

Bolton Hospice

Bolton Hospice

Inspection report

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

Ratings

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

Summary of findings

Overall summary

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

- Mandatory training was provided and mainly completed on time. The service had enough staff to care for patients and keep them safe. Staff understood how to protect patients from abuse. The service managed infection risks well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines and safety incidents well.
- Staff gave patients enough to eat and drink and gave them pain relief when they needed it. Managers monitored the effectiveness of the service. Staff worked well with other services for the benefit of patients, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families, and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could mainly access the service when they needed it.
- Leaders had good experience and understood the service's vision and values. Staff were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However,

- Some consumables were found to be past their expiry date. Substances which were hazardous to health were found not to be locked away appropriately. Staff did not complete regular safety checks of equipment; electrical safety testing was out of date on some items and 2 fire extinguishers were overdue planned servicing.
- Policies and procedures were not always up to date.
- Clinical supervision was inconsistent. Ad hoc training was not always recorded. Staff appraisals were not completed in line with the policy.
- Some staff spoke of difficulties with the service's culture.

Summary of findings

Our judgements about each of the main services

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

Summary of findings

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Summary of this inspection

Background to Bolton Hospice

Bolton Hospice is a charitable organisation providing hospice services for adults for people living in Bolton and the surrounding areas. The inpatient service has 18 beds (16 of which are commissioned), a wellbeing hub, which provides support to service users including symptom management, outpatient clinics and wellbeing sessions and a hospice at home service for people who are being cared for at home. The service also provides support for families, friends and carers of people using its services.

The service is registered for the treatment of disease, disorder or injury and has a registered manager (also the chief operating executive) in place to oversee this.

The service was rated good in January 2017 following a comprehensive inspection in September 2016.

How we carried out this inspection

We carried out an unannounced, comprehensive inspection of the service on the 12 and 13 December 2023. We completed 1 off site interview with the vice chairperson on the 21 December 2023.

During the inspection the team:

- Inspected the premises, including the cold room, the inpatient ward, the day therapy area and the multi faith room.
- Spoke with 18 staff and 3 volunteers.
- Spoke with 4 patients and 3 loved ones about their experience of care.
- Reviewed recruitment files for 7 members of staff and 3 volunteers.
- Reviewed Fit and Proper Person files for 4 members of staff including the chief executive officer and the chairperson.
- Looked at 8 patient records.
- Reviewed a wide range of policies and procedures.

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>.

Areas for improvement

Action a service **SHOULD** take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service **SHOULD** take to improve:

- The provider should ensure they clearly record any ad hoc training delivered to support the needs of complex patients who attend the hospice. Regulation 17(1).
- The provider should ensure they operate effective systems and processes to ensure the rotation of single use consumables within the service and to monitor the maintenance of equipment including electrical items and fire extinguishers. Regulation 17(1).

Summary of this inspection

- The provider should continue to act to proactively address staff concerns regarding organisational culture and look to promote the Freedom to Speak Up process further, ensuring that staff feedback is consistently acknowledged and acted upon. Regulation 17(1).
- The provider should take action to ensure confidential patient records are consistently stored in a secure environment. Regulation 17(2)(d).
- The provider should ensure all staff and volunteers employed receive appropriate supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18(2)(a).

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	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Hospice services for adults

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

Is the service safe?

Good 

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

Mandatory training

The service provided mandatory training in key skills to all staff. Staff mainly kept up to date with mandatory training.

Nursing and clinical staff mainly kept up to date with their mandatory training learning.

Clinical staff completed training on recognising and responding to patients with learning disabilities, autism, and dementia. Managers recruited, trained, and supported volunteers to help patients in the service. Volunteers were provided with an induction which covered key topics such as health and safety, safeguarding, and fire safety. Volunteers were encouraged to contact the volunteer co-ordinator or trained staff if they had any concerns they wished to raise.

Safeguarding

Staff understood how to protect patients from abuse. Staff completed their safeguarding training in a timely manner.

The service had a safeguarding adults and a safeguarding children's policy. The policies provided guidance for staff on how to identify and report any safeguarding concerns. The safeguarding children policy provided information on Female Genital Mutilation (FGM). Flow charts outlining the procedure to escalate concerns were clear and relevant contacts were detailed.

The service had dedicated leads, trained to level 3, for safeguarding children and safeguarding adults.

Trustees received safeguarding training for adults and children.

Nursing and medical staff received training specific for their role on how to recognise and report abuse. Staff completed their training on time.

Hospice services for adults

Volunteers were provided with a handbook when they started which provided information regarding safeguarding and could refer to safeguarding displays within the hospice. However, some volunteers who had supported the service for over a decade had not received any refresher training for safeguarding children or adults.

Staff completed the PREVENT online core training course on time (raises awareness of signs of extremism and radicalisation within patients).

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

Staff knew how to identify adults and children at risk of or suffering significant harm and knew how they would work with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There were processes on how to escalate concerns which included contact details for raising alerts with external authorities.

Staff followed safe procedures for children visiting the ward. The service completed Disclosure and Barring Service (DBS) checks for staff and volunteers. We reviewed 7 staff files, 2 volunteer files and 4 senior manager files and they all had a DBS in place.

The service completed a 'badge audit' in September 2023. All staff, including physiotherapists, porters, managers, and volunteers on the inpatient unit and on the wellbeing hub wore a photographic badge when audited.

Safeguarding procedures were clearly displayed throughout the hospice.

