The Congregation of the Daughters of the Cross of Liege

St Raphael's Hospice

Inspection report

London Road
North Cheam
Sutton
Surrey
SM3 9DX

Tel: 02080997777
Website: www.straphaelshospice.org.uk

Date of inspection visit:
19 July 2016
20 July 2016
22 July 2016

Date of publication:
29 November 2016

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 19, 20 and 22 July 2016 and was announced. The service was last inspected in September 2013 and at that time was meeting all the regulations we looked at.

St Raphael's Hospice is a voluntary organization, part of the registered charity of the English Province of the Daughters of the Cross of Liege. The hospice provides end of life and palliative care to people living in the South London Boroughs of Sutton and Merton. The hospice accepts referrals made by GP's, specialist nurses or hospital consultants. A team of specialist consultants, doctors, nurses, health care assistants and a range of other health and social care professionals, therapists and volunteers provide care, treatment and support to people with a life-limiting illness and their families/carers and friends.

The hospice comprises of a 14 bedded in-patient ward, the Jubilee day care centre, overnight family accommodation and a café known as the Orangery that is open to the public. There are various community teams that operate out of the hospice which include the Clinical Nurse Specialist Community Palliative Care Team (CPCT), "Hospice at Home" and "Hospice neighbours" services that provides people and their families care and support at home. The hospice also has a respite care service for people and a pastoral and counselling service for both people and their families. At the time of our inspection there were eight people staying on the ward at St Raphael's and approximately 250 people receiving community palliative services at home.

The service had a registered manager who was also the hospice's Director of Care Services (DCS). A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

Management, staff and volunteers were highly motivated and committed to ensuring people and their families received the best possible end of life care, treatment and support. The hospice enabled people to experience a positive, comfortable and dignified death that was delivered in accordance with a person's personal needs, choices and preferences. Practical and emotional support was provided to people and their families.

People received personalised care, treatment and support. People were supported to make informed choices about their end of life care and to have as much control as possible about what happened to them before and after their death. They were involved in planning their care and supported to make decisions on their preferred place of death. Consent to care was sought by staff prior to any support being provided.

The management team demonstrated a strong commitment to delivering people with high quality and safe end of life care. The management structure showed clear lines of responsibility and leadership. The service had developed effective governance systems and there was a strong emphasis placed on continuous

improvement of the service. The service regularly reviewed their performance and where further improvements were identified appropriate actions were taken. Managers used learning from near misses, incidents and inspections to identify improvements that would positively enhance the lives of people receiving a service from St Raphael's.

The hospice was committed to working collaboratively with others. Staff worked in close partnership with external health and social care professionals and other organisations to deliver and share best end of life practice and care for people affected by a life limiting illness.

People told us they were very happy with the service they received from St Raphael's. We saw staff looked after people in a way which was kind, respectful and compassionate. Feedback we received from people, their families and external community health and adult social care professionals supported this. Staff ensured information they wanted to communicate to people was done in a way that people could understand.

People said they felt safe staying on the ward or receiving care and support in their own home from the community teams. Staff knew what action to take to ensure people were protected if they suspected they were at risk of abuse or harm. Risks to people's health, safety and wellbeing had been assessed and strategies to prevent and manage identified risks were robust. This enabled staff to support people as safely as possible on the ward and at home. The service managed accidents and incidents appropriately and suitable arrangements were in place to deal with emergencies. The provider's recruitment processes ensured staff and volunteers were suitable to work with people who received a service from the hospice.

The provider ensured regular maintenance and safety checks were carried out at the hospice to ensure the building and equipment remained safe. The hospice was clean and there were processes in place to protect people from the risk of infection.

Staff had built caring and friendly relationships with people and their families. We observed people and staff engaging in warm conversations throughout our inspection. There were sufficient staff to meet people's needs, and staffing levels were regularly reviewed and adjusted accordingly to meet people's needs. One-to-one staffing was provided to further support people and maintains their safety when required.

Staff were clear about their roles and responsibilities. People received care from a range of health and social care professionals who received effective training and good support from their line managers and senior staff. Training needs were regularly reviewed and staffs' competency to continue undertaking certain tasks such as handling medicines or operating mobile hoists were routinely tested. Systems were in place to support staff and to enable them to reflect on their own practice and that of other staff. This help to ensure they had the right knowledge, skills and experience to meet people's individual needs and wishes. Volunteers also received training and support to assist them in their roles in the hospice and in the community.

People were supported to maintain relationships with people who were important to them. There were no restrictions on visiting times at St Raphael's and families could stay overnight. People and their families/carers were able to access a wide range of group and individual social activities and educational classes at the day centre. People were supported to be as independent as they wanted and could be.

Personalised care plans reflected people's specific needs and preferences in respect of how they wanted to be cared for, treated and supported. These plans and associated risk assessments were regularly reviewed and kept up to date. This gave staff clear guidance and instructions about how they should care and support

people and their families.

There was strong emphasis on the importance of good nutrition and hydration and a commitment to providing people with what they wanted to eat and drink. There was an excellent choice of meals, snacks and drinks, and staff went out of their way to buy people specific food if it was not available at the hospice. People received the support they needed to remain healthy and well. People were supported to receive good health care both from the hospice and other external community health and social care professionals. People received their medicines as prescribed and staff knew how to manage medicines safely.

Staff were aware and respectful of people's cultural and spiritual needs including before, during and after death. There was a multi-faith chapel at St Raphael's where people could practice their faith or just spend time in peaceful reflection. There was also a chaplaincy service to support people and their families with their spiritual needs.

Staff were aware of who had the capacity to make decisions and supported people in line with the Mental Capacity Act 2005. Where appropriate, staff liaised with people's relatives and involved them in discussions about people's care needs. Managers and staff understood when a Deprivation of Liberty Safeguards (DoLS) authorisation application should be made and how to submit one. This helped to ensure people were safeguarded as required by the legislation. DoLS provides a process to make sure that people are only deprived of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them.

The service had an open and transparent culture. The service had systems in place to obtain feedback from people, their families/carers, staff and other health and social care professionals about the hospice. Specifically about what they thought the hospice did well and what they could do better.

