Greenwich & Bexley Community Hospice Ltd

Greenwich and Bexley Community Hospice

Inspection report

185 Bostall Hill
Abbey Wood
London
SE2 0GB
Tel: 02083122244
www.communityhospice.org.uk

Date of inspection visit: 20 - 21 September 2022
Date of publication: 02/12/2022

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

Ratings

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

Summary of findings

Overall summary

We carried out an unannounced inspection of Greenwich and Bexley Community Hospice using our comprehensive methodology on 20 and 21 September 2022. The service was last inspected in 2016, using a different methodology. On this occasion we rated it as good overall, because it was good for safe, effective, caring and responsive and outstanding for well led:

- The service had enough staff and volunteers to care for patients and keep them safe. Staff and selected volunteers had training in key skills, understood how to protect patients from abuse, and managed safety well.
- The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good treatment records. The service managed safety incidents well and learned lessons from them. Senior managers collected safety information from multiple locations and used it to improve the service.
- Staff and selected volunteers provided excellent care and treatment, gave patients enough to eat and drink and gave them pain relief when they needed it. Managers and trustees monitored the effectiveness of the service and made sure staff and volunteers alike were competent. Staff and volunteers worked very well together for the benefit of patients and supported them as well as their loved ones when making decisions about their care.
- The service took account of patients' individual needs and made it easy for people to give feedback. People could access the service when they needed it.
- Leaders ran services very well using reliable information systems and supported staff and volunteers to develop their skills.
- Trustees, staff at all levels and volunteers understood the service's vision and values, and how to apply them in their work or voluntary duties. All we spoke with felt respected, supported and valued. They were focused on the needs of patients receiving care and were clear about their roles and accountabilities.
- The service engaged well with patients and other stakeholders to plan and manage services and trustees, staff and volunteers were highly committed to improving services proactively.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	Good 	Since our last inpection of this service, we have changed the methodology we use. We rated this service as good overall, because it was safe, effective, caring, and responsive. We rated well led as outstanding.

Summary of findings

Contents

Summary of this inspection

Background to Greenwich and Bexley Community Hospice

We undertook this inspection as part of a random selection of services which have had a recent direct monitoring approach (DMA) assessment, that resulted in a decision of 'no further regulatory action'. This inspection was carried out to seek assurance about this decision and to identify learning about the DMA process.

Greenwich and Bexley Community Hospice is an independent service operated by a charitable company. The hospice provided personalised care to improve the quality of life and wellbeing of people living with a life-limiting or terminal illness who reside in either London borough.

The hospice had a 13-bedded inpatient ward as well as a community service, along with rehabilitation, care home support and a counselling service. In addition, the hospice was contracted to provide hospital-based palliative care support to an NHS hospital located in Greenwich.

The charity cares for around 3,000 people annually and palliative or end of life services are provided free of charge to people living in the 2 boroughs. The hospice receives around a third of its funding from the NHS and employs around 200 staff supported by over 450 volunteers.

We use the term 'selected volunteers' in this report to describe patient-facing volunteers who performed roles within the hospice under direct supervision of staff members. These included members of the young ward volunteers scheme, rehabilitation volunteers and the compassionate neighbours project. Other voluntary roles included administration support and fundraising.

Greenwich and Bexley Community Hospice has a registered manager in post and is registered with the CQC to provide the following regulated activities:

- Treatment of Disease, Disorder and Injury
- Diagnostic and Screening Procedures

How we carried out this inspection

This was an unannounced inspection. You can find information about how we carry out our inspections on our website:

https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

The hospice leadership team demonstrated outstanding practice in the way they prioritised patient needs and choices as well as their outward facing recovery and transformation following the pandemic. We saw evidence of a culture that invested in and developed staff who received high praise from stakeholders. Building on their COVID-19 recovery programme, the leadership team had recently introduced a new 5-year strategy that should bring significant benefit to the hospice and the community it serves. Aspects of the team's work with stakeholders had resulted in award nominations at national level.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Hospice services for adults

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

Are Hospice services for adults safe?

Good

We rated it as good because:

Mandatory training

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

We saw policy documents and training management records which indicated all hospice-based staff and volunteers had completed training modules tailored to their roles. There was a structured induction programme that staff and volunteers completed on appointment and the service had a training matrix which identified the required training for each group.

Training was delivered using a combination of practical skills sessions (such as moving and handling, basic life support and first aid) or by electronic learning packages that were accessed via the internet.

In addition to people based at the hospice, there was a clinical team located at an NHS hospital as part of a palliative care contract. These staff completed role-specific and mandatory training provided and managed by the NHS trust as a condition of the contract. We saw records indicating that staff met trust training targets.

Clinical staff completed training on specific skills such as basic life support as well as recognising and responding to patients with mental health needs and dementia. Staff and selected volunteers said they completed training on recognising and responding to patient's mental health needs and dementia and we saw records indicating 95% training compliance.

Managers monitored individual training status and alerted staff and volunteers when they needed to update their training. Compliance with mandatory training exceeded the service target of 80% in all 18 topics apart from moving and handling, which were practical sessions. Managers explained that these sessions had been delayed during the response to the pandemic and we saw that 6 classes had been booked from September through to November to address the backlog. Overall mandatory training compliance for the 12 months up to September 2022 was 94% for clinical staff and 93% for administrative staff and volunteers.

