report

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

### Ratings

#### Overall rating for this location

Good 

Are services safe?

Good 

Are services well-led?

Good 

# Summary of findings

## Overall summary

We inspected this service using our focused inspection methodology. We carried out a short notice announced visit to Primrose Hospice on 14 November 2023.

This inspection only looked at the key questions safe and well led, the ratings for all other key questions will remain the same as the last inspection. Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate

Our overall rating of this location stayed the same. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had required training in key skills, understood how to protect patients from abuse, and managed safety well. Staff controlled infection risk well. Staff assessed risks to patients and kept good care records. Staff managed safety incidents well and learned lessons from them.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

In addition:

- Leaders managed priorities proactively to ensure the quality of care was maintained within financial challenges and effectively addressing issues the service faced.

We found the following outstanding practice:

- The green and sustainable initiatives undertaken by the service.
- Initiatives for the service to be an employer of choice.
- The staff survey (2022/2023) undertaken by an independent company identified the service as one of the best performing hospices benchmarked against 32 similar services.

# Summary of findings

## Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	Good	

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# Summary of findings

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# Summary of this inspection

## Background to Primrose Hospice

Primrose Hospice is a service that operates under The Primrose Hospice Limited. Primrose Hospice is a charitable organisation offering care and advice to patients living with a life-limiting illness and supporting families in the Northeast Worcestershire area. Care and treatment are provided by a clinical nurse specialist, qualified nurses, health care assistants, a physiotherapist and an occupational therapist. Services are based at Primrose Day Hospice (please note the day hospice location falls outside regulated activities and it was only the care and support provided by clinicians that was inspected and included within this report). Primrose Hospice does not have an inpatient unit. Patients can receive care and support in their own homes when appropriate. A pilot hospice at home service was introduced in April 2023.

The current registered manager has been registered with the CQC since September 2022.

The service is registered to provide the following regulated activities:

- Treatment of disease or injury.

Under this regulated activity the service provided:

- Hospice services.

Primrose Hospice was last inspected on 18 May 2016 and was rated good overall and good in all domains. No regulatory breaches were found at the last inspection.

## How we carried out this inspection

The inspection team included 2 CQC inspectors. During our inspection we spoke with 9 staff including the registered manager and chief executive. We also spoke with 2 patients.

We reviewed 6 patients' notes and a range of policies, procedures and other documents relating to the running of the service.

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

# Our findings

## Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Hospice services for adults	Good	Not inspected	Not inspected	Not inspected	Good	Good
Overall	Good	Not inspected	Not inspected	Not inspected	Good	Good

# Hospice services for adults

Safe	Good 
Well-led	Good 

## Is the service safe?

Good 

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

### Mandatory training

**The service provided mandatory training in key skills to all staff and made sure everyone completed it.**

Staff received and kept up-to-date with their mandatory training. Staff had access to mandatory training by a mixture of e-learning modules and face-to-face sessions. The service worked alongside other hospice services to share training resources and training opportunities. Staff had attended resuscitation and life support training at another location, similar arrangements were in place for other face to face staff training.

Staff had access to their electronic training record. This enabled staff to review when mandatory training required updating and to book onto training courses.

Staff completion of mandatory training was 99.2%. Information provided showed which staff were not up to date with their training and the reason for this which for example, included staff on long term sickness and new staff undertaking their induction.

The mandatory training met the needs of patients and staff. Mandatory training covered a range of topics which included end of life care, basic life support, infection control, hand hygiene, consent, fire safety, equality diversity, whistleblowing and moving and handling.

Clinical staff had all completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Staff confirmed they had received training in dementia awareness, supporting people with a learning disability (tier 1) and additional learning disability training had been undertaken since our inspection, The Mental Capacity Act and Deprivation of Liberty Safeguards, training records provided also confirmed this.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff and their manager received an email which identified an update of a mandatory training module was required. If training was not arranged staff and their manager would receive a further email reminding them to book/ complete their training.