People felt comfortable raising any issues they might have about the hospice with managers and staff. Complaints or concerns raised about the hospice were investigated and, where necessary, appropriate action taken to resolve the issue. The provider had a positive approach to using them to improve the quality of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People received safe care both at the hospice and in their own home. Staff were aware of what to do if they witnessed or suspected abuse was taking place. They were confident to challenge unsafe practice and report any concerns to their manager or a senior member of staff.

Assessments were undertaken to identify any risks to people who received an inpatient service from the hospice and these were regularly reviewed. The hospice's environment was safe and maintenance took place when needed.

Staffing levels were flexible and regularly reviewed to ensure there were the right number of staff on duty at anyone time to meet people's needs. Staff and volunteers were appropriately checked to ensure they were suitable to provide care and support to people.

Medicines were stored safely and systems were in place to ensure that people received their prescribed medicines when they needed them. Processes were in place to protect people against the risk of development and spread of infections and infectious diseases.

Is the service effective?

Good

The service was effective. People and their families received support from skilled and experienced staff, which included volunteers.

In addition, staff had regular opportunities to improve their existing knowledge and skills by attending in-house medical forums, mentoring sets and bi-monthly oncology tutorials.

Managers and staff knew their responsibilities in relation to the Mental Capacity Act 2005 and DoLS. People were involved in making decisions about their treatment and care needs. When complex decisions had to be made staff were aware how to make decisions in people's best interests.

People were supported to receive the health care they needed

both from staff who worked for the hospice and other external community health and social care professionals. There was a strong emphasis on the importance of good nutrition and hydration and a commitment to providing people with what they wanted to eat and drink in a flexible manner.

Is the service caring?

Good

The service was caring. People and their families spoke consistently about the caring and compassionate attitude of staff and volunteers who worked for the hospice. We saw staff were caring and supportive and respectful of people's privacy and dignity.

The service ensured people were enabled to experience a comfortable, dignified and pain-free death, according to their wishes and preferences. Staff understood people's emotional needs and focused on their wellbeing as well as that of their families. A bereavement service was available for relatives to access.

People were fully involved in making decisions about the care and support they received and felt managers and staff listened to them. Staff were respectful of people's cultural and spiritual needs.

Is the service responsive?

Good

The service was responsive. People received person-centred care. Assessments were undertaken to identify people's physical, social and psychological needs and wishes. This ensured staff understood people's needs and preferences.

Care plans were kept under constant review and the service responded quickly to people's changing needs and wishes.

People were encouraged to maintain relationships with the people that were important to them.

The provider had a positive approach to using complaints, concerns and feedback to improve the quality of the service.

Is the service well-led?

Good

The service was well-led. The management team demonstrated a strong commitment to providing people with high quality care.

Managers and staff worked to continually improve and develop the service. Systems were in place to routinely review the

service's performance and to look for innovative ways to improve.

The service had an open and honest culture. People's views were sought and valued and encouraged to get involved in developing the service. Staff also felt able to express their opinions and that they would be listened to.

The service worked collaboratively with other community health and social care professionals and agencies to deliver and share best end of life practice and care for people with a life limiting illness.

St Raphael's Hospice

Detailed findings

Background to this inspection

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

This inspection took place on 19, 20 and 22 July 2016 and was announced. We gave the provider 48 hours' notice of the inspection because we needed to be sure senior managers and staff would be available to speak with us on the day of our inspection. The inspection team consisted of a lead inspector, a second inspector, a specialist CQC pharmacy inspector and a specialist social work advisor with experience of working in a hospice.

Prior to the inspection we reviewed the information we held about the service, including the statutory notifications we had received from St Raphael's. Statutory notifications are notifications that the provider has to send to the CQC by law about key events that occur at the service. We also reviewed the information included in the provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with five people staying on the ward at St Raphael's, ten managers, 15 members of staff and six volunteers. This included the registered manager/DCS, the Chief Executive Officer (CEO), the head of nursing (Matron), the chair of the Advisory Committee, the head of clinical governance, the manager of the Hospice at Home team, the manager of the Jubilee day centre, the head of human resources, the head of housekeeping, the volunteer services coordinator, ten nurses (including the clinical lead nurse specialist), two healthcare assistants, two housekeepers, a physiotherapist, a medical student on placement at the hospice and a member of the chaplaincy service.

We also spoke on the telephone with eight people and 14 family members/carers who receive a hospice at home service. In addition we received feedback from five community health and social care professionals who worked in the London Boroughs of Merton and Sutton. This included representatives from two Clinical Commissioning Groups (CCG), two NHS Foundation Trust Hospitals, two care homes and a community pharmacist.

We undertook general observations during time we spent on the ward and at the day centre. We also sat in on a ward staff handover meeting, a music session held in the day centre and attended a multi-disciplinary medical journal club discussion group in the hospice's St Bede's education and training centre.

We looked at five people's care plans, including advanced care plans, medicines records for three other people who were staying on the ward, files for ten members of staff and two volunteers, and a range of other records relating to the overall management and governance of the hospice. This included accident and incident reports, complaints, compliments, health and safety and maintenance checks, quality monitoring reports and St Raphael's most recent annual quality account report. A quality account is a legal requirement for all healthcare services that receive NHS funding to produce statutory accounts annually. The account focuses on how money is being spent by the hospice, the quality of the service they provide and key priorities for the next 12 months.

Good

Is the service safe?

Our findings

People on the ward and those being supported at home consistently told us they felt safe with staff from the hospice. One person said, "I've never felt so safe. The ward is always staffed", while another person told us, "I've got to know the nurses and volunteers who visit me at home really well, so I feel totally at ease with all of them." From the various feedback provided to the hospice by families we noted that they were satisfied their relative had been well cared for by staff who knew how to keep them safe from abuse, neglect and harm.

People were protected from the risk of abuse because the provider had taken reasonable steps to identify abuse and prevent it from happening. Staff and volunteers were provided with guidance and training so they understood their role in keeping people safe from abuse. For example, we saw safeguarding adults at risk and whistleblowing policies and procedures were available for all staff in their staff handbook, which outlined when and how to report any concerns they might have.