We saw meeting notes that indicated training compliance was reported to the board of trustees and senior leadership team through a quality and safety committee. Additional support and oversight were achieved through the use of 'board champions', who were accountable for areas of activity such as equality, diversity and inclusion, safeguarding, fundraising, communications and data protection.

All staff and volunteers we spoke with were up to date with their mandatory training and said they had been given time to complete the topics.

Safeguarding

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

Staff and volunteers we interviewed knew how to make a safeguarding referral and who to inform if they had concerns. The provider had an up to date safeguarding policy that reflected national guidance. Staff and selected volunteers described how to raise any concerns initially with their supervisor or line manager.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. We saw that staff and volunteers received safeguarding training specific for their role on how to recognise and report abuse. According to records, 95% of regulated staff groups had received their annual safeguarding training at level 2 for adults and children. These figures were better than the annual target of 80% set by the board.

The hospice had clearly defined recruitment pathways and procedures to help ensure that the relevant recruitment checks had been completed for all staff and volunteers. These included disclosure and barring service (DBS) checks prior to appointment along with occupational health clearance, references and qualification and professional registration checks if relevant. Managers explained that these checks were reported to the NHS trust in respect of the team working there. We saw documents that indicated these processes were followed.

Cleanliness, infection control and hygiene

Hospice managers and staff maintained good standards of cleanliness and hygiene and there were reliable systems in place to prevent and protect people from healthcare-associated infection. The hospice was visibly clean and clutter-free.

All staff and selected volunteers had received mandatory training in infection prevention and control (IPC) and patient-facing staff received further training. All areas we inspected were cleaned to a high standard and had suitable furnishings which were clean and well-maintained. Flooring and chairs were made from easy clean materials.

Managers and staff used records to identify how well the service prevented infections. Cleaning records were up-to-date and indicated that areas we visited were cleaned regularly. We observed cleaning staff cleaning high touch surfaces and other areas during our inspection visit.

Staff and volunteers followed infection control principles including the use of personal protective equipment (PPE). IPC annual training compliance ranged from 92% - 100%, which exceeded targets.

We saw ample supplies of PPE items such as disposable aprons and gloves in dispensers on walls and we saw these items being used. There were hand washing guidance posters prominently displayed in each room. Antimicrobial hand-rub dispensers were mounted on the walls at strategic points throughout the hospice. Spill kits had been provided to assist staff and selected volunteers safely clean any fluids from floors or work tops.

Access to the inpatient section of the hospice was controlled by coded locks and automatic doors. Managers explained this was part of the measures undertaken to help protect inpatients who suffered from reduced immunity due to their condition or medication.

We observed staff cleaning equipment after patient contact, and we saw that cleaning equipment and cleaning consumables were colour-coded to help prevent the spread of bacteria between areas.

Clinical waste was correctly separated in colour-coded bins.

The service ensured that the health and safety of everyone who had contact with the deceased person's body after death was protected. Clinical staff explained how the body of a deceased person was looked after and managers described the arrangements made with local undertakers. The hospice mortuary had been closed since the onset of the pandemic and deceased persons were collected directly from the ward. Senior managers told us this arrangement was likely to remain in place in future.

Environment and equipment

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

The design of the environment followed good practice guidelines, such as that contained in Health Building Note 00-01 General design guidance for healthcare buildings (DHSC 2021).

The hospice was located on extensive grounds and comprised 3 floors, housing a ward, day care facility and rehabilitation gymnasium along with canteen, conference rooms, administration offices and stores areas. All floors were connected by a wheelchair-accessible lift and stairs were also available. Curb-free access and patient 'drop off' spaces were provided outside the main entrance, which utilised automatically opening doors to assist people with limited mobility access the hospice.

Ambient low-energy lighting, ventilation, equipment and consumables met national standards. Staff carried out daily safety checks of specialist equipment. Storage areas appeared visibly clean and well-organised. Non-public areas such as store cupboards were secured by keypad locks to control access.

Fire safety equipment and safety evacuation signs were located at key points and we saw fire evacuation aids situated on the upper floors. External contractors were used to check the environment and equipment, such as fire extinguisher servicing, fire system testing, medical gas safety and portable appliance testing.

We noted 1 fire extinguisher in the medical gas storeroom that had an out of date service label. This was immediately addressed by the management team.

There was first aid equipment including an automated external defibrillator located at the main reception along with oxygen sited in the inpatient ward. Emergency equipment items were checked weekly and recorded on log sheets, which were collected by management and audited.

On the ward, we observed that patients could easily reach bedside call bells and staff responded quickly when called.

Staff and selected volunteers carried out daily safety checks of equipment they used. We saw equipment service and calibration records that matched identification labels placed the items. We checked a selection of electrical devices and saw they were labelled with the dates of the most recent test which provided a visual check that they had been examined to ensure they were safe to use.

Specialist equipment needed to provide care and treatment was available based on need and provided in a timely way. We checked a variety of items such as syringe pumps (portable devices that administered continuous doses of medication) which we observed in use in community and hospice care settings. These were calibrated and maintained through service contracts and used in accordance with the manufacturers' recommendations.

We learned that the hospice had been successful in negotiating funds from NHS commissioners to purchase new syringe pumps in sufficient quantities to replace the syringe pumps used by palliative care teams in local NHS organisations.

The service disposed of clinical waste safely. Waste was correctly separated, and clinical waste disposed of appropriately. We checked bulk waste containers and found they were secured in a locked compound.