Cleanliness, infection control and hygiene

Staff used infection control measures when visiting patients on wards and transporting patients after death.

The service was visibly clean and had suitable furnishings. Patients' relatives and loved ones completed a questionnaire between April 2023 and September 2023 in which all 29 respondents stated they were 'very satisfied' with the cleanliness of the ward.

The service generally performed well for cleanliness. Patient led assessments of the care environment (PLACE) are an appraisal of the non-clinical aspects of NHS, independent and private healthcare settings which are completed by teams made up of staff and members of the public. They are completed annually. For 2023, the service scored 100% for cleanliness and for condition, appearance, and maintenance.

Staff carried out an infection control audit at least every 12 months. We reviewed an audit completed on the 13 July 2023 which was completed on the inpatient ward. The audit was detailed and covered hygiene facilities, training, and hand hygiene. The service was found to be 88.5% compliant. An action plan was developed to address issues identified for improvement.

The service completed an infection control audit for hand hygiene in July 2023 and scored 89%. An action plan relating to audit findings was devised in September 2023. Actions required, responsible staff and actions taken were documented. We saw that 83% of staff had completed the hand hygiene mandatory training.

Hospice services for adults

Cleaning records were up-to-date and demonstrated all areas were cleaned regularly. The housekeeping team were visible and active throughout the inspection.

Staff followed infection control principles including the use of personal protective equipment (PPE). The World Health Organisations' "5 stages of handwashing" posters were evident above sinks for staff, patients, and loved ones to follow. PPE was available and used appropriately by staff. Staff adhered to infection control principles, they were bare below the elbow and were seen to be washing their hands following every patient contact.

For every community visit, staff changed all PPE before entering the patient's home and removed it once outside.

The service used infection control measures to prevent the spread of infection before and after the death of a patient. There were suitable arrangements with funeral directors for the transfer of the deceased.

There were no concerns about the identification and management of hospital acquired infections.

The service completed checks for legionella and pseudomonas (bacteria found in water). Their latest check, reported in May 2023, showed 100% compliance for checks of outside taps, patients' rooms, patient area taps and the wellbeing hub.

The service had a procedure for the infection prevention and control of COVID-19 which had been updated in October 2023 with the latest information. This included guidance on testing for patients and staff, as well as visiting patients who were positive with COVID-19.

Environment and equipment

The design, maintenance and use of facilities and premises kept people safe. Staff managed clinical waste appropriately. Staff did not always store substances which were hazardous to health in locked cupboards.

Patients could reach call bells and staff responded quickly when called.

The layout of the service was appropriate for people with accessibility needs. All patient facilities were located on the ground floor apart from the multi faith room which could be accessed via a lift. The service had wide corridors, double doors, and accessible toilets to ensure ease of access. All patient rooms had a patio with a garden view. All the areas we inspected, apart from the decommissioned patient rooms, were well maintained and free from clutter. The service did not have a viewing room for families to view their loved ones when they died. This had been removed and used for storage during the COVID-19 pandemic, but the service had plans to reinstate this area.

Secure access was required for clinical areas which included the cold room. The cold room was in a private area of the service to ensure dignity for the deceased. We reviewed the services risk assessment for the cold room which had last been completed in June 2023. Potential risks and controls were carefully considered and documented.

The service provided evidence of regular temperature checks of the cold room and of the cooling blankets (used to keep deceased patients cool).

Staff carried out daily safety checks of specialist equipment. Regular checks of the resuscitation equipment used in the event of an emergency were undertaken and documentation was consistently completed.

Hospice services for adults

On the inpatient ward we found items including male continence products and colostomy products which were past their expiry date. Whilst these presented a low risk to patients, the provider should take steps to ensure all consumables are disposed of after their expiration date.

Staff did not always store substances which were hazardous to health (COSHH) in locked cupboards. Three COSHH substances were not locked away on the inpatient ward. The service had an up to date COSHH policy and detailed risk assessment forms detailing COSHH items deemed to be hazardous to the health of staff and visitors. Following the inspection, the service provided evidence that 76% of staff had completed COSHH training.

Staff told us equipment needed for care and treatment was readily available and any faulty equipment could be replaced promptly. The hospice had access to specialist equipment, such as bariatric equipment or specialist pressure relieving equipment.

The inpatient ward had 2 fire extinguishers which showed they had been inspected in August 2022 and required a further inspection in August 2023 which meant this was overdue. The service provided assurance that an external company had completed a thorough risk assessment of the fire equipment in October 2023. Whilst this was an oversight by the external company, it remains the providers responsibility.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their lives.

Staff completed risk assessments for each patient on admission to the inpatient ward, using recognised tools which were reviewed regularly, including after any incident. Patient records included risk assessments for pressure ulcers, nutritional needs, and risk of falls. These were reviewed and updated periodically on a weekly basis or sooner if there had been any change to the patient's condition.

All patients on the inpatient ward were monitored using the Australian modified Karnofsky Performance Status assessment tool scale (AKPS), alongside clinical judgement. Any unexpected deterioration was escalated for review to the medical staff.

The Hospice at Home service told us they did not complete the risk assessments as this was completed by the district nurses.

Staff carried out frequent patient observations meaning they could act on any signs their condition had worsened. Staff worked closely with patients to identify care plans so that treatment was individualised. Staff were aware of how to identify and escalate patients with signs of sepsis. Staff explained patients would be transferred to the local NHS trust. The service did not have a sepsis policy but had access to the local trusts guidance on sepsis and a tool which was used to review the 6 signs of sepsis.