The provider considered it mandatory for all staff and volunteers to receive safeguarding adults and children training, which was delivered by the local authority's safeguarding lead. This training was refreshed annually. Staff also received training on equality, diversity and human rights to help them understand how to protect people from the risks associated with discriminatory practices and behaviours. Staff were knowledgeable about how to recognise the signs that a person may have been subject to abuse or neglect and were aware of their responsibilities to report any safeguarding concerns they might have. The hospice has a safeguarding lead who told us they would escalate any safeguarding concerns to the local authority safeguarding team as necessary. The safeguarding lead regularly liaised with the local authority's safeguarding team to ensure they had up to date training and knowledge so they could support other colleagues at the hospice as required.

The provider identified and managed risks appropriately. Assessments were undertaken to identify any risks people might face, such as developing pressure ulcers, falling and becoming malnourished. Where people were identified as being at risk management plans were put in place for staff to follow. For example, if people were at risk of falls, preventative measures were put in place that included lowering the person's bed and/or providing them with one-to-one staff support. One member of staff told us, "I was asked to work today as an extra pair of hands to provide one-to-one care to a person because they're at a high risk of falling." All the staff we discussed risks with demonstrated a good understanding of the specific risks each person faced and how they could protect people from the risk of injury and harm. Where new risks had been identified people's records and the white board located in the office were updated as and when required to ensure staff had access to all the information they needed to kept people safe. We also saw health and safety risk assessments in respect of people's internal home environments had been carried out for people who received a hospice at home service.

The service managed accidents and incidents appropriately. We saw care plans were immediately updated in response to any accidents and incidents. This ensured care plans and associated risk assessments remained current and relevant to people's needs. We saw records contained detailed information about the

occurrence of any incidents involving people using the service, action taken to support people and prevent similar incidents reoccurring. The managers reviewed all incidents that occurred to identify any trends or patterns.

The provider had suitable arrangements in place to deal with emergencies. There was a major incident procedure and a business continuity plan to help staff deal with such events. For example, a fire risk assessment was in place for the building and personal emergency evacuation plans (PEEP) had been developed for people on the ward. This provided staff with clear guidance if people needed to be evacuated from the premises in an emergency. Staff demonstrated a good understanding of their fire safety roles and responsibilities. Staff received on-going fire safety and emergency training, and were aware of the procedures to follow in the event of a fire.

The premises and equipment were appropriately maintained. Equipment was serviced and checked in line with the manufacturer's instructions. For example, maintenance checks and servicing were regularly carried out at the hospice by suitably qualified professionals in relation to mobile hoists, pressure relieving mattresses, fire extinguishers, fire alarms, emergency lighting, portable electrical equipment and water, gas and heating systems.

We observed the environment was kept free of obstacles and hazards which enabled people to move safely and freely around the ward. We saw chemicals and substances hazardous to health were stored safely in locked cupboards when they were not in use. Staff had received health and safety training and there was a lead who took overall responsibility for health and safety management at the hospice.

The provider's recruitment process was thorough and ensured staff and volunteers were suitable to work with people who received a service from the hospice. This included prospective staff completing an application form and attending an interview. Staff and volunteer files indicated the provider had carried out all the relevant pre-employment checks on staff and volunteers before they were permitted to work for the hospice. This included proof of identity, the right to work in the United Kingdom (UK), relevant qualifications and experience, character and work references from former employers, a full employment history and Disclosure and Barring Service (DBS) checks. It was the provider's policy that DBS checks would be renewed every three years in line with recognised best practice. Nurses' registration with the Nursing and Midwifery Council (NMC) was also checked to ensure that they were allowed to practise in the UK.

We saw staffing levels were sufficient to meet people's needs and to provide personalised and individual care both within the hospice and the community. A person's relative told us, "Staff are very quick to respond to the call bell when I've used it for my [family member]." Several people mentioned the high staff to inpatient ratio working on the ward and about staff having the time to sit and talk with them. During our inspection we observed staff responding promptly to call bells. It was also clear from discussions with staff that they felt the ward was adequately staffed. One member of staff said, "We get plenty of quality time to spend with patients just talking with them and their families."

Staffing numbers were determined according to people's needs. We saw the staff rota was planned in advance and took account of the level of care and support people required on the ward. Managers met daily to discuss the staff rota and determine whether or not numbers remained sufficient to meet people's needs that day. They told us they had the authority to book bank staff to ensure short notice sick leave could be covered quickly, and also provide additional one-to-one staff support if a person's dependency levels had increased. Managers gave us a good example of how they ensured patient safety when the hospice decided not to accept more than eight inpatients on the ward at any one time because of a lack of suitably qualified nurses to work at night. This decision ensured the number of staff deployed in the hospice at night

continued to be sufficient to meet people's needs.

The hospice was kept clean. People commented on the cleanliness of the ward. One person's relative told us, "The hospice is always so clean. I think the staff do a great job keeping it that way." Cleaning staff demonstrated a good understanding of their responsibilities and the importance of maintaining high levels of cleanliness. We observed staff washing their hands and using hand gel before entering and upon leaving people's rooms. Staff wore personal protective equipment (PPE) as required. Staff followed appropriate guidelines in relation to the safe management of clinical waste and soiled linen. Appropriate systems were in place to minimise risks to people's health during food preparation, for example through the use of colour coded chopping boards and the daily checking of fridge and freezer temperatures. Managers and senior staff undertook regular checks on the cleanliness of the service and addressed any concerns with the domestic staff so they could be rectified.

The service managed medicines safely. We received positive feedback from people about the way the hospice handled their prescribed medicines. Comments included, "I would highly commend the service for the way they look after my medication" and "I'm always given my medicines accurately and on time." We observed staff administering a person their prescribed medicines in a caring and professional way. We saw people had individualised medicines administration (MAR) sheets, a list of known allergies and information about how people preferred to take their medicines. Our checks of stocks and balances of people's medicines confirmed these had been given as indicated on their MAR sheets. Medicines were administered by nurses that had received training in the safe management of medicines. The competency of these nurses to continue handling medicines safely was reassessed annually.

Medicines were stored securely in locked medicines cupboards outside each person's bedroom and also in the treatment room. This ensured that medicines were available at the point of need and that the provider had carefully thought about the provision of people's prescribed medicines. Controlled drugs were appropriately stored in accordance with legal requirements, with daily audits of quantities done by two members of staff. There was a robust procedure in place for the disposal of unwanted medicines, including patient's own drugs if they chose to dispose these at the hospice. Medicines for disposal were placed in appropriate pharmaceutical waste bins and there were suitable arrangements in place for their collection by the pharmacy. Managers and nurses told us they were happy with the arrangement with the supplying community pharmacy and felt they regularly received good advice and support. This included the provision of training to nursing staff in respect of high risk medicines such as warfarin and medicines reviews. This was evidenced by checking the record of several medicines reviews that had been carried out within the last six months for people staying on the ward.