Assessing and responding to patient risk

Staff of all grades demonstrated a person-centred approach to planning and delivery of care which kept people as safe as possible and recognised patient choice.

We observed a medical round which helped demonstrate how the hospice multidisciplinary team planned and reviewed care in ways understood by the patient and their loved ones as well as supporting patient choice.

Staff knew about the increased needs associated with end of life care (such as rapid changes to pain medication) and we saw good examples of how these were identified in advance care plans and implemented. Advance care plans are designed to improve care by anticipating common needs experienced by people at terminal phases of an illness or condition.

Staff completed risk assessments for each patient using a recognised tool, and reviewed this regularly, including after any incident. Patient records showed risks were assessed and up to date. These included risks of falling and developing pressure ulcers.

We saw that people who were dying were reviewed by a consultant from the team on a daily basis or more frequently as needed. The hospice inpatient unit, community and hospital palliative care teams all had ready access to medical support including a resident medical officer who was a mid-grade specialist; one of the on-call consultants or the on-site senior medical consultant.

Staff shared key information to keep patients safe when handing over their care to others. The service had a deteriorating patient policy in accord with national guidance and patient preference. Staff knew what to do in an emergency and we saw that staff and selected volunteers had completed mandatory training in basic life support or emergency first aid.

Good

Hospice services for adults

Staffing

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

Managers could adjust staffing levels daily according to the needs of patients. On the days of our inspection we saw that the service had sufficient medical, nursing and support staff and these matched the planned numbers.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants in accordance with national guidance. The service reported low vacancy rates and low staff turnover for nurses and support staff.

Medical staff employed by the hospice included consultants, mid-grade specialists and GPs undergoing training in palliative care. Other support was provided on a part time basis by GPs who had a special interest in hospice care.

Senior managers explained that a new consultant had recently been appointed and stated this was welcome news given the nature of the specialism and challenges faced nationally in recruiting people with the right expertise and experience.

Managers made sure all bank and agency staff had a full induction and understood the service. Staff told us shifts were always covered. The service had low rates of agency nurses. When necessary, the service used regular in-house bank staff who were familiar with the service.

Records

Detailed records of patients' care and treatment were kept safe. Records were clear, up to date, stored securely and easily accessible.

Patient notes in the community and the inpatient unit were comprehensive and all staff could access them easily. We checked samples of records from inpatient and home care parts of the hospice, as well as a sample from the NHS hospital in-reach team. We found all to be accurate and complete.

Hospice patient notes were a combination of electronic records and paper-based medication charts, while the in-reach team used the electronic patient record system operated by the NHS trust.

Managers explained that a system for electronic prescribing and medication administration charts had been commenced and implementation due for completion in January 2023.

Patient treatment notes were commenced by the teams on receipt of referral and maintained as the patient progressed through their respective care pathways. Care plans were consistently completed and individualised to meet the care needs of patients. We saw that care plans were reviewed at least weekly or sooner if the patient's care needs changed.

Nursing staff regularly documented syringe pump checks which were performed in accordance with national guidelines to help ensure the pumps were administering the medicines correctly.

Records were stored and archived securely. Staff as well as volunteers had completed record keeping and information governance awareness as part of induction and mandatory training. Mandatory training compliance for these topics were 92% for information governance for all staff and 97% for record keeping for managers, which exceeded the target of 80% set by the board of trustees.

Records were stored and archived securely. In the hospice, the paper-based records were stored securely and electronic records protected by 2-factor authorisation codes. The NHS hospital in-reach team had access to electronic records which were protected by access linked to photo identification cards provided by the NHS trust.

We observed staff maintaining the confidentiality of records and saw that computer screens were locked when unattended.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Staff completed medicines records accurately and kept them up-to-date. Allergies were correctly recorded. We noted that 91% of staff had completed their annual update on medication administration and 100% had completed blood transfusion mandatory training.

Staff stored and managed all medicines and prescribing documents safely. An NHS trust pharmacy was contracted to manage, audit and provide medication stocks. Within the inpatient ward, medicines for individual patients were stored in secure lockers located at the side of every bed. This meant that medication designed to reduce pain or sickness were kept readily available.

We saw that medicine stocks were stored securely, including those that needed to be held in temperature-controlled refrigerators. Designated staff had access to the locked medicine room and all stock including controlled drugs were logged, signed and dated when used.

Controlled drugs were checked daily and audited weekly, and the record logs we viewed were fully completed. The NHS trust pharmacy had arrangements to remove expired stock and destroyed unused controlled drugs. The director of care had been appointed as the controlled drugs accountable officer (CDAO). This is a legal requirement for certain healthcare organisations and are senior managers responsible for all aspects of controlled drugs management within their organisation. We saw examples of completed CDAO occurrence reports submitted quarterly.

Hospice staff followed systems and processes when safely prescribing medicines. Medicines records were complete and contained details on dose, when patients received them, review dates, and any reasons for omissions. Staff stored and managed prescribing documents in accord with hospice or trust policy.

We saw quality bulletins on a staff notice board and staff confirmed they were briefed on safety alerts and incidents to improve practice.

Incidents

The service managed patient safety incidents well. Staff and volunteers recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Good

Hospice services for adults

Staff raised concerns and reported incidents and near misses in line with hospice policy. Staff knew what incidents to report and how to report them. Staff informed us of incidents they had reported and feedback they had received regarding actions taken.