Staff arranged psychosocial assessments and risk assessments for patients including if they were thought to be at risk of self-harm or suicide. The service had access to a clinical psychologist through the local NHS trust for 1 day a week, who provided support for hospice patients and their families. Staff could also access the local mental health trust for further support. However, staff did not have specific training on supporting people with mental health difficulties such as depression or anxiety and did not have a mental health link nurse.

Hospice services for adults

Shift changes and handovers included all necessary key information to keep patients safe. We attended a nurse handover and found that patients medications, backgrounds, social circumstances, physical and psychological well-being were all discussed in detail. We also reviewed the doctor's handover from the 14 December 2023. Once again, the handover notes were detailed and provided all the key information. The progress section of the document went into detail regarding the patient's presentation, what medications were required and any input with family members.

Staff shared key information to keep patients safe when handing over their care to others.

Nurse staffing

The service had enough nursing and support staff. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had 4 vacancies for registered nurses, which meant staffing the inpatient ward had been a challenge. The senior leadership team had a workforce plan to recruit further nurses and had recently employed 2 registered nurses on a secondment from a local NHS Trust for 6 months.

Managers adjusted bed numbers according to staffing shortages and the acuity of the patients. Despite having capacity for 16 commissioned beds the service had reduced to 10.

Managers worked to accurately calculate and review the number and grade of nurses, nursing assistants and nursing associates needed for each shift in accordance with national guidance. Nurse staffing levels were based on the 'safer staffing' acuity tool.

Staff from the different services supported each other if required. For example, the community service and education team would support the inpatient ward and the wellbeing hub staff would support the hospice at home service.

Managers ensured a senior nurse was always available on the night shift.

The inpatient ward, hospice at home and wellbeing hub had their own line managers. The inpatient ward and the hospice at home service also had a consultant attached to each.

The hospice at home service had enough staff. They employed 1 senior nurse, 3 registered nurses and 1 clinical support nurse.

The service employed a clinical nurse practitioner who supported all areas of the service.

Agency staff were used in the clinical support nurse roles by the service.

The service had 2 social workers from the local authority based on site to support with providing information to patients with their discharge from the hospice including packages of care.

The inpatient unit and the Hospice at Home service had the highest amounts of sickness, in comparison to other sectors of the service including housekeeping and the education team. The inpatient unit lost a total of 569 days between June and December 2023 and the Hospice at Home service lost 204 days in the same time period. Stress and anxiety (personal and work) were noted as key reasons for sickness for the hospice at home service and inpatient unit. The service emphasised that staff had access to occupational health support, wellbeing resources and free confidential counselling at a local service.

Hospice services for adults

The service had 10 staff (a combination of nurses, clinical support nurses and bank staff) leave their roles between June 2023 and December 2023. The main reasons were documented as 'new opportunities and bank nurses not always getting regular shifts.

The quality and governance committee agenda meeting minutes stated there had been 19 leavers between 1 September 2022 and 31 August 2023. From those figures, 5 were planned retirements. The remaining 14 equated to 16.28% of the services workforce which was below the average turnover for health care services which is 37.3% (statistics from the professional body for HR and people and development).

Medical staffing

The service had enough medical 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 locum staff a full induction.

The medical team was led by the medical director, who worked clinically within the hospice.

The service had enough medical staff to keep patients safe. The service employed 2 consultants, 1 advanced nurse practitioner and 2 speciality doctors.

We reviewed the medical rota from the 20 November 2023 to the 10 December 2023. This showed there was an adequate number of doctors on all shifts. The service had a good skill mix of medical staff on each shift and reviewed this regularly.

The service had 1 full time trainee doctor in post and 4 trainee doctors on integrated training posts. The service had trained 10 doctors in the last year, had taken 12 1-week work experience placements for sixth formers who wanted to apply for medical school and 5 medical students had been on a placement as part of their university course.

The service had 3 GPs for their on-call rota. The service always had a consultant on call during evenings and weekends.

Managers made sure locums had a full induction to the service before they started work. This consisted of a virtual corporate induction and working alongside fully qualified doctors and nurses prior to being asked to work on call.

The service had low turnover rates for medical staff. There were no medical staff vacancies at the time of the inspection.

The service had low sickness rates for medical staff.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, and easily available for all staff providing care. Patient records were not always stored appropriately.

Patient notes were detailed, and all staff could access them easily.

The staff based on the inpatient ward mainly used electronic records.

Hospice services for adults

We reviewed records for 8 patients from the inpatient ward, hospice at home service and the wellbeing hub. Patient records were legible, structured, complete, and up to date. Nursing and clinical assessments were carried out on patient admission. Risk assessments were updated and any decisions from multidisciplinary team meetings were recorded in the patients notes.

When patients were transferred to a new team, there were no delays in staff accessing their records.

Records were not always stored securely. On the 2 days which we inspected we found a record cabinet that was unlocked with records for 4 patients. We also found records under the reception desk on the inpatient ward. The provider took action during the inspection to change their approach to how records would be stored securely.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. The service used the local NHS Trusts antimicrobial guideline for adults for the prescribing, supply, administration, and monitoring of antimicrobial agents (therapeutic substances used to prevent or treat infections).