### Safeguarding

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff were trained to the appropriate safeguarding levels.**

# Hospice services for adults

Staff were trained to the appropriate level of safeguarding children and adults as per national guidance. The National Intercollegiate Document 'Adult Safeguarding: Roles and competencies for healthcare staff' (August 2018) states all staff, including non-clinical staff, who have regular contact with patients, their family or carers, or the public should be trained to level 2. All patient facing staff had completed safeguarding adults and children level 2 training.

At the time of the inspection, a safeguarding lead was in place, and they were trained to level 3 in safeguarding adults and children. The safeguarding lead received clinical supervision from an outside agency to ensure current and safe practice was met.

Following the inspection, the service trained additional staff in safeguarding adults' level 3, such as the registered manager and other service leads. This meant staff working directly with patients had more people to seek advice from if required.

Safeguarding concerns were discussed during team meetings, daily handovers and multidisciplinary meetings. Staff said they shared information; actions undertaken and consider if further actions were required.

Staff gave examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The service had a safeguarding adults and children policy dated 23 March 2023. The policy included all types of abuse including, domestic violence, female genital mutilation and radicalisation. Staff were knowledgeable about safeguarding and gave us examples of actions taken when potential safeguarding concerns had been highlighted. Information was displayed strategically on noticeboards which highlighted types of abuse and actions which should be undertaken to safeguard vulnerable people.

The service had a safeguarding risk assessment which identified potential hazards. The risk assessment included a score for the severity and likelihood of the risk with an overall score which determined overall level of risk, actions required were recorded with dates and names for compliance. Confirmation was also recorded when actions had been undertaken and identified any ongoing actions when required.

There were robust recruitment processes in place for staff and volunteers including Disclosure and Barring Service checks.

Nurses' professional registration was confirmed and ongoing checks of renewal of registration was undertaken with the regulatory body (Nursing and Midwifery Council).

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us any safeguarding concerns were discussed with the safeguarding lead, head of clinical services and during multidisciplinary meetings. Staff said whilst it was mainly the safeguarding lead who made safeguarding referrals to the local authority, in their absence referrals would be made by a senior nurse to ensure vulnerable people were protected. Posters were displayed which identified types of abuse and actions should undertake should they have any suspicions abuse may have occurred.

## Cleanliness, infection control and hygiene

**The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection.**

# Hospice services for adults

Patients mostly attended their appointments with clinical staff in the day hospice. The day hospice was clean and had suitable furnishings which were clean and well-maintained.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Housekeeping staff kept the premises clean and there were schedules and checking systems in place to ensure all areas were cleaned as indicated in the identified cleaning schedule. There were facilities to support good infection prevention control in the toilets, corridors and clinic rooms.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff confirmed they had a sufficient PPE equipment, such as gloves and aprons to carry out procedures and personal care activities. Staff were observed to be 'arms bare below the elbow'. Handwashing sinks and hand sanitizer dispensers were accessible and were available throughout the day hospice. Information about effective handwashing was displayed at handwashing sinks signs. We observed staff washing their hands and using hand sanitiser between contact with patients.

All staff had received hand hygiene training in the last 12 months. A hand hygiene audit undertaken by the service in October 2023 confirmed all staff met required hand hygiene standards. The audit included checks with an ultraviolet machine which confirmed effective handwashing. Staff had short clean nails, no nail extensions or varnish and no stoned rings or wrist watches to aid effective handwashing to reduce this risk of cross infection.

All staff had received infection prevention and control training in the last 12 months.

## Environment and equipment

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

The design of the environment followed national guidance and was accessible, safe and warm for those patients who attended. The day hospice was outside our regulations it provided a safe and warm environment which met patients' needs. Patients attended outpatient appointments within the day hospice, and it was a central base for all staff.

The service had enough suitable equipment to help them to safely care for patients. Staff reported that equipment including hoists, pressure relieving equipment and wheelchairs were available and suitable for patient's needs within the day hospice. Records showed equipment was maintained with appropriate service contracts in place. Resuscitation equipment was available and was checked weekly.