Staff received feedback from investigation of incidents, both internal and external to the service. Managers shared learning about incidents with their staff and included learning from other services.

The hospice was a part of a network of similar providers in the region and managers described how they shared learning and good practice at regular meetings. We saw examples of learning from safety accidents that had occurred in other hospices.

Staff met to discuss the feedback, identify trends and look at improvements to patient care. Information was cascaded to staff at team and department meetings. We saw actions that had been taken following incidents.

Managers debriefed and supported staff after any serious incident. Staff told us and we saw records of support offered to staff after upsetting incidents.

Managers understood their obligations under Duty of Candour (DoC). This statutory duty, under the Health and Social Care Act (Regulated Activities Regulations 2014) requires providers of health and social care services to notify patients (or other relevant persons) of certain safety incidents and provide them with reasonable support.

Are Hospice services for adults effective?

Good

We rated it as good because:

Evidence-based care and treatment

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

Staff and selected volunteers followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service had a range of policies, protocols and standard operating procedures to support the delivery of services.

Guidance utilised included appropriate publications form the National Institute for Health and Care Excellence (NICE). Best practice guidance such as 'Ambitions for Palliative and End of Life Care' and the 'Gold Standards' Framework were embedded in policies for practice.

Policies were updated within their review dates and staff followed them to plan and deliver high quality care.

Senior managers explained that the hospice had refreshed the quality and safety committee since the pandemic, which was responsible for overseeing the effectiveness of care, as well as monitoring activity levels, patient feedback and to benchmark aspects of hospice care against other providers.

Good

Hospice services for adults

Nutrition and hydration

Staff and volunteers gave patients enough food and drink to meet their needs and improve their health. The service adjusted for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, particularly those with special nutrition and hydration needs. Staff regularly checked if patients were eating and drinking enough to stay healthy and help with their recovery.

Within the community setting, staff worked with other agencies to support patients who could not cook or feed themselves.

We saw that staff monitored and documented urine output in care records to help ensure patients were not becoming dehydrated.

Staff on the inpatient unit contacted dietitians if needed and supported people with their preferences. We heard how the hospice caterer met with patients, if required, to discuss preferences and individualised menus.

Staff fully and accurately completed patients' fluid and nutrition charts where needed and encouraged intake in line with patient wishes.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff used recognised pain assessment tools and observation of the patient to assess and document the level of pain relief required.

Patients had access to pain relief when they needed it. Anticipatory medicines were prescribed for patients on the inpatient unit and 'just in case' medicines in the community for symptom control. These were medicines prescribed to be administered as needed and not as a regular prescription. We found 'just in case' medicines were prescribed and given as needed.

The service admitted patients to their inpatient unit to fully assess how their symptoms could be effectively controlled. The assessment was based on information the patient had provided about how they wanted to live their life and activities they would like to undertake. We saw an example of this during a ward round and observed alternate pain control methods utilising local anaesthesia being discussed, agreed and then rapidly implemented.

Patient outcomes

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

The service leads monitored patient outcomes using recognised tools such as the palliative care outcome scale. Managers and staff used the results to improve patients' care and treatment.

The service audited how many people achieved their preferred place of death, had their decision documented and reasons for not achieving their choice. We saw data indicating that over 94% of relatives felt their loved ones had died in the right place. This feedback, along with other key patient experience data was monitored by the quality and safety committee, which reported directly to the board of trustees.

Outcomes for patients were positive, consistent and met expectations. Relatives fed back their views of care and consistently informed us the service provided followed patient choice and exceeded their expectations.

Managers and staff carried out a comprehensive programme of audits to check improvement over time. The service had a plan of annual audits which were reported to the executive team and trustee board. Improvement actions were identified following these audits and demonstrated how staff compliance with practice had improved.

Managers shared and made sure staff understood information from the audits. We saw information was presented to staff in formats which clearly showed audit results and where improvements were needed.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The service had pre-recruitment checks on staff and volunteers to meet CQC regulation requirements.

Managers gave all new staff and volunteers a full induction tailored to their role before they started work. People we spoke with described how they received a full induction tailored to their role. A central education team monitored compliance with competency based training and managers had access to online training records. Bank staff received a full induction, regular mandatory training, and received regular updates.

Managers supported staff and volunteers to develop through yearly, constructive appraisals of their work. Staff of all grades including volunteers confirmed they had annual appraisal meetings when they could discuss training needs and opportunities. Managers identified where staff and volunteers had performance issues promptly and supported them to improve.

There was a nurse consultant who led the learning and development staff and volunteers. Managers identified any training needs their staff and volunteers had and gave them the time and opportunity to develop their skills and knowledge.

Managers supported clinical staff to develop through regular, constructive clinical supervision of their work. Staff received clinical supervision/one-to-one meetings on a regular basis. Managers reported that 96% of staff had appraisals with a small percentage on long term absence or maternity leave.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Meetings had a standard agenda for discussion, sharing learning and providing a voice for staff to represent their views to the executive leadership team.

Multidisciplinary working

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

Good

Hospice services for adults

We saw evidence that all responsible for delivering care worked closely together to benefit patients. Staff and selected volunteers held regular and effective multidisciplinary meetings to discuss patients and improve their care.

These were held weekly and attended by all disciplines within the hospice. Staff discussed how they could best support patients and contacted external support if it was needed.

Staff worked across health care disciplines and with other agencies when required to care for patients. Clinical nurse specialists visited GP surgeries regularly to attend meetings which discussed patient care and identify those who may benefit from accessing hospice care.