Good

Is the service effective?

Our findings

People told us staff were competent and that they had the right knowledge, skills and experience to understand and meet their needs and wishes. Feedback from people and their families included, "Staff do a fantastic job", "I think all the staff know what they're doing and are so good at what they do" and "Staff who visit us at home know what I need and like and that includes the volunteers". Comments we received from external community health care professionals was equally complimentary about the hospice and their training programme that was available to all healthcare professionals. One community professional told us, "St Raphael's run a very good end of life training course. It was the best training on end of life care I have ever attended," and another community professional said, "St Raphael's are running joint teaching sessions with us on syringe pump training to care homes in the local area."

There was a comprehensive training programme in place for staff. Records we looked at showed most staff had an academic or vocational palliative/end of life care qualification and that staff had completed training in many other areas. This included training in dementia awareness, moving and handling, food hygiene, malnutrition and assistance with eating, equality and diversity, dignity and respect, prevention and control of infection, medication safe handling awareness, health and safety, emergency aid awareness and fire safety. Staff and volunteers received a thorough induction that included shadowing experienced members of staff. Competency tests were undertaken before staff were able to undertake tasks unsupervised, for example before they administered medicines or used a mobile hoist.

We saw some medical and nursing staff had received additional training in pain/symptoms management in relation to palliative/end of life care, resuscitation, wound management and tracheostomy care. Other staff had attended training in bereavement and 'how to have difficult conversations' about end of life care.

The hospice staff have been making arrangements to care for and support people with end of life care needs with other medical conditions and people living with dementia. Day centre staff told us they had attended a training course on how to improve the quality of life for people living with dementia, which enabled them to spend time with people stimulating all their senses. Staff told us that it enabled everyone to be involved in the activity and get some enjoyment as it did not rely on people verbally communicating or being physically active.

Staff and volunteers told us they felt they received all the training they needed to meet the needs of the people they supported. One member of staff said, "The end of life care training I've received since I've been working at St Raphael's has been the best," while another member of staff told us, "I cannot fault any of the training. It's always relevant and there's plenty of it." Systems were in place to ensure staff stayed up to date with training identified as mandatory by the provider.

Managers told us in addition to the training described above staff had regular opportunities to improve their existing knowledge and skills by attending in-house medical forums, mentoring sets and bi-monthly oncology tutorials given by the medical director. During our inspection we sat in on the medical journal club meeting which discussed palliative care for Muslim people and their families. This shows that the hospice

was considering the specific needs of people from ethnic backgrounds who lived within the local community. The meeting was well attended by a range of clinical and health care professionals from St Raphael's and the local community.

The hospice took into account national strategies when delivering a service and had good links with the National Institute for Health and Care Excellence (NICE), General Medical Council (GMC), Nursing Midwifery Council (NMC) and Medical Student Education Programme. Managers told us these links had helped the hospice develop specific study days for the specialism in the education department. The service also had a bi-monthly medical journal club which we attended during our inspection and saw proactively supported shared learning with external community health and social care professionals and organisations, such as local GPs, NHS Trusts, Clinical Commissioning Groups (CCG) and local authorities. This enabled community health and social care professionals to develop and share best end of life and palliative care practice with one another on a regular basis. Staff had sufficient opportunities to review and develop their working practices. Records indicated staff were expected to regularly attend individual supervision meetings with their line manager and group meetings with their fellow co-workers. Staffs overall work performance was appraised annually. There were also reflective practice sessions where staff could discuss any issues about different situations they had experienced. One member of staff gave us a good example of how they had found a particular reflective practice session useful after they had been involved in a difficult end of life care case. Staff told us they received good support from their managers, senior staff and co-workers. One member of staff told us, "The managers are so supportive here. We have team meetings every month and supervisions are regular." Another member of staff said, "The managers are very approachable and I feel very much supported by them and the rest of the team at St Raphael's."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw appropriate arrangements were in place to enable people to give informed consent to their care and support before this was provided. Care plans showed people's capacity to make decisions about specific aspects of their care was assessed. This gave staff the information they needed to understand people's ability to consent to the care and support they received. We saw staff always offered people a choice and respected the decisions they made. Staff had received MCA and DoLS training and managers and staff we spoke with demonstrated a good understanding and awareness of people's capacity to consent and to make decisions about the care and treatment they received.

There was a strong emphasis within the hospice on the importance of good nutrition and hydration. People told us the food they were offered at the hospice was "good" and that they were always given a choice at mealtimes. Typical comments we received included, "The food is nice," "The catering staff ask you to choose from the daily menu what you would like to eat before each meal and if you don't like what's on the menu they will prepare you something you do fancy" and "No complaints about the food. It's lovely." We saw the daily menus on both days of our inspection offered people a wide variety of meals to choose from each day. There was flexibility in the meals offered and people were able to request specific meals.

Catering staff told us although the hospice had set mealtimes people could eat whenever they wished. Catering staff also told us they regularly went shopping locally to buy items of food that were not available in the kitchen which people had requested. One member of the catering staff gave us an example of some unusual ingredients they had purchased from a specialist retailer in order to prepare a specific dish for a person because it reminded them of their childhood.
Records showed catering staff had completed their required training in food hygiene, malnutrition and assistance with eating and equality and diversity. We saw an advice booklet which had been given to staff and was available in people's room to help people with a small appetite choose what they could eat and drink. Throughout our inspection we observed staff offering people hot and cold drinks at regular intervals. We also saw jugs of water and various juices in people's rooms which they and their guests could help themselves to whenever they wished. Staff told us there is a small kitchen where people's relatives can make hot beverages when the Orangery café was closed.