The service employed an occupational therapist and physiotherapist who assessed patients' needs in their own home and provided small items of equipment, such as commodes, perching tables and walking aids from the hospice equipment store to support patients' immediate needs. Staff could request other equipment from the local NHS trust.

Staff disposed of clinical waste safely. Clinical waste was segregated from domestic waste and disposed of and collected regularly. Clinical waste bins were kept locked and were in a locked enclosure. Used syringes and needles were disposed of in required containers which met the requirements of the regulations with a date of opening recorded and filled up to the correct level.

## Assessing and responding to patient risk

**Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.**

# Hospice services for adults

Staff completed risk assessments for each patient during their first appointment using recognised tools for pressure risk, falls and nutrition. Risk assessments were reviewed three monthly or more frequently when patients' needs had changed. For example, a patient who had fallen, staff had reviewed their falls risk assessment and put additional actions in place to mitigate against increased risk of falling. Risk assessments for pressure ulcers identified additional actions required when patients skin was reddened, and they were at increased risk of pressure ulcers.

Risk assessments identified patient's wishes such as when they requested whether to receive further treatment in hospital.

Staff managed emergencies in line with policy and procedures. If a patient became unwell whilst attending an appointment or during a visit by staff to the patients' home, they would either seek clinical staff advice or would ring 999. Staff gave an example of attending a patient's home who developed chest pain, they called 999 and the patient was transferred to hospital.

The service had access to mental health liaison and specialist mental health support. If staff were concerned about a patient's mental health, they could access the counselling team which was a separate part of Primrose Hospice. The counsellors and social workers within the team would refer the patient to the general practitioner (GP) for ongoing care and management.

Staff completed, or arranged, psychosocial assessments which covered all the aspects of a person's life to get a picture of their mental state, when required risk assessments for patients' thought to be at risk of self-harm or suicide were completed. If staff identified patients or their loved ones expressed suicidal or self-harm thoughts, they could refer them to the counselling team and urgently to their GP. As part of the treatment (and when needed counselling) agreement consent was given to share information with the patients GP. Staff also told us in addition to the risk assessment for suicidal expressions and self-harm staff would also make a safeguarding referral to ensure the patient's needs were investigated and they had all required support from health professionals.

Staff shared key information to keep patients safe when handing over their care to others. Staff worked closely with health and allied health professionals and other agencies to ensure they had all required information about patients and their care and support needs. During the inspection staff said they liaised closely with staff working with the inpatient hospice of the local NHS trust, clinical nurse specialists both in the community and the acute hospital trust, the local authority and local care homes to arrange safe admission and discharge of their patients.

Shift handovers included all necessary key information to keep patients safe. There was a staff handover at the beginning of every day and included all staff on duty that day including allied health professionals. The handover included all patients due to attend appointments that day, patients who would be seen at home by the hospice at home workers and any new referrals to the service. Each patient was discussed, their diagnosis, treatment, family and friend support, accommodation, and any identified risks. There was a multidisciplinary team meeting weekly which discussed new patients, patients who had a 3 monthly review and any patients whom staff were concerned had deteriorated. In addition, the service also had a weekly multidisciplinary meeting which included a consultant in palliative care.

## Staffing

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

# Hospice services for adults

The service had enough nursing and other staff to keep patients safe. Alongside nurses and health care assistants the service also employed a physiotherapist, an occupational therapist, complementary therapists, counsellors and administration staff to support patient care.

Primrose Hospice volunteers supported staff in wide range of roles. Within the regulated activity this included administration, reception duties and some housekeeping duties to support care provision.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants. Staff duty rotas were completed with at least two trained nurses on duty for each day plus an additional health care assistant depending on the needs of the patients expected to attend that day. In the case of unexpected staff sickness or absence, patient dependency on that day was assessed and a decision made as to whether it was safe to operate the day hospice or whether it should be cancelled.

The clinical nurse specialist had 2 pre booked patients appointments daily. The clinical nurse said they were flexible and would call or visit patients who required additional support when needed.