The service had a medicines reconciliation policy. It had clear guidance on how medical staff collate the appropriate details regarding the patient's medicines on admission. It defined clear procedures for the staff when a patient was discharged, including the importance of a detailed discharge letter with reference to any medication changes.

The hospice had an arrangement with a local trust external pharmacy provider for the supply and disposal of medicines. Clinical pharmacy services were provided for a total of 24.5 hours per week. A specialist pharmacist worked 16.5 hours whilst the additional 8 hours was split between a band 4 and a band 2 member of staff. Clinical pharmacy services provided guidance and support for staff and attended routine medicines management committee meetings.

We reviewed a sample of medicines and found they were all in date.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Staff completed medicines records accurately and kept them up to date. Medicines, including medical gases were stored safely and securely, in locked medicine cupboards within storage rooms. Patients' medicines were kept in a locker in their rooms. There was a system to check all medicines were within date and suitable for use.

Staff completed regular checks on medicines required in an emergency. Medicines requiring cold storage were kept in a refrigerator within the recommended temperature ranges and were monitored regularly.

The service audited their management of medications regularly. They audited medicines reconciliation, prescription forms, general medicines, and intravenous fluids.

The pharmacist for the service had completed an annual audit for general medicines in May 2023. The service scored 91% for the audit. The audit findings were listed with recommended actions and staff were allocated responsibility for tasks.

We reviewed prescription charts and found they were accurate, complete, legible, stored securely. Patients' allergy status was clearly recorded on the prescription charts.

Hospice services for adults

Staff clearly recorded and monitored medicine related incidents with lessons learned and actions plans in place to ensure potential errors in the future were minimised.

Staff completing medicines rounds wore tabards, to make others aware they were concentrating on the administration of medicines to prevent any disturbance.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services.

Patients told us they were given clear and accurate information on medicines they were given and their expected effect.

Incidents

The service managed patient safety incidents well. Staff knew what incidents to report and how to report them. When things went wrong, staff apologised and gave patients honest information and suitable support.

Senior leaders told us the hospice strongly encouraged a culture of reporting incidents and near misses, with an emphasis on learning.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with the services policy. The chief executive officer (CEO) and medical director reviewed incidents regularly.

Staff we spoke to were aware of their responsibilities regarding the duty of candour legislation. The duty of candour requires registered providers and registered managers to act in an open and transparent way with people receiving care or treatment from them.

The service had a duty of candour policy which clearly outlined the process for staff to follow when patients suffered moderate or serious harm. The service provided examples of the last 3 incidents from 2023, none of which required the duty of candour to be carried out due to them being low harm incidents.

Between the 1 July and the 30 September 2023, the service reported 95 incidents on their electronic, internal reporting system. The main categories for clinical incidents related to controlled drugs. From 16 incidents relating to controlled drugs, 3 were reportable to the local intelligence network. Information about the misuse of controlled drugs is shared with the local intelligence network.

Learning opportunities from the reviews of accidents, incidents and near misses were identified and shared with staff. For example, from the review between the 1 July and 30 September 2023 the learning opportunities included the importance of choosing the correct categories for data input to ensure accurate recording and the importance of accurate and safe prescribing with contemporaneous record keeping.

Is the service effective?

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

Hospice services for adults

Evidence-based care and treatment

Care and treatment was based on national guidance and evidence-based practice. Staff protected the rights of patients subject to the Mental Health Act 1983.

Policies and procedures were accessible for staff electronically. Policies which were up to date and accessible appropriately referenced current good practice and national guidelines from organisations such as the National Institute for Health and Care Excellence (NICE) and Royal Colleges.

The department of health's 5 priorities for care (recognition of dying, sensitive and effective communication, involvement in decisions, emotional needs being met and individualised care plans) had been achieved when we reviewed patients care records.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. The service offered mental health support for patients and their loved ones including psychological input from the psychologist, bereavement support and a 24-hour helpline. Patients and loved ones were also signposted to relevant NHS mental health services if this was required.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives, and carers.

Nutrition and hydration

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

Staff made sure patients had enough to eat and drink, particularly those with specialist nutrition and hydration needs. Patients and those close to them told us there was a wide choice of foods available and catering staff went out of their way to provide foods of choice and preference. Patients' water jugs were regularly refilled throughout the day as needed.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it.

The service took into consideration patients' individual, religious and cultural needs and offered patients alternatives for food and drinks if required.

The service scored 98% for quality and choice on the PLACE audit which took place in 2023.

Patients' loved ones were asked to complete a questionnaire following them dying. Respondents rated how satisfied they were with the provision of snacks and meals. From April to September 2023, 81% of respondents stated they were 'very satisfied', 12% were 'satisfied' and 7% were 'neutral'.

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.

Hospice services for adults

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff used the 'Abbey pain scale' which is a tool to assist in the assessment of pain for patients who are unable to articulate their needs, for example if they had communication difficulties. We reviewed patients' medicine charts which documented the Abbey pain scale.

Patients and their families told us pain relief was administered in a timely manner when it was needed.

Staff prescribed, administered, and recorded pain relief accurately. The medical director had completed an audit in July 2022 for pain management. They reviewed 20 sets of patient's records. The service scored 97%. The next audit for pain management was scheduled for July 2023 but the audit was completed in November 2023 and had yet to be presented to the senior leadership team.

Patient outcomes

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

The service participated in relevant clinical audits. The service was participating in the national multi – centre research study 'CHELsea II trial in hydration at the end of life' in collaboration with a university. The service had also participated in the Northwest audit group for seizure management with the results pending.