People's nutritional needs were assessed by staff as part of the initial planning of their care and support. Care plans indicated people's food and drink preferences and dislikes, dietary requirements and the level of support they required for eating and drinking. Catering staff told us they were in daily contact with medical and nursing colleagues to ensure they were updated about the special dietary requirements of people staying on the ward. Catering staff were aware of each person's individual dietary needs and clearly knew if someone required a diabetic meal, a soft diet, pureed food or if they had any allergies. We saw the hospice used a system of red trays, plates and cups system to help staff identify which people needed additional support when eating or drinking or had special dietary needs, such as a pureed diet. These people will have their meals served on a red tray and plates which enables staff to monitor and help these people when eating and drinking so their dietary needs are met.

We saw evidence that if people were assessed as being at risk of malnutrition or weight loss, appropriate action had been taken by staff to refer them to specialist health care professionals, such as a nutritionist or dietician. Staff closely monitored and recorded the dietary intake of people identified at risk of malnutrition on a daily basis, which ensured they had all the information they needed to determine whether they were eating and drinking sufficient amounts to remain hydrated. We saw that care plans for people who were in the last stages of life, contained additional information for staff about how to keep people hydrated and comfortable.

People were provided with care and support from a multi-disciplinary staff team which included specialist palliative care doctors and nurses, healthcare assistants, therapists, counsellors and specially trained volunteers. This included offering people and their families' a range of complementary therapies including, aromatherapy, massage, relaxation and reflexology. Multi-disciplinary team meetings were regularly held at the hospice to ensure people's health care needs were routinely reviewed.

If people had specific needs that could not be met by the team at the hospice, referrals were made to the required professional. For example, there were instances where the service referred people to the hospital for specialist care. Staff told us discussions would be held with people as to when they wished to be referred to hospital and for what illnesses and symptoms they wished to receive treatment. Most people had an up to date Do Not Attempt Resuscitation (DNAR) and their advanced care preferences and decisions were clearly stated in their care plan. This meant staff were aware of the person's wishes and enabled the team to ensure people received medical treatment in line with their preferences. If people went to hospital in an emergency written information was provided to the ambulance staff.

People told us the ward at St Raphael's was a comfortable place to stay. One person's relative said, "The rooms are a nice size and I particularly like the little garden and patio my [family member] can access from

their bedroom", while another relative told us, "My [family member] was allowed to bring some family photographs and pictures from home to make the room more homely." The hospice has 14 single occupancy bedrooms all with an en-suite bathroom and access to a small enclosed garden and patio area. We saw these rooms were light and airy. There was also a day centre, a multi-faith chapel and several small meeting and consultation rooms. Public areas were accessible for people with mobility needs and wheelchair users. The bathrooms provided a wide range of facilities, including mobile hoists to ensure people could use them safely. All beds had adjustable heights which meant they could be lowered if someone was at risk of falling out of bed.

The hospice had an equipment room where walking frames, commodes and specialist armchairs were stored. This meant, the hospice could respond quickly to ensure people had the equipment in their own homes when they needed it. Staff told us the hospice had good links with other organisations providing a range of equipment, such as pressure relieving mattresses. A manager gave us a good example of how they had obtained a pressure relieving mattress from an external organisation on a weekend to ensure a person who had expressed a wish to die at home could do so.

Good

Is the service caring?

Our findings

People and their families told us they were very happy with the service they received from the hospice. Typical comments made included, "Definitely very happy with the hospice. They're there for me anytime I need any advice or support", "Brilliant service. Very good support" and "I've been so pleased with every aspect of the service my [family member] has received from St Raphael's. It's absolutely outstanding here."

Feedback we received from people about the staff and volunteers who worked for the hospice was equally complimentary. People described staff as "kind" and "compassionate". People felt they had developed close working relationships with staff. Comments made included, "They [staff] make us feel so comfortable and nothing is too much trouble for them. The staff are all so kind and caring", "Very impressed with all the staff including the nurses, volunteers and the café workers – they all go the extra mile" and "All the staff have been so sensitive and respectful of what has been a very difficult time for our family."

Comments we received from external community health care professionals were also positive. One community professional said, "Overall I've found the team at St Raphael's supportive to the care needs of patients who use our hospital and responsive to the needs of our patients in the local community." Another community professional told us, "We have never had any negative dealings with St Raphael's."

Staff treated people with respect. People looked at ease and comfortable in the presence of staff and we saw they supported people in a caring and dignified way. For example, we heard conversations between staff and people on the ward were characterised by warmth and compassion.

People and their families were fully involved in the end of life care planning process that included finding out what was important to the individual, assessing their symptoms and pain so these could be managed appropriately and what outcomes they wanted to achieve. People told us they felt comfortable discussing their health care needs and preferences with staff who took time to explain their care and treatment options. Typical feedback we received included, "We were involved from the start. My [family member] and I agreed we were in this together and the service involved us both just as we wanted" and "There's been plenty of discussion about everything, I am totally in the picture." People and their families told us they had been given a patient and family booklet when they first started receiving a service from St Raphael's which contained detailed information about the hospice's core values and their end of life care services and facilities. We also saw an advance care plan leaflet was given to people and their relatives that made it clear their personal preferences and choices for end of life care formed the bases of the care planning process.

People's care records included information for staff about how they could actively encourage and support people living with dementia to get involved in helping them plan the end of life care they receive. Staff gave some good examples of how they used short sentences and good eye contact to enable them to communicate more effectively with people living with dementia. Staff confirmed they had received dementia awareness training.

Staff told us they had received training on how to have difficult conversations which enabled people to

express their end of life care preferences. This ensured people had the opportunity to let their family, friends and professionals know what was important and mattered to them in the event of them not being able to express their wishes. Several relatives who had family members who had expressed a wish to die at home told us how supportive staff had been when it came to ensuring their family members dying wishes were meet. Staff told us they always found out what was important to people and tried to meet those wishes. A physiotherapist gave us a good example of how they had supported a person to ride their bike after they had expressed a wish to go cycling again. A manager also gave another example of how the service had respected a person's, who was an inpatient, expressed wish to be offered resuscitation despite resuscitation not being appropriate for the majority of patients under the care of the hospice.