The local NHS trust included the hospice in meetings regarding end of life care for their patients. Community nursing staff from the local community NHS trust worked closely with hospice staff to provide coordinated care for patients. Staff referred patients for mental health assessments when they showed signs of mental ill health.

Seven-day services

Key services were available 7 days a week to support timely patient care.

Hospice services were available 24 hours, 7 days a week. Community staff told us that this often comprised of multiple personal care visits, plus the option of 'night sitting' when requested.

Specialist nursing and medical support was available 7 days a week and patients were reviewed daily. Social work support was available 5 days a week and specialist consultants were also available for advice at all times.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests 7 days a week. These were often provided by other services and hospice medical and clinical staff knew how to access the support.

Health promotion

Staff gave patients practical support and advice to live well until the end of their life. The service had relevant information for patients to use and make choices. Staff discussed options with patients giving honest information and impacts their choices would have on their wellbeing.

Emphasis was given to how patients wanted to live their lives and methods of meeting those choices. Therapy teams supported people to maintain or improve their independence. The family support team provided support including emotional support, for patients and their families.

Therapy programmes such as respiratory workshops supported people to manage their symptoms. These were delivered in partnership with an NHS foundation trust respiratory team and had commenced in response to the COVID-19 pandemic. Managers explained that the partnership involved hospice physiotherapists who had been seconded to the trust and had subsequently been continued to increase the number of patients with end-stage lung disease accessing hospice support.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff and selected volunteers supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Good

Hospice services for adults

Staff and selected volunteers understood how and when to assess whether a patient had the capacity to make decisions about their care. Patient records showed that staff and selected volunteers gained consent from patients for their care and treatment in line with legislation and guidance.

Clinical staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and knew who to contact for advice.

Patients' consent for referral to the hospice was documented and hospice staff audited this process each year and fed back results to referrers.

Treatment escalation plans were audited and results fed back to staff. Consent was also audited and issues raised if any were found.

Staff and volunteers received consent training as part of induction and received mandatory training in the Mental Capacity Act. Training compliance was 95%, which exceeded the board target of 80%

We reviewed completed consent forms and found these were completed fully.

Are Hospice services for adults caring?

Good

We rated it as good because:

Compassionate care

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

Staff and volunteers were discreet and responsive when caring for patients. Staff and volunteers took time to interact with patients and those close to them in a respectful and considerate way. Patients were strong in their praise of all aspects of care. We saw evidence of thank you cards on notice boards sent by patients for the care they had received. In addition, we reviewed similar comments made about the service in patient survey results and social media sites linked to the hospice website.

Patients said staff and volunteers treated them well and with kindness. We spoke with patients and relatives during our inspection. They consistently described a positive experience and said staff and volunteers treated them well and with kindness. Staff and volunteers followed policy to keep patient care and treatment confidential.

A relative passed on a testimonial to us after learning of our unannounced inspection, which included these comments: "Their follow up and support was simply superb, and the love and kindness shown by… and the whole team at the Hospice is a real and continuing genuine blessing. Allowing… the rabbit to visit so regularly was always reassuring and gratifying".

Good

Hospice services for adults

Staff and volunteers understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients. For example, we saw recent dashboard reports that indicated 96.6% of patients reported positively in the last quarter about caring, dignity, information and involvement with staff of all grades.

Staff told us the hospice conducted weddings in the gardens, multi-faith chapel or bedside allowing patients to celebrate special occasions with loved ones and they did all they could to ensure these were special events.

The hospice had a chaplaincy team to conduct ceremonies but, if patients wanted, they contacted other religious leaders to conduct ceremonies. The hospice conducted both heterosexual and same sex wedding and civil ceremonies

Stakeholders such as the ICS and NHS trust reported that at all levels of the organisation, the staff of the hospice demonstrate kindness and concern for others, be that patients, families, staff or system partners. Another NHS clinician commented about the excellent working relationships and said that the outreach team "really worked in a compassionate way" that was supportive of individuals and the wider health and care system.

Emotional support

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

Staff and volunteers gave patients and those close to them help, emotional support and advice when they needed it. Patients praised the way they felt staff and volunteers took time to interact with them and answer questions.

Staff supported families and those close to the patient and offered emotional support. Relatives told us how they had been supported by hospice staff and could not have asked for any more support.

We met the hospice chaplain and viewed the multi-faith facilities provided for patients, visitors and staff. These included ablution facilities for people of the Muslim faith and managers described how these were added following feedback from a family.

Staff and volunteers understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff gave us examples of relatives who were children or people living with specific needs, or were particularly anxious, were supported to visit their relative in the hospice unit.

The hospice has a wellbeing support worker who provided individually tailored activities for patients as well as carers and bereaved people. Managers described a 'Walk and Talk' group that had been established in partnership with a trust belonging to a professional football club based in south-east London.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Interactions we observed indicated that staff and volunteers talked with patients in a way they could understand, using communication aids where necessary.

Good

Hospice services for adults

Patients and their families could give feedback on the service and their treatment and staff and volunteers supported them to do this. Patients gave overwhelmingly positive feedback about the service.

Are Hospice services for adults responsive?

Good

We rated it as good because:

Service delivery to meet the needs of local people

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

Facilities and premises were of a high standard and appropriate for the services being delivered.