Internal audits for the services environment, syringe pumps, constipation and bowel management and a general medicines audit had been completed.

The service completed an audit for the care of deceased patients which reviewed the temporary body store area, the hygiene facilities and equipment and procedures. The service scored 100% on the audit from December 2023.

The service provided data on falls and pressure ulcers between January and September 2023. The service had no moderate harm, severe harm, or deaths from falls during that period. The amount of pressure ulcers was similar throughout the months up to September 2023.

The hospice at home service undertook 603 visits between April and September 2023. For all the patients who died under the care of the hospice at home service, there was only 1 patient who did not achieve their preferred place of death.

Competent staff

The service did not always document staffs additional training competency. Managers did not always appraise staff's work performance in a timely manner. Supervision meetings to provide support and development did not occur frequently.

Staff were qualified and had skills and knowledge related to end-of-life care and palliative care. The service ensured nurses between band 2 and band 5 had competencies which were assessed and reviewed by an appropriate supervisor. The service did not have a competency assessment for band 5 staff, but this was being developed.

Hospice services for adults

The hospices education team was located onsite. The education team provided various training courses to staff and professionals across the local area. Courses for professionals across the local area included 'end of life care' training and communication skills training. The education team also provided palliative care training (palliative care education passport) for in house staff and other professionals including allied health practitioners, assistant practitioners, and care home staff.

Staff were required to revalidate in accordance with their registration body.

When patients with complex needs were transferred to the hospice, staff told us they followed policy to provide safe care and received training, if necessary, from the referrer. The service called this 'on the job' training. Compliance with this training was not always documented clearly.

The service provided data suggesting staff had received tracheostomy training by the previous clinical skills educator, but this had not been documented. Despite there being a clinical protocol in place for nasogastric tubes, we did not see any evidence of training.

A senior member of staff told us staff were trained in sepsis awareness. We received the training compliance for staff on the inpatient ward and did not see any evidence of staff being trained in 2 modules which were 'sepsis' and 'sepsis awareness.'

Managers gave all new staff a full induction tailored to their role before they started work. Following the induction new members of the team completed a probationary period and were reviewed at 2 weeks, 3 months, and 6 months.

Managers ensured the relevant checks were in place for consultants, occupational health physicians, pharmacists, physiotherapists, and the psychologist who were working under practicing privileges.

The spiritual care and bereavement support lead provided teaching sessions for internal medical staff and other staff members regarding good spiritual care.

Nursing staff told us they used to benefit from sessions held with the doctors on topics such as pain relief, but they had stopped.

Managers did not always support staff to develop through yearly, constructive appraisals of their work. The service provided us with an audit for appraisals completed from August 2023. Clinical staff had an overall appraisal completion rate of 76% which did not include staff on long term leave such as sickness, absence, or maternity leave. However, 99% of non-clinical staff had completed their appraisals. The leaders of the service acknowledged the clinical appraisal rate was below their target and highlighted turnover had been a contributing factor to appraisals not being completed in a timely manner.

Staff told us they did not receive supervision from senior staff due to high absence rates and not having enough staff to do so. We did not see evidence of formal, regular, and recorded supervision taking place. Following the inspection, the service provided evidence of some de – brief sessions which had been completed by the inpatient service in November 2023 and outlined that clinical supervision was responsive to the level of need at that time. The service also provided evidence of resilience based clinical supervision training being scheduled for senior members of staff who would then cascade the training to other members of staff.

Hospice services for adults

Multidisciplinary working

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

The staff members from the different services mainly worked well together. Team members were aware who had overall responsibility for everyone's care. Staff supported different services when they were short on staff. We saw good working relationships between some of the nurses and support staff on the inpatient ward and the wellbeing hub. The hospice at home staff worked in pairs. However, some nurses from the inpatient ward felt the decisions were made by the doctors and senior leadership team and did not always feel able to express their opinion.

Staff held regular and effective internal meetings to discuss patients and improve their care. Meetings were daily (Monday to Friday) and were attended by the Hospice lead nurse, the medical team, the liaison nurse, the occupational therapists, physiotherapists, and social workers. The meeting allowed the professionals the opportunity to discuss the referrals for the day, the advice line calls that had been received and to plan the day of care.

The service worked closely with social care to ensure the continuity of care for people and their families.

The locality multidisciplinary meetings were held once a week via a teleconference call. There was representation from the hospice, hospital, and community palliative care teams. Patients who had been referred to the service from the previous week were discussed. Patients physical, psychological, and spiritual needs, as well as care plans and any further concerns were discussed during the meetings. The services had arrangements in place to discuss patients urgently if required.

Seven-day services

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

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

There was 24-hour emergency support helpline available 7 days a week for patients and their relatives if they required any support and guidance.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on the ward. Staff provided support for individual needs to live a healthier lifestyle.

Patients' health was assessed by staff when they were admitted to the ward or support was offered by the Hospice at Home service. Staff told us they discussed health promotion and lifestyle choices with patients. Staff signposted appropriate patients to services which could support them to lead healthier lives.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment.

Hospice services for adults

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff clearly recorded consent in the patients' records.

Staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). The completion rate for staff was 83%.

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

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. Staff had completed 5 DoLS applications between July and September 2023.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

The service completed a DNACPR audit annually. We reviewed an audit completed on 10 consecutive patients who had been inpatients on the inpatient ward in November 2023. We found that 100% of the mandatory questions had been completed. Patients notes also contained the relevant details and staff scored 100% on this area as well.