People's privacy was respected and their dignity maintained. People told us staff were respectful and always mindful of their privacy. Several people told us they liked having their own single-occupancy room with en-suite bathroom and toilet facilities and access to their own enclosed private garden. One person said, "There is absolutely no comparison whatsoever to being in a four bedded shared ward in hospital and having your own private room at St Raphael's." People also confirmed that their privacy was maintained when staff visited and supported them at home. We saw separate rooms were available at the hospice to have conversations with family members if people did not wish for this to take place in their room. We also saw staff knocked on doors and then awaited a response before entering. Staff were respectful once a person had died and ensured the person's body was treated with dignity and respect. Staff told us how they gave family members the space and time they required to stay with their loved ones after death. Family members were also given the opportunity to attend a bereavement meeting where they could obtain practical advice and support about arranging the funeral.

People were supported to maintain relationships with their families and friends during the last moments of their lives. People's families were supported to visit the hospice at times that suited them and the person receiving care. There were no restrictions on visiting times. One relative commented, "The staff are so welcoming and actually encourage you to stay as long as you like. You can help yourself to hot drinks and I know you can stay overnight if you want." To help support relatives to be close to their family members and to make their stay more comfortable, the hospice has a family room which was included as part of the recently built Orangery complex. Staff also told us people could have visitors stay overnight in their room if they wanted to be closer. The hospice recognised the importance of supporting families through this period of time and ensured that children were welcome to visit their parents. We saw there was play area with toys available for them. Where people had pets, the staff encouraged relatives to bring the family pets so people could be close to their pets.

Bereavement support in the form of counselling was available to people and their families. Counselling was provided by the psych-social team and a bereavement service that was run by specially trained volunteers. There was a monthly bereavement support group and the hospice made contact with bereaved family members within six months of their relative's death to enquire how people were coping and whether or not they needed additional support at that time. Families told us they had been offered counselling and support before and after their family member had passed away. A person's relative told us they continued to be supported by the hospice and remained in regular contact with the staff long after their family member had passed away because of the educational and social activity classes run by the Jubilee day centre specifically for bereaved family members and former carers.

Furthermore, children and young people who were recently bereaved received specialist support from appropriately trained therapists. Staff told us there were bereavement support days for children, young people and their primary carers following the bereavement. There were also remembrance services held throughout the year, which gave families, friends and staff the opportunity to remember people who had

passed away.

Staff encouraged and supported people to be as independent as they wanted to be. We saw a risk-assessment the hospice used when a person expressed a wish to self-administer their medicines, which included information about medicines and whether or not a person was capable of managing their own medicines safely. There were also initiatives to help people stay at home for as long as possible rather than be admitted to the hospice or to hospitals. Managers told us about a six week Hope course for people, their families and carers run by the Jubilee day centre that used "positive psychology and empowerment" to help people living with a life-limiting illness and their families manage better at home. Managers said they had seen the Hope course help people have a better understanding of what options were available to people in respect of end of life care. Members of the community palliative team told us they helped people maintain their independence at home by supporting people to manage their physical and psychological symptoms better.

The hospice was committed to meeting people's cultural and religious needs and preferences. During our inspection we attended a multi-disciplinary discussion group in the hospices education and training centre about improving the end of life care and support they provided to people who were of a Muslim faith and their families/carers. Managers told us they regularly invited religious leaders from the local community to discuss the cultural and spiritual aspects of end of life care and death for people from the culture or faith they represented. Staff were aware of and respectful of people's diverse cultural and spiritual needs including before, during and after death, and had received equality and diversity training. Several staff told us they had access to information about religious rites and practices which included Christian, Muslim, Sikh, Hindu and Jewish faiths. Catering staff we spoke with demonstrated good awareness of the diverse religious and cultural dietary requirements of the people who were staying on the ward at the time of our inspection. Staff had access to an interpreting service so they were able to communicate with people who were unable to speak English. This ensured people had the information they required to make decisions about their care, and communicate their wishes.

A chaplaincy service was available to support people and their families with any spiritual or religious needs they had. A member of the chaplaincy team told us the spiritual care service was able to support people and their families with funeral arrangements. There was a multi-faith chapel within the hospice where people could practice their faith or just spend time in peaceful reflection. We saw Christian symbols on the walls in all the bedrooms we viewed which staff told us could be taken down or replaced with something else of religious significance to the individual occupying the room.

Good

Is the service responsive?

Our findings

People's individual needs, preferences and differences were respected. People told us the hospice provided them with a personalised service which was responsive to their personal end of life care needs and wishes. One person's relative said, "My [family member] received individual care from the minute they came to St Raphael's", while another person's relative told us, "The staff have definitely got the personal touch. They treat you like an individual here".

New referrals to the hospice were received by the First Point of Contact team and the triage team responded by providing people, their families and professional representatives, including GPs and district nurses, with the hospice's first line of support.

Discussions with people about their physical, social and psychological support needs were undertaken by the community palliative care team as part of the initial assessment. We saw each person had a care plan that was tailored to meet their individual needs and preferences. These personalised plans provided clear information for staff about people's physical and emotional care needs, life history, individual preferences that included dietary and religious requirements and family and social relationships that mattered to them. We also saw advance care plans in people's records which documented their wishes and preferences in regards to end of life care. On the ward it was explained to people during the development of their advance care plans and the supportive care they could receive. This enabled people to make informed choices as to when and if they wanted to be taken to hospital for active treatment. Their choices were documented in their care records. The service also used the Gold Standards Framework, a tool for ensuring a structured and evidence based approach for end of life care.

People's needs and wishes were regularly reviewed. During staff handover meetings on the ward we saw a full overview of each person who was staying there. Care plans were reviewed daily or more frequently if required, to ensure the care and treatment people received was in line with their current needs and took into account the frequency with which people's needs and preferences might change. It was also clear from staff handover meetings and subsequent recording systems that information regarding changes to people's care needs were communicated across the entire staff team so they were all aware to make sure people's changing needs were being met. For example, all staff were made aware during handover that one person staying in the ward now needed one-to-one staff following a falls incident.

Staff were aware of the signs and symptoms to look for that indicated a person's health was deteriorating and knew how to appropriately manage people's changing health care needs. One member of staff told us, "As soon as I see a patient's health is deteriorating I would immediately notify the nurse in charge of the ward." Staff were proactive in reviewing people's changing needs and preventing any other complications. For example, we saw pressure relieving mattresses were available and people were regularly turned to relieve pressure to particular areas of the body and reduce the risk of pressure sores developing.