The hospice at home service was a new initiative which commenced in April 2023 and was being piloted. Hospice at Home employed 2 part time health care assistants who provided support for up to 2 patients daily Monday to Friday. Only patients who already received support and were known to Primrose Hospice could receive support from hospice at home. Hospice at home sessions were pre booked to provide support to the patient with activities of daily living such as personal hygiene or mobility or support to the carer to enable them to attend appointments.

The number of nurses and healthcare assistants matched the planned numbers.

There were no staff vacancies. Staff turnover was minimal within the clinical team. The chief executive said they had a recruitment and retention group which had identified actions to make the service a preferred employer to retain staff.

The service had low sickness rates. Managers monitored sickness rates and types of sickness. Between November 2022 to October 2023 staff sickness was 3.7%.

The service did not use bank or agency staff.

## Records

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

Patient notes were comprehensive and identified staff could access them easily. The service used electronic patient records. The electronic records had been set up as identified templates to ensure staff completed required information in a consistent manner. The electronic record flagged if information was required or needed to be updated for example the Recommended Summary Plan for Emergency Care and Treatment document. We reviewed 6 sets of patient records, and each contained all appropriate information.

Records were stored securely. Electronic patient records were password protected and could be accessed and completed by identified staff to maintain patient confidentiality and we saw an example of this. An audit of 20 randomly selected patient records identified there was no evidence of any hospice staff or volunteers inappropriately accessing or viewing notes.

# Hospice services for adults

When patients transferred to a new team, there were no delays in staff accessing their records. All clinical services used the electronic patient record system so when patients transferred from 1 service line to another, their records were easily accessible to identified staff. Nursing and allied health professionals had access to electronic patients records to ensure continuity of care was provided.

If records were received in paper format, for example the do not attempt cardiopulmonary resuscitation decisions form this would be scanned into the electronic system for reference. The service had access to information about their patients from the local NHS trust and GP to ensure continuity of care. Information was also shared with the NHS trust, GP and local in-patient hospice about support the patient received at Primrose Hospice.

## Medicines

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

The service did not prescribe or administer medicines. The service did have an anaphylactic shock pack for emergency use only within the day hospice and would administer if required. Staff were trained as part of Basic Life Support and Anaphylaxis training session by the NHS trust.

Patients at risk of haemorrhage were prescribed midazolam on a drug chart by a GP. The patient was advised to always carry this medication. In the event of an incident staff would administer this emergency medicine.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. The clinical nurse specialist discussed and advised patients on pain relief and symptom control and when needed would request a prescription from the patients GP.

No controlled drugs were stored or used at Primrose Hospice. The hospice was exempt from having a Controlled Drugs Accountable Officer but maintained safe processes for managing patients' own medications.

## Incidents

### **The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.**

Most staff said they knew what incidents to report and how to report them. Staff told us all safeguarding concerns were raised with the safeguarding lead. Some staff were unclear how incidents were reported but said they would tell the head of clinical services. The head of clinical services confirmed they had a paper system for reporting incidents. Following our inspection, managers confirmed all staff had been made aware of how to report incidents and the accident, incident and near miss policy had been shared with all staff.

The providers accident incident and near miss policy did not include reporting of safeguarding concerns. We asked the provider for a summary of incidents reported, they provided a list of clinical incidents. We were also told the safeguarding lead completed a report every three months which was shared with senior managers, the clinical governance meeting and the board of trustees. It detailed all safeguarding concerns and referrals. We were not aware of any incidents which were not reported when they should have been. Information provided following our inspection provided assurance of the effectiveness of incident reporting.

# Hospice services for adults

The service had no serious incidents. Managers had shared learning with staff about patient falls which although had not resulted in serious injury may have. Managers also worked closely with all similar services and shared learning about serious incidents with their staff that happened elsewhere.

Staff understood the duty of candour. They were open and transparent. Staff apologised when things went wrong. Managers investigated incidents thoroughly and patients were involved in these investigations.

## Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good.