Is the service caring?

Good 

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We witnessed staff interacting with patients in a discreet, responsive, and caring way. The CEO evidently had good relationships with patients, which we witnessed as they provided a tour of the building.

The service had a policy for the care of the deceased patient. It clearly outlined a procedure for staff to follow when a patient had died which promoted dignity and respect.

Staff always introduced themselves and explained the focus of their care. It was clear patients knew the staff well and the service had leaflets with information on each of the nursing staff that patients and family members could read.

Patients said staff treated them well and with kindness. They told us staff "could not do enough" for them and provided examples including staff baking cakes for them and them and their loved ones receiving gifts at Christmas and chocolate eggs at Easter.

Hospice services for adults

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude. For example, a patient communicated a preference for receiving hygiene support exclusively from female staff to uphold their sense of dignity, and staff duly respected and accommodated this request.

Staff understood and respected the personal, cultural, social, and religious needs of patients and how they may relate to care needs. The spiritual care and bereavement lead had planned and presided over 3 funerals for patients who had died whilst under the care of the hospice.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed staff in the wellbeing hub sitting with patients and family members and giving them the opportunity to talk. Staff were kind, caring and recognised the emotional needs of the patients.

The staff understood the emotional and social impact a person's care, treatment, or condition had on their wellbeing and on those close to them. The service provided support from occupational therapists, social workers, a psychologist and bereavement support workers to patients and their loved ones.

The bereavement support service provided support to anyone who required their input from the inpatient ward, wellbeing hub or hospice at home service. The bereavement support officers were mainly a team of volunteers who offered 1:1 sessions and group sessions with family members and loved ones. The service offered pre-bereavement support which helped patients loved ones prior to them dying.

The service provided a 24-hour support and advice line which was available for patients, carers and healthcare professionals on palliative care and end of life care issues. The advice line was manned by a senior member of the clinical team.

We reviewed cards from patients' relatives that had been sent following them dying. The cards all reflected how caring, compassionate, and empathic staff had been.

The service held remembrance events for patients that had passed, which family members could attend. The service held an event called a 'time for remembrance' in 2023 which 50 people attended and had over 500 views online.

The service had a quiet area based in the family room. The service provided a book which had the names and dates of patients who had died. A 'tree of life' was also in the room which allowed patients relatives to write messages about their loved ones who had died.

Understanding and involvement of patients and those close to them

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

Staff talked with patients, families, and carers in a way they could understand. We spoke with 4 patients and 4 family members who all told us staff involved them in their care and treatment and did so in a non-condensing and compassionate manner. One patient said, 'I always feel included in every decision that is made and the care is continuously excellent'.

Hospice services for adults

Staff explained how they used communication aids and translation services when necessary to ensure patients were involved in decisions about their care.

Staff supported patients to make decisions about their care. Staff explained to us how patients would be offered rapid discharges if they were required. The patient liaison nurse would support the transfer of the patient to their home or other chosen place of death.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Patients' families and loved ones gave positive feedback about the service. The Hospice provided us with their 'end of life survey of relatives satisfaction questionnaire' data from the inpatient unit and the hospice at home service between April and September 2023. From 44 questionnaires being sent out for the hospice at home service, 5 were completed and on average 80% were happy with the care. The inpatient unit had a higher completion rate, 44% of questionnaires sent to families following a loved one dying had been completed. Almost every question was answered positively.

Is the service responsive?

Good 

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

Service planning and delivery to meet the needs of the 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.

Managers planned and organised services, so they met the needs of the local population. Daily safety huddles were held in which admissions, discharges and deaths could be monitored and reviewed.

The hospice had a referral and admissions policy. The policy outlined how the service provided symptom control and end of life care for patients aged 18 and above with progressive life limiting illnesses.

The service, on occasions, accepted patients who did not live locally and were under 18. The service worked collectively with other local hospices to ensure care for all patients within the area. The admissions coordinator for the hospice reviewed patient referrals and admissions daily.

The hospice had an inpatient unit, a hospice at home service and a wellbeing hub (day therapy services) for patients to access.

The hospice at home service offered a 7-day service which ran until 4.30pm. Hospice at home nurses had caseloads and worked closely with district nurses, adult social care providers and GPs to provide care and treatment for community-based patients referred to the hospice.

The premises were appropriate for the services being delivered. There was local access to the service by car or public transport with areas dedicated to car parking. The layout of the inpatient and the wellbeing hub promoted accessibility in all areas. Patients' rooms faced out on to the gardens which surrounded the hospice, and the wellbeing hub had enough room for patients in wheelchairs to attend.

Hospice services for adults

The service had open communal areas and quiet areas for patients and their families. They had a well-maintained garden which inpatients could see from their rooms. Patients and loved ones had access to a multi faith room which was located on the premises. There was a spiritual care and bereavement support lead for the hospice for the hospice who was able to contact local religious leaders for them to attend the hospice.

The service had systems to help care for patients in need of additional support or specialist intervention. Patients could be referred for specialist care such as speech and language therapy, tissue viability nurses, dietitians, and psychiatric support for patients with mental ill health.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia.

The wellbeing hub provided access to talking therapies classes for managing anxiety, breathlessness, counselling, and bereavement support.