Staff were knowledgeable about people's needs and the level of support they required. One member of staff said, "I realised the real meaning of end of life care when I started working here", while another member of

staff told us, "The term holistic is used all the time in nursing, but I never saw it until I started working at St Raphael's." One member of staff gave us a good example of how they had encouraged a person who received a hospice at home service and their next of kin/carer to activity classes at the Jubilee day centre because it was felt although this individuals' personal and health care needs were being met as a couple their social and emotional needs were not.

St Raphael's also provides a hospice at home service for people who choose to spend the later stages of their illness in their own home. The hospice at home team is managed by a clinical nurse specialist and included a staff nurse and health care assistants who provide physical, practical and emotional support to people and their families. People's individual needs were regularly reassessed and reviewed and the hospice at home team worked flexibly and in collaboration with other healthcare professionals within the community in order to respond effectively to people's changing needs and/or preferences.

There was a 24 hour advice line which enabled people who received a hospice at home service, their families, carers, GPs and other healthcare professionals looking for information on complex palliative care and life-limiting illness to contact staff for advice and support whenever they needed it. This helpline was staffed by clinical nurse specialists from the community palliative team who could assess advice, manage symptoms and offer support to people at times of crisis. People told us the 24 hour advice line helped them to remain connected to the hospice. A person's family member gave us a good example of how they often used the advice line to "touch base" with staff from the hospice and to have a general chat about how they were coping. Staff from specialist community palliative teams told us as part of their handover meetings there was always a discussion about the calls that were received during the night and any that needed to be followed up. The team worked very flexibly to support people and to ensure that they got the assistance they needed especially when they were very near the end of their life. Visits were planned in accordance with need.

People using the community and the inpatient service were able to access the outpatient service and attend a range of group and individual social activities that included art and music therapy sessions. Feedback we received from people who attended the hospices day centre included, "I love coming to the Jubilee day centre. It's a great way to stay in touch with the staff at St Raphael's and the activities are usually good fun", "My [family member/carer] enjoys coming to the Jubilee centre with me because it gets us both out of the house" and "I enjoy meeting up with friends at the day centre to have a good old chat". We observed a music session being facilitated by staff in the day centre during our inspection and saw people receiving a hospice at home service, their family members/carers and volunteers all smiling and joining in the activity.

The provider ensured people received daily news and were kept up to date with important events. The hospice arranged for people to receive a free daily newspaper to be delivered to their room. We saw there was an iPad which people could use to access the internet. In addition there was a play station with a selection of games and Wi-Fi available on the ward for patients use.

The hospice ensured people were not socially isolated. Relatives told us staff periodically checked on people in their room and frequently engaged them in conversation. Day centre staff said they kept people staying on the ward informed about the social activities taking place at the Jubilee centre and would offer one-to one-activity sessions to people, if they chose not to take part in the group activities.
Paragraph 7 line 1 add word hospice after volunteer and in front of neighbour's
Line 3 add word hospice in front of neighbour's
Line 5 same correction

The hospice also has a volunteer hospice neighbour's service which provides social visits to combat

loneliness and social isolation for people that are unable to get out and about that easily. Feedback we received from people who used the hospice neighbour's service was very complimentary about the friendliness of the volunteers and how much they looked forward to their visits. Staff gave us a good example of how they had matched a person receiving the hospice neighbour's service with a volunteer who both had military backgrounds.

The hospice took a key role in the local community and was actively involved in building further links and in improving the knowledge of the local population in respect of end of life care. The relatively new Orangery café is located in the heart of the hospice and provides light meals, snacks and beverages not only to patients, their families, visitors and staff but also to the general public. This meant members of the public could visit St Raphael's whenever they liked, find out more about end of life care, the hospice's role in the local community and build a link with them. Two relatives told us the Orangery provided them the opportunity to enjoy having a meal or a drink whenever they visited their family member because the space was so relaxing.

The hospice supported people and their relatives with any social, employment or legal needs, including any help they required with social benefits, welfare advice, and legal matters such as appointing a power of attorney. The hospice was also able to arrange advocacy support for people, for example, around advanced care planning.

The provider had a positive approach to using complaints and concerns to improve the quality of the service. People told us if they were unhappy with the service they received from the hospice they felt able to raise their concerns with them. People were also confident the hospice would take their concerns seriously and would take appropriate action to resolve any issues they had raised. Several people referred to a booklet they had been given that included information about how to make a complaint if they were dissatisfied with the service they received.

The service had a procedure in place to respond to people's concerns and complaints which detailed how these would be dealt with. There was a complaints log which recorded details of any complaints or concerns raised. The record indicated the service had received a number of formal complaints in the last six months which had all been dealt with within the provider's stated timescales and resolved to the complainant's satisfaction. Managers told us complaints were monitored and discussed at corporate governance meetings for learning and to ensure that they had been appropriately dealt with and the necessary action had been taken where required to improve people's experiences of the service.

Good

Is the service well-led?

Our findings

People, their families and external community professionals were all very positive about the way the hospice was managed. Comments we received included, "The hospice is so well run. It's wonderful"; "The managers are marvellous. Clearly they all know what they're doing and are very good at their jobs" and "We have always worked closely with St Raphael's and I've always found the managers to be professional".

There was a clear management structure to ensure accountability and for the service to be provided seamlessly. Senior staff were allocated lead roles. Throughout the organisation staff understood their lines of responsibility and accountability for decision making about the management, operation and direction of the hospice and its services. Managers demonstrated good leadership and a strong commitment to providing people with safe, high quality care. Managers and staff spoke about their vision for St Raphael's including the importance of its core values that included individualised care, respect, accountability, integrity, teamwork, leadership and excellence. Managers also talked about supporting staff to ensure their vision and values ran through the care and support they provided.

The service had reviewed their values, vision and mission statement in consultation with the staff team. The service's values reflected the aim of the hospice to deliver safe, dignified and compassionate care and to put people, at the centre of everything they did. Staff were clear about the service's values. Several members of staff showed us an easy to carry portable card they had each been given which set out the hospices core values. It was evident from comments we received from staff throughout our inspection that they shared and worked in accordance with these values. One member of staff told us, "I feel so proud and privileged to work for such a wonderful organisation", while another said, "We've always put people and their families at the heart of everything we do at St Raphael's".