### Leadership

**Leaders proactively managed priorities to ensure the quality of care within financial challenges and effectively addressed issues the service faced. They were highly visible and approachable or patients and staff.**

The senior manager leadership team of the service included a chief executive, head of clinical services, chief operating officer and head of family support services. Most services which Primrose Hospice provided were out of scope of the CQC regulated activity they were registered for (this included retail, counselling, alternative therapy and fundraising).

The senior management team had identified roles and responsibilities to support the service. Managers had a good understanding of the challenges and priorities as a small charity with minimal NHS funding which was heavily reliant on fundraising and charitable donations.

Primrose Hospice had a board of trustees who had a range of skills to provide oversight of the service. Staff said they felt the service had an approachable, visible and effective senior leadership team with a supportive trustee board.

The relationship between the senior leaders and trustees was positive and supportive. In a staff survey in 2023 run by an independent company, the service was recognised as one of the highest scoring hospice services, benchmarked against 32 other hospice services. The survey identified improvement in communication (32% to 80%) and confidence in the senior leadership team (51% to 80%). The chief executive was proud of achievements the service had made which had improved staff satisfaction, they included the work undertaken to be a preferred employer.

Management was flexible, caring, and effective and staff were regularly appraised and attended required training.

### Vision and Strategy

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

The service had a vision and strategy which was stretching, challenging and innovative with proactive identified actions and plans in place to achieve the strategy.

# Hospice services for adults

The service strategy was aligned to local plans in the wider health and social care economy, and how services were planned to meet the needs of the population to improve care and patient wellbeing, tackle health inequalities and obtain best value for money. Managers and staff worked closely with local hospitals, commissioners and other NHS partners to support families. Staff knew and fully understood the vision, values and strategy, and their role in achieving them. Staff and key stakeholders were involved in the development of the strategy, vision and values.

The strategy included providing a quality service whilst 'future proofing' the service and ensuring sustainability of services against increasing costs with minimal (13%) NHS funding and being reliant on charitable donations and fundraising. As part of the strategy the service had developed a 'Green and Sustainable Group' which included a range of 'green' projects including updating the building for better energy efficiency, the installation of solar panels to deliver 50 to 60% of their electricity, a biomass boiler to reduce expenditure in future years, and the use of recycling bins throughout the main building.

## Culture

**Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.**

There were high levels of staff satisfaction and staff morale. Staff said they felt supported respected and valued. Staff said they were proud to work for the service and the high-quality care they provided. The staff survey identified 100% of staff were proud to work for Primrose Hospice. Several staff (including the chief executive) said it was a privilege to work for the service and provide support to patients and their loved ones.

The chief executive recognised the challenges as a charitable organisation to attract staff to work for the service and looked at ways it could be an employer of choice. Challenges including competing with NHS salaries and terms and conditions. A 'recruitment, retention and remuneration group' had been set up in July 2022. The group ensured all staff had a voice with representatives from all departments to bring concerns or issues. The group fed into both the senior management team and board of trustees working with other staff groups such as the recruitment, retention and remuneration group working towards being the employer of choice. Staff salaries had been increased, improved staff training opportunities and increased staff social events to enable all the team to get to know each other away from the work environment. The employer of choice group also collated staff exit meeting information to ensure they were aware of the reasons staff were leaving so that when needed lessons could be learnt and improvements made.

There was strong collaboration, team-working and support and a common focus on improving the quality and sustainability of care and people's experiences. The culture of the service centred on the needs and experience of the patients and their families who used services. Staff were passionate about delivering high quality care and treatment for patients requiring it as well as their loved ones.

The culture encouraged openness and honesty at all levels within the organisation, leaders and staff understood the importance of being able to raise concerns without fear of retribution. To support staff to 'speak up' the organisation had 2 Freedom to Speak Up Guardians who worked to ensure the organisation was an open, transparent and inclusive workplace. Processes were in place which guaranteed confidentiality for anyone wishing to contact the Freedom to Speak Up Guardians.