Managers planned and organised services, so they met the changing needs of the local population. We learned that demand had increased by an estimated 20%, which managers stated had presented significant challenges around recruitment. The community team, inpatient unit and hospice hospital palliative care team had maintained a flexible and responsive service to meet the needs of the patients who used the service. Staff worked with individuals and offered appointments to suit the needs of patients.

Community services were available early in the morning, later in the evening and offered an overnight service to accommodate patient need.

Service leads worked with local commissioners, the NHS trust and primary care providers to plan hospice and end of life care for patients in the region. Managers attended strategy meetings and offered services to support where there were gaps in this provision.

Managers and staff told us about clinical members of the hospice who worked with and supported specific groups of patients. These included a speciality doctor with mental health and prison service experience, along with a 'prisons link' clinical nurse specialist (CNS), who supported patients who were serving prisoners at nearby facilities for adults and young offenders. The hospice also had CNSs working in learning disabilities, heart failure. These specialists advised and supported patients and staff from community services, local care homes as well as hospice inpatients.

Senior managers explained that the hospice social work team had been increased to 3 full time staff and provided a 5 day a week service dealing with patient welfare issues such as complex guardianship cases.

The hospice, in partnership with another hospice in the region, targeted hard to reach groups in the community. One example was carers who had no recourse to public funds who were supporting a family member at the end of their life. This is a condition imposed on people due to their immigration status, such as those on work, study and family visas coming to the UK.

The hospice led a consortium working with the local authority to help residents access support under the Care Support Act. Managers explained that in the past patients known to the Hospice were potentially eligible for support and thanks to the project their patients were now accessing this more rapidly. Moreover, the team could provide more personalised care for people with a learning disability or mental health problem.

Feedback was positive from stakeholders we contacted, who told us that managers were always willing to consider ways their teams could work with colleagues from other organisations and faith groups in the best interests of the local communities.

For example, stakeholders told us about the “close working relationship” with district nurses and community health teams to arrange “joined up” home visits for end-of-life patients, providing end of life training to care home staff and basing specialist palliative care teams within the acute hospital.

Managers described how the hospice had formed a hospice education learning partnership with another hospice in the region. Commenced in 2019, the programme had since been extended, in association with a specialist NHS trust, to providing end of life care related education and training for community based nurses, allied health professionals and support workers in south east London.

Meeting people’s individual needs

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

Staff kept detailed records of patient preferences including developing Advance Care Plans and treatment escalation plans, which documented how they wanted to be treated at the end of their life. Where referrals to their service did not have a record of this type of choice, staff fed this back to the referrer and provided education on how to complete the information.

We saw examples of patient assessments which included, patient, carers, nursing and medical staff and choices were documented. The electronic patient record had templates to support the assessments and care plans including end of life care, falls management and wound care. Managers explained that these can be adapted and tailored to help ensure care was individualised.

Nursing staff coordinated their visits with community nursing staff who were also providing care for patients.

Where they could, they provided care, which community nurses would have otherwise delivered, to prevent duplication of visits. Staff documented care provided and contributed to the records of the community nursing teams to ensure they had up to date information on care needs.

All patients had a care assessment and those under the care of the personal care support service had a plan booklet which remained in their homes. We saw clear records of individualised care plans. They included things which were important to the patient and ranged from family members to day-to-day activities and the patient's favourite mug. For example, staff described how the inpatient unit had a drinks trolley service in the evening which provided the opportunity for patients to have an aperitif if desired, and to help promote appetite. Relatives told us how staff responded promptly and effectively when a patient changed their mind about preferred place of death.

Staff adapted care to meet individual needs of patients and their families and carers. Staff consulted and recorded in detail, the wishes of the patient and those close to them. This included how patients wanted to live the life they had left. Staff made every effort to fulfil their wishes wherever they could. We were told about incidences where patients had been prescribed medicines that limited their cognitive function prior to referral to the hospice or where their mobility had reduced, which interfered with their independence. The team including therapists worked to improve and mitigate effects of medication or treatment, including managing pain in alternative ways to improve cognition.

Staff and relatives described support arrangements put in place such as overnight accommodation for relatives along with music and pet therapy sessions.

Patients were given a choice of food and drink to meet their cultural and religious preferences. The chef at the inpatient unit consulted with patients to provide a diet which suited them. We saw how staff attended to detailed needs of patients, in a gentle and unhurried way.

Managers made sure staff, and patients, loved ones and carers could get help with communication when needed. Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

Relatives told us how staff had supported their siblings with additional communication needs by using sign language. The service had information leaflets available in languages spoken by the patients and local community.

Additional translation support was available via telephone through a specialist service and staff knew how to contact the service if need be. Managers told us that the hospice also had a register of clinical staff who were fluent in other languages, to help support communication with those who did not have English as a first language.

Senior managers stated that the hospice has recently run training for patient facing staff on sexual orientation and gender identity, which was part of a hospice commissioned project to improve the care and accessibility of services for people who identified as LGBTQ+. This hospice was working with a local inclusion charity to support this work.

Access and flow

People could access the service when they needed it and received the right care promptly.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes. The average waiting time for inpatient referral to admission was one day and the average length of stay (2021-2022) was 10 days.

We saw how community staff managed a rapid response referral for a patient who was approaching the final hours of their life and relatives we spoke with also told us when they had needed urgent support, the service had responded by visiting within 24 hrs. Managers explained that the hospice has contracted with other community services to provide a rapid response visiting nurse overnight in Greenwich and the service used an electronic appointment system to support prompt visits and follow ups.