Aromatherapy, head massage, crystal therapy, reiki and reflexology were available for inpatients, outpatients and Hospice at Home patients and their relatives. A hair and image volunteer came into the Hospice 1 day a week and cut and styled inpatients and outpatients' hair if requested.

The service worked together with third parties to support a number of clinics and groups which were held at the Wellbeing Hub. Clinic rooms were provided free of charge. These included an anaesthetics and pain clinic, a heart failure clinic, a Motor neurone disease (MND), lymphedema and phlebotomy clinics, the heart failure clinic and psychology clinics led by a clinical psychologist. A local pulmonary fibrosis group used the service for weekly pulmonary rehabilitation sessions, a singing group for lung health and various meetings.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs.

Wards were designed to meet the needs of patients living with dementia. The PLACE audit from 2023 scored the service 97% for the environment being appropriate for patients with dementia and 99% for being suitable for patients with a disability.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Patients had 'white boards' in each room with information which was relevant to them which patients told us created 'talking points. Communication pads were available for patients who had communication difficulties.

Staff told us how they made reasonable adjustments for people with autism. They took a holistic approach to understanding the individuals needs and catered to those needs. For example, a staff member explained how they had changed an autistic patient's assessment times to coincide with their schedule.

Staff reviewed the changing needs of patients through regular comfort rounds and medical reviews.

Hospice services for adults

Patients with additional complex needs were located in beds closer to the nurse's station which ensured oversight of their needs.

The service had a room designed for bariatric patients, which was located on the inpatient ward.

Patient's pets were allowed onto the inpatient unit. The service had unrestricted visiting hours to enable patients' families and loved one to visit them at any time. Patients were able to have visitors stay overnight.

Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Staff had access to communication aids to help patients become partners in their care and treatment.

Staff told us how they had arranged events at the service including a christening, a wedding and a 50th wedding anniversary.

Access and flow

Patients could access the specialist palliative care service when they needed it. Waiting times from referral to achievement of preferred place of care and death were in line with good practice. The service had arrangements in place which ensured urgent admissions and rapid discharges when needed.

Patients were referred to the hospice by relevant professionals. The patient liaison role was pivotal in reviewing patients accessing the service.

Staff completed formal assessments to select patients for admission to the inpatient ward, which ensured those who required end of life care were prioritised.

Managers monitored waiting times for the services offered. The waiting list for the hospice at home service, bereavement support service and outpatients were 0. The waiting list for the inpatient ward was 8 patients which was the longest the CEO had known it to be. The wait for accessing the service was due to an increase in patient referrals which had increased on the following quarter, the bed capacity being reduced to ensure safe staffing levels and barriers to discharging patients due to problems with social care provision. The senior leadership team were aware of this risk and had employed 2 nurses from the local NHS trust on a secondment to increase staffing levels.

Patients' average length of stay at the Hospice between April and September 2023 was 14 days which was an improvement on the previous quarter which was 18 days. The service had reduced bed capacity to 12 in June 2023 and 10 in September 2023 to manage the staffing challenges and clinical complexity of the patients.

The wellbeing hub (day services and outpatients) received 210 referrals in the period of April to December 2023.

The Hospice at Home services referrals had increased to 78 between April and September 2023.

The spiritual care and bereavement support lead received 22 bereavement support referrals and 25 spiritual care referrals between April and September 2023.

Hospice services for adults

Staff, including managers planned patients discharges when it became apparent that it was possible or desired. The main reasons were if a person's problems had resolved or stabilised if the patient no longer required specialist palliative care or if their needs could be met by primary care.

The service provided an urgent discharge for patients which was mainly used when the patient wished to die at home and their prognosis was short. The urgent discharge was completed following a discussion with the doctor, clear identification of ongoing care and a full assessment of the patient's needs.

Staff supported patients when they were referred or transferred between services.

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. The service included patients in the investigation of their complaint.

Patients, relatives, and carers knew how to complain or raise concerns.

The service received 4 formal complaints (3 clinical) and 3 informal complaints between the 12 June and 30 November 2023. We reviewed the complaints which had different themes including concerns regarding staff attitude, medicines not being provided in a timely manner and inadequate staffing. Complaints mainly related to the inpatient service with 1 in that time frame relating to the hospice at home service. The number of complaints remained the same as the previous 12 months.

The service clearly displayed information about how to raise a concern in patient areas. The complaints procedure clearly outlined how to raise a complaint about the standards of care and what actions to take to escalate the complaint further if it had not been resolved. There was also a suggestion box located at the main reception of the Hospice for patients and their loved ones to utilise.

Staff from all the services offered understood the policy on complaints and knew how to handle them. Managers investigated complaints and ensured they were responded to in line with the internal policy.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Is the service well-led?

Good 

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

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They supported staff to develop in leadership roles. The clinical leads were visible, although some staff did not always feel senior leaders were approachable in the service.

Hospice services for adults

The CEO of the hospice was experienced in their role and had been employed by the service since 2012. The CEO chaired the Greater Manchester hospices provider collaborative.

The hospice had a board of trustees, which consisted of 10 trustees including the chair. The CEO reported to the board of trustees and was supported by the senior management team.

The senior leadership team included the CEO, the medical director/consultant, the clinical nurse director, the director of income, generation and communications and the finance and corporate services director.

The medical director was responsible for the management of the medical team across the hospice.

The medical director and the advanced nurse practitioner were responsible for the management of the nursing team across the hospice as the nurse director was not in work during the time of the inspection.

Leadership and management training had been delivered at level 4 for managers and at level 2 for registered nurses and supervisors.