The CEO and chair of the Advisory Committee told us that there was a strong commitment at St Raphael's to continually develop, improve, and be open to new ideas and innovations. For example, the hospices relatively new overnight accommodation for families was built in direct response to feedback they had received from people and staff about the lack of space they had at St Raphael's for people with large families to stay close to their loved one receiving end of life care.

Managers promoted an open and inclusive culture which welcomed and took into account the views and suggestions of people using the service. People and their families told us they were actively encouraged and supported to share their views about the hospice. One person said, "Staff are so good at making me feel like I have been heard and that's really important to me", while another person's relative told us, "We feel we can ask staff anything and they're straight on it when we ask for things to be done". We saw the hospice used a range of methods to gather people's views and experiences. This included a forum for carers that was regularly held in the day centre, twice weekly consultant ward rounds where patients and their families were given the opportunity to discuss any health and social care issues they might have, and stakeholder satisfaction questionnaires. It was clear from the findings of the most recent questionnaires we looked at that people were satisfied with the hospices in and out-patient services.

The provider acted on feedback they received to improve the quality of the service and support provided to people and their relatives. Several members of staff told us the family rooms had been built in response to feedback received from people about the lack of overnight accommodation for their families and friends at St Raphael's. This meant that family members who wished to remain near their loved one could be easily accommodated overnight by the hospice in more comfortable surroundings. Managers also gave us a good example of how the service had arranged for an Occupational Therapist to give a talk to families and carers about their work after they had received feedback from families and carers that indicated this group of stakeholders wanted to know more about the roles of these community health and social care professionals. This helped ensure families and carers had a better understanding of the end of life care roles and responsibilities of community professionals.

Managers valued and listened to staff and volunteers. Staff were complimentary about the hospices executive team and managers and said they were approachable, open and honest. One member of staff told us, "If I had any concerns about St Raphael's, which I don't, I know I could speak to any of the managers about it." Staff also described St Raphael's as being a "wonderful" place to work. A number of initiatives had been introduced to support staff including a staff forum, reflective practice group and debriefing sessions were held with staff after they had been involved in complex cases or incidents to give them the opportunity to talk about any concerns they had or where they felt they would have done things differently. Several volunteers told us they often trained alongside paid members of staff which they said made them feel they were a valued member of the hospice team. One volunteer said, "I feel included. It's like being part of one big happy family working here."

The provider had established good governance systems to assess monitor and improve the quality and safety of the service people received from the hospice. This included a quality improvement committee that met every two months, which was attended by various senior managers and heads of departments. In addition to this there were bi-weekly senior management and monthly head of department and department meetings which steered the hospice's approach to staff training and education, health and safety, infection control and a drugs and therapeutic committee that met three times a year. These groups had standing items on their agendas and regularly reviewed clinical incidents, complaints, policies and procedures, patient information, patient/user feedback and financial monitoring.

There was also a rolling programme of audits being undertaken that covered high risk areas. Audits that had been carried out in the past two years had included pressure ulcer prevention and management, patient record keeping, the effectiveness of the out of hours telephone advice service and pain management and dignity in the dying stage. Findings from these audits were presented to the various committees described above. Where an issue had been found, an action plan was put in place which stated what the service needed to do to improve. Managers told us areas for improvement identified in these audits due to a lack of staff knowledge or awareness were incorporated into the staff training programme. For example, action was taken to reassess staff's competencies to handle medicines safely after a medicines audit undertaken by the hospice had identified a number of medicines recording and administration errors.

Accident and incident forms were regularly reviewed and analysed in order to determine if there were any identifiable trends. For example, if there was an increase in the number of falls in a month. The risk management team looked at the details of the incident and if there was any learning required to reduce the risk of the incident reoccurring. Staff told us any accidents or incidents that happened were discussed during staff meetings to ensure everyone was aware what had happened, together with any lessons to be learnt and changes required.

The hospice had strong links with the local community. Approximately 550-600 volunteers supported the

hospice in various ways. This included working in St Christopher's numerous charity shops or directly supporting inpatients who stayed at the hospice or through their various community supporter groups. For example volunteers worked in shops, in the garden, on reception, in the day centre, on the ward and transporting people to the hospice. Some were also involved in events to raise funds for the hospice.

The hospice worked in close partnership with external community professionals. Feedback we received from external community health and social care professionals was positive about the working relationship they had with St Raphael's. This included, "We have a very successful relationship with St Raphael's. I have always found them very responsive to any requests we make for advice or support", "If we need a visit or any advice from the hospice there is never a problem" and "The staff from the hospice helped us appropriately manage the pain being experienced by a person who lived at our care home. They gave this lady a pain free and peaceful death".

Members of the hospice at home team told us they had good working relationships with other external community professionals also involved in their patient's care, which often included a person's GP, district nurses, Marie Curie night nurses and social services care managers. This ensured people received consistent and co-ordinated care and support at home. A member of the community palliative care team gave us a good example of how they had visited people with a learning disability living in a care home to help the provider and the people using the service have a better understanding of end of life care. This meant people with learning disabilities living in residential care could make more informed decisions and choices about how they wanted their end of life care needs and wishes to be met.

The hospice kept up to date with good practice guidelines and attended various groups to develop and share best practice which included being active members of the Social Care Institute for Excellence (SCIE); Quality and Service Improvement Network Group (QSING), whose members included Princess Alice and Trinity hospices'; The London Cancer Alliance: Hospice UK: the South West London Hospice Collaborative group that provided end of life care education across the region, and the medicines management committee for Sutton and Merton. The hospice also had close links with academic institutions including Cecily Saunders Institute Kingston and St Georges University hospitals, London Caldicott Guardian Group, the end of life care network group in the area, and was the palliative care resource to Vanguard nursing homes project in Sutton.

The hospice was responsive to national strategies and had also good links with the National Institute for Health and Care Excellence (NICE), General Medical Council (GMC), Nursing Midwifery Council (NMC) and Medical Student Education Programme. Managers told us these links had helped the hospice develop specific study days for the specialism in the education department. The service also had weekly medical journal club and bi monthly multidisciplinary journal club which we attended during our inspection and saw proactively supported shared learning with external community health and social care professionals and organisations, such as local GPs, NHS Trusts, Clinical Commissioning Groups (CCG) and local authorities.