Managers and staff worked to make sure patients did not stay in the hospice longer than they needed to. Managers monitored patient moves between services and actively liaised between services to prevent duplication of care provided.

Staff supported patients and their families when they were referred or transferred between services. We saw staff reassure community patients and their families of the standard of care a service would provide and what to expect as an inpatient at the hospice.

Learning from complaints and concerns

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

Good

Hospice services for adults

The service clearly displayed information about how to raise a concern in patient areas. Staff and volunteers we spoke with understood the policy on complaints and staff knew how to handle them.

Greenwich and Bexley Community Hospice had a complaints policy which was in date and reviewed on an annual basis.

Patients and relatives were able to provide feedback in person through patient survey tools used by the hospice, as well as external bodies such as Healthwatch and NHS choices. We saw data that indicated these were collated for each area of the organisation and reviewed as part of quarterly reports prepared by the quality and safety committee.

Managers described clearly how they investigated complaints and identified themes. Every complaint was investigated using root cause analysis and we saw quality dashboard reports that showed complaint rates accounted for 1% of patient interactions over the last year. There were 8 verbal complaints and 9 written complaints about care received 2021/22. Nine of the 17 complaints were upheld. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff understood the policy on complaints and knew how to handle them. Complaints were a standing agenda item for each team or department meeting and progress against actions were discussed. Wherever possible staff acknowledged concerns and worked to resolve them before they became formal complaints. Staff could give examples of how they used patient feedback to improve daily practice. This included patient stories which were discussed at team meetings. Staff used the story to identify how they could improve any aspect of the patient/carer experience.

Staff and selected volunteers received mandatory training on complaints handling, customer service and duty of candour.

Are Hospice services for adults well-led?

Outstanding ☆

We rated it as outstanding because:

Leadership of the service

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff and volunteers. There was a strong emphasis on educational support for staff at all levels and leaders actively supported staff and volunteers to develop their skills and take on more senior roles.

There was compassionate, inclusive and effective leadership at all levels. Leaders demonstrated the required levels of experience, capacity and capability needed to deliver high quality and sustainable care. Trustees acted as critical friends for service leads to drive improvement. Patient and family experience were always considered.

Staff told us on numerous occasions that the leadership team was visible and approachable and how this was an improvement since the recent additions to the team. We were told and could see, there were strong channels of communication from board to operational levels which ensured the voices of, patients, carers, volunteers and staff were heard, listened to and acted upon.

The senior leadership team was stable and worked cohesively across all levels. The chair of the board of trustees was well informed of the skill mix of the board and had identified areas where the board could be further developed in line with the ongoing vision of the service.

Trustees completed an induction programme to familiarise themselves with what the trustee role entailed. The chair and senior leaders confirmed the trustees provided an appropriate level of challenge to reports presented to them. The senior leadership team and the trustees understood the quality and sustainability challenges facing the hospice.

There was a clear leadership strategy. The board and trustees met regularly to review, develop and evaluate this. There was succession planning with a number of leadership development programmes for managers within the organisation.

Staff told us they felt well supported by the management. Staff told us there was strong leadership, who were a cohesive friendly and approachable team. Staff felt confident in approaching them regarding issues to do with their professional or personal life.

Leaders within the service went out of their way to ensure they were visible and approachable. Staff told us leaders from all levels within the organisation were supportive and members of the senior leadership team and trustees could be seen daily and always had time to share ideas and answer any questions.

All staff and volunteers we spoke with felt valued and told us they enjoyed working at the hospice and expressed pride in the care and support provided to patients and their loved ones.

Vision and Strategy

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

We saw that senior leaders engaged with the wider health economy and were engaged with appropriate networks aligned to their service and its future vision and strategy. We saw that the strategy aligned to local plans in the wider health and social care economy.

Senior managers explained that 2 independent reports had been commissioned as part of a recovery and transformation programme (RTP), which was commenced during the COVID-19 pandemic. These looked at all aspects of operations and led to the review and development of a new 5 year strategy published in 2022.

We saw posters and leaflets about the new vision and strategy displayed at various points around the hospice and also published on the hospice website. The hospice vision statement was “We believe that every person facing death should have the best quality of life possible, experience dignity, peace and comfort and be supported to make the choices that are right for them.”

The strategy for the hospice covered 3 priorities, which focussed on listening to all voices in our community, growing and empowering the hospice team and making the most of digital technology. Plans included clear statements on objectives, desired outcomes as well as value statements designed to support the goals.

Staff and volunteers spoke knew about the new strategy and spoke about the vision and values in positive terms. They were able to relate these to how they put patients at the centre of the delivery of care and treatment.

The vision and values were communicated to staff and volunteers through team and governance meetings as well as internal communications newsletters and poster displays.

Culture

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

There were high levels of staff and volunteer satisfaction across all levels of the service. Staff and volunteers were proud of the organisation as a place to work and spoke highly of the culture. Staff and volunteers felt respected, supported and valued.

The hospice had a wellbeing lead who coordinated activities for staff as well as Schwartz rounds and the establishment of staff trained as mental health first aiders.

The service had obtained funding support from the integrated care system to enhance wellbeing support for staff and volunteers which included a wellbeing area and access to clinical counselling services. The hospice leadership had also negotiated funding for a neighbouring hospice and worked with them in partnership to deliver the wellbeing support online and in person.