Leaders understood and had plans to manage some of the issues the service faced.

Staff did not always feel they could approach their leaders. Some staff told us how they felt anxious in meetings with senior leaders.

Most staff knew there was a Freedom to Speak Up Guardian but were not aware who it was or how to access them.

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 understood and knew how to apply them and monitor progress.

The service had a mission statement which was “Our mission is to provide the very best hospice care for everyone in need, enabling people to live well with a life limiting illness.”

The services values were to be compassionate, respectful, professional, excellent, inclusive, and collaborative.

The services principles included providing equity of access for patients, the promotion of dignity, respect and compassion, the commitment to safe and compassionate care, to provide excellent standards of clinical and nursing care and spiritual care and support for all faiths and none.

The service had strategic priorities for each of their ‘cornerstones’ which were ‘our finances’, ‘our services’, ‘our community’, and ‘our people’ (staff, volunteers, and trustees). Progress against which was reviewed frequently. The service provided a review completed on the 28 November 2023.

The service had a business plan. The aims of the plan were ‘to be well led and well run’, ‘to be cost effective and financially sustainable’, ‘to be the best at what we do’ and ‘to be well known, valued and respected’.

Hospice services for adults

Progress against the services vision and strategy was reviewed by the trustees and senior leadership team. We saw evidence of the strategy being reviewed on the 28 February 2023. The threats to progress achieving the services vision including the workforce shortages and growing demand had been reviewed and mitigations considered.

The clinical service strategy was reviewed by the senior leadership team and the board of trustees. The service provided evidence of meeting minutes from January, March, and July 2023.

Despite the services values being relayed to staff through fortnightly meetings, most staff, apart from the senior leadership team, were unsure of the vision and strategy for the service.

The values were displayed in various areas throughout the hospice.

Culture

Most staff felt respected, supported, and valued. Staff were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work.

Most staff that we spoke to felt respected, supported, and valued by senior leaders and the CEO. A minority of staff did not feel this way and explained how they felt unsupported and sometimes undermined by leaders and managers.

The staff that expressed concerns about the culture told us the issues with staffing had been predicted for some time and were frustrated management had held back on recruiting staff. Following the inspection, the service provided evidence that workforce updates with clear explanations for shortfalls in staff were provided to staff regularly.

Most nursing staff felt that staff worked together well but a minority said they were undermined by the medical staff team and felt they had authority over them.

A member of staff who was supportive of the CEO and the senior leadership team told us there had been some periods of unsettled management which had impacted on the culture of the organisation.

Some staff felt regular team meetings would be helpful to highlight issues, but they were not taking place. Some staff were unaware of incentives such as employee of the month, although the service had plans to introduce the 'hospice value rewards' in 2024.

Staff on the inpatient ward had recommenced 'Schwartz Rounds' from the 16 November 2023 with the senior leadership and were to be scheduled every 3 months. Schwartz rounds provide a structured forum for staff, clinical and on clinical to discuss the emotional and social aspects of working in healthcare.

Despite the cultural issues identified by some staff, this did not impact on workers being focused on the needs of the patients receiving care.

The provider took part in a biennial staff and volunteer survey which was last completed in 2022. The positives from the survey included staff feeling proud to work for the organisation and feeling like they made a difference. In contrast, some of the results indicated clinical staff were feeling overwhelmed by stress at work.

Hospice services for adults

Following the staff and volunteer survey key themes were identified as focus areas for further improvement. These included communication, wellbeing, reward and appreciation, leadership and people management, training development and career progression and caring for the environment. Four task and finish groups were formed, each led by a member of the management team, to develop an action plan for each area which have formed the workforce action plan.

The service provided examples of how equality and diversity was promoted in staff's daily work. We saw evidence of emails sent by the CEO to the staff celebrating black history month and Diwali. Staff were encouraged to attend events for the LGBTQ+ community including pride. The service was working with ethnic minority groups in the local area to improve accessibility to the service for these groups of people.

All staff completed equality and diversity training.

Governance

Leaders operated effective governance processes. Staff at all levels were clear about their roles and accountabilities.

The CEO and the senior leadership team which was made up of the medical director, clinical nurse director, finance and corporate services director and income generation and communications director were responsible for the operational management and the running of the service.

The service had an elected Board. The Board of Trustees met at least 6 times year and facilitated 3 sub committees which were finance, quality and standards and building. Trustees were also involved in other strategy groups including health and safety and workforce.

The service had various sub committees which reported to the board. These included the health and safety committee, the quality and governance committee and the strategic development committee. We saw evidence of these groups meeting regularly and issues being fed up to board if required.

The service implemented a new business management system in April 2023. The first 2 modules launched were regarding accidents, incidents, near misses and complaints. The system allowed direct reporting of incidents and complaints and provided an audit trail. Between October 2022 and September 2023, the service recorded 443 incidents, which was a 42% increase on the previous year. The service reported 68% clinical incidents and 32% non-clinical incidents. Senior managers felt this reflected a good culture relating to incident reporting. Most incidents were low level and there were 0 serious untoward incidents or deaths resulting from any incidents.

The clinical nurse director and CEO reviewed all incidents, including complaints from across all areas of the Hospice business on a weekly basis. The quality and governance committee meetings also provided an overview of incidents, minutes of which were shared with the full board of trustees.

The service had an infection, prevention, and control team, who met quarterly which we saw evidence of. The group reviewed