All staff and their close family members had access to The Employer Assistance Programme that could be accessed anonymously by any member of staff for wellbeing, mental health support, GP access and financial advice. Reports shared have identified this service had been used by staff.

# Hospice services for adults

The duty of candour was understood by staff we spoke with. Staff felt able to raise concerns and told us there were no barriers when escalating incidents or complaints. Staff said they were open with patients and their loved ones when things went wrong and were encouraged to do so by leadership. Appropriate learning and actions were taken when concerns were raised.

## Governance

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

During 2022/23 the service had reviewed and updated its internal governance arrangements ensuring that decisions and issues were fully discussed at group, committee, or board level as appropriate and, that scrutiny and opportunities for improvement were clearly recognised and acted upon.

The provider's trustee board and senior management team had clear reporting and committee structures which included clinical governance, information governance, health and safety and finance and income generation.

The trustee board and clinical group governance committee met on a quarterly basis to review quality and safety for the service. The service had separate committees and groups which met more frequently and fed into the clinical governance committee and leadership meetings. The membership of the groups included operational and leadership staff and trustees. Meetings were summarised and presented at the clinical governance committee.

There were bimonthly senior management meetings. These meetings discussed operational information about the service including staffing, audit results, risks, incidents, safeguarding referrals, complaints and patient feedback. Minutes of the meetings were taken and circulated afterwards. We reviewed clinical governance committee minutes for May 2023 and August 2023. Each meeting had standing agenda items which included but were not limited to activity monitoring and audit, risk management, reported incidents, complaints, safeguarding, service reviews and patient and carer feedback. Actions were identified and were discussed at subsequent meetings when appropriate.

There were quarterly trustee board meetings which reviewed the performance and development of the service, finance and funding arrangement, risks, incidents and complaints. They were formal meetings and minutes were taken and circulated. The main trustee board received minutes from each of the trustee board governance committees. They also received service update papers, updates on strategic priorities, financial information and sometimes a presentation on a service area and/or an issue for debate and discussion. The senior management team were present for board meetings. The head of clinical services and the chief executive attended the clinical governance committee, information was fed to staff at team meetings, in the form of minutes and emails.

Minutes of the quarterly clinical governance committee showed incidents, complaints, safeguarding, policies, quality and performance, audits, safety alerts and patient satisfaction were all reviewed as part of the agenda.

The service received a small grant from the NHS and had annual contract meetings producing a quality report which included achievements and priorities for previous and future years.

# Hospice services for adults

## Management of risk, issues and performance

**Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.**

Managers had systems in place to monitor and manage performance. These included local monitoring and comparison with other (hospice) service performance both locally and nationally.

The service and provider collected data on the quality of the service from a variety of sources and used this to improve performance and identify and escalate risks. Regular audit processes checked to ensure performance met the required standard, however safeguarding training requirements of the National Intercollegiate Document 'Adult Safeguarding: Roles and competencies for healthcare staff' (August 2018) were not met at the time of the inspection. The service made improvements and shared learning when the results of audits showed data was not up to the expected standards.

The annual quality accounts 2022/2023 provided information about the quality of the service provided and had been shared with the board and management team.

The service had a risk register. Risks were rated red (critical), orange (high), yellow (moderate) or green (low) depending on the level of risk. Measures and controls to manage the risks were recorded and review dates were noted to ensure risks were monitored. Highest risks included financial risk, risk of fraud and data security, business continuity and staffing. The risk register was updated to reflect actions taken.

The risk register showed risks with identified named committees or groups who were responsible for oversight and reporting to the senior management team and board of trustees.

The service had a business continuity plan which included actions to be undertaken in the event of a power failure, disruption to water supply, extreme staffing challenges and IT failure. Information was available to staff and identified actions and included key people to contact with contact numbers.

The service continually monitored safety performance. Managers reviewed incidents which informed safety data. The clinical services manager had displayed safety information which included pressure ulcers, medication errors and falls in staff areas for information.

## Information Management

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

Performance measures and data were being collected, monitored and reviewed. Staff, managers, the trustee board and commissioners had access to quality and performance data.

The hospice had a new electronic medical records system in April 2023 which connected the service and shared patient records with NHS and GP services improving communication across services and the quality of care.

# Hospice services for adults

The new clinical computer system included an Integrated Palliative Outcome Score (IPOS) comparison tool to enable reporting on outcome measures had been developed. As part of the initial clinical assessment, clinical staff completed the IPOS measurement tool. The questions were scored on a scale of 1 to 4 and assessed a patient's symptoms and needs with regards to physical, social, psychological, and spiritual aspects. IPOS can be compared over time and can measure the effectiveness of the service in helping them to improve the care provided.

The service measured and recorded patient outcomes by using a variety of tools that were patient specific and demonstrated the effectiveness of occupational therapy.

Data or notifications were submitted as required to external organisations.

## Engagement

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

The leadership team were enthusiastic and proud of the engagement work the service undertook, both internally, with external organisation, service users and their carers and the public.

The service had been recognised as one of the highest scoring hospice service within the staff survey in 2023 ran by an independent company and benchmarked against 32 other hospice services.

Representatives of the hospice including the leadership team regularly gave interviews on radio stations and local newspapers to highlight the work the hospice and increase awareness within the community of services provided for all including difficult to access groups locally. Increased media coverage also promoted the importance of volunteers in all areas and from all backgrounds.

The service used patient feedback, including complaints, concerns and complements, to shape the services moving forward. Therefore, the service changed the approach to ensure care staff were available to allow carers time to themselves.

Primrose Hospice collaborated widely with other organisations, such as other hospice services (locally and regionally), charities and the NHS, to ensure they connected with other services and benefited from shared experience and best practice. Primrose Hospice had an agreed memorandum of understanding with 3 other hospices setting out an intent to work together for the benefit of all hospices within the current Integrated Care System.

Multidisciplinary team meetings were held at Primrose Hospice and included representatives from the NHS, including the local community palliative care team and palliative care consultant to ensure collaboration in the best interests of patients and clients.

The service were collaborating with a university to develop novel methods of surveying patients and clients online to ensure services provided met patients' needs.

The staff survey was undertaken in March 2023 by an independent organisation and identified improvement from the previous survey in 2021. The survey positively identified staff satisfaction and staff morale. The survey was benchmarked against other hospices and performed better across all areas and was also benchmarked against other similar services.

Primrose Hospice had 350 volunteers with a wide range of skills, experience and backgrounds to support care provision.

# Hospice services for adults

The hospice was a member of the umbrella organisation for 206 hospices in the UK which provided them with access to information looking at best practice and research in end-of-life care and education opportunities.

As relatively small organisations some posts in hospices can be isolated and have resulted in several groups for staff in different roles across similar services being set up which Primrose Hospice staff attend. The groups have both supported staff, developed professional practice to provide quality palliative and end of life care.

The service was represented at the Hereford and Worcestershire Palliative and End-of-Life Care Network.

The clinical team worked closely with local community health teams for the benefit of patients.

## Learning, continuous improvement and innovation

**All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.**

The hospice worked closely with other similar services, the NHS, professional bodies and several universities to share knowledge, expertise and provide education and training opportunities for staff working for Primrose Hospice and other staff working in other organisations.

The hospice was part of a regional (Midlands) hospice network looking at training and education across 15 hospices. The aim was to improve training opportunities, share expertise, reduce duplication, and develop a training suite that benefited from economies of scale.

An annual Palliative Care Conference was arranged within Worcestershire. The Chief Operating Officer for the service was the chair of this committee and liaised with the local university, other hospices, and the NHS to host a professional and beneficial annual conference.

Whilst counselling services were outside of our scope of regulation, it is noteworthy to identify the hospice had been accredited by British Association for Counselling and Psychotherapy, one of a very small number to achieve this. Being accredited meant they followed best practice in this area.

Again, this was outside our scope of regulation however the hospice had taken student social workers on placement, feedback from them had been excellent.