The service promoted equality and diversity in daily work and had an open culture where patients their visitors and staff and volunteers could raise concerns without fear.

The service had developed a 'senior leadership manifesto', which set 8 values and behaviours expected of the guard and we were told the effectiveness of the system was regularly reviewed. The service had invested in staff and volunteer wellbeing support and we heard positive examples of this from staff we spoke with.

Staff and volunteers informed us they felt confident to raise concerns with the leadership and felt listened to. They were updated on all organisational service developments.

The service had commissioned an online platform where staff could raise concerns, anonymously if they wished, and chose who dealt with the concern from 5 appointed contacts including board members. The hospice had a whistleblowing policy and equality and diversity training was included in the mandatory training matrix for employees.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff and volunteers 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.

An effective and defined governance structure was in place to ensure accountability and delivery of the strategy was maintained.

Trustee 'champions' had been assigned by the chair to each board sub-committee to ensure consistent and appropriate challenge at all levels. We reviewed meeting minutes, status reports and quality accounts and saw that performance, staffing, finance and incident information including complaints was discussed at each level. Committees received and reviewed the minutes and actions of related subcommittees.

Levels of governance and management functioned effectively and interacted with each other appropriately. Governance within the hospice was overseen by the board of trustees and executive management team through the quality and integrated governance framework.

The framework, and supporting policy, provided the structure for managing and reporting on a range of auditable metrics to the board and to the clinical commissioning groups. Board-led sub-group committees, all of which were attended by a trustee, included the finance, information governance and information technology committee and the quality and safety committee.

There was a programme of clinical and internal audit to identify areas of risk and improvement and actions were taken to improve performance.

Management of risks, 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 and volunteers contributed to decision-making to help avoid financial pressures compromising the quality of care.

There were clear and accountable arrangements for identifying, recording and managing risks. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

The executive management team and the trustees were able to describe the service's main risks, and these matched the risks identified on the hospice's risk register. The risk register covered all areas of the service. The risk register was laid out in a way that risks were listed by the staff member responsible for overseeing the risk. Risks were rated by the impact that it could have upon the safety or provision of the service. We saw actions listed against highly rated risks.

Staff we spoke with could articulate the main risks to the service with funding, recruitment challenges and the cost of living crisis being the main risks to the hospice. Performance data was analysed and presented at committee and board of trustee levels.

The service had plans to ensure continuity of care in the event of an emergency.

Information management

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

The information systems were integrated and secure. The hospice collected a variety of data and analysed it to help managers understand performance, make decisions and improvements. There were good processes for submitting statutory notifications to the CQC and the hospice was actively participating in testing new systems with the CQC.

The service had a data protection policy which outlined the purpose for processing personal data and retention periods and disposal methods. Information security was managed in line with national guidance.

There was an electronic human resources system that was used as a database for all grades of staff, including clinicians. A separate customer relationship management system was used for information about volunteers.

Any safety alerts were received by the director of care and service transformation and cascaded to the appropriate departmental managers.

Engagement

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

Senior leaders and trustees had an inspiring shared purpose and strived to deliver and motivate staff to succeed. There were consistently high levels of satisfaction across all staff and volunteers we spoke with.

The service engaged well with patients, staff, volunteers and the public and local organisations to plan and manage appropriate services and collaborated with partner agencies and stakeholders effectively.

Patient experience stories were shared at both board and staff meetings to highlight patient views and feedback and were also used as an opportunity to share learning and champion good practice. A staff pulse survey was undertaken each year and the service responded to any comments made to improve the quality of the patient's experience.

There was regular communication with staff via the staff newsletter and individual one-to-one meetings.

We spoke with stakeholders from the NHS and local commissioners, who told us the Chief executive and her team were an integral part of the local system leadership and commented favourably about the way the hospice worked closely with them on "all aspects of system resilience" and acted as critical friends when appropriate. Stakeholders also spoke in positive terms about the level of confidence they had in the leadership of the hospice and one senior manager commented: "we could learn from their openness and willingness to self-reflect".

Learning, continuous improvement and innovation

All staff and volunteers were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Staff were actively supported to attend and present research at national conferences and we saw that 70 units of education (including short courses and post graduate studies) had been funded or part funded for a wide range of staff and were underway.

The service had invested in external clinical supervisors to provide clinical supervision for all patient facing staff including doctors, registered nurses, allied health professionals, social workers, counsellors, health care assistants and support staff and clinical administrators.

The service had obtained community development lottery funding to improve links with community and faith groups. The service had an established 'compassionate neighbours' programme as well as a young ward volunteers' programme.

There were around 200 local volunteers in the compassionate neighbour programme, who were matched with patients and encouraged to spend time with them. The young ward volunteers are aged 17-23 years and attend the hospice for 4 hours a week for 6 months and are supported to gain their care certificate as part of their experience.

Good

Hospice services for adults

The senior management team were committed to improving palliative service provision across the region and acted as a strategic partner in a number of initiatives. These resulted in award nominations at regional and national level for key individuals such as the chief executive, who also acted as the lead for palliative and end of life care for southeast London.

We saw from papers that patient and staff stories were shared at board meetings as well as newsletters to staff and volunteers. These provided an opportunity to hear directly from people their experiences of using and delivering services. We saw these stories were impactful, reflective and informative. Leaders shared these stories, took actions where there was a need to develop the service and improve people's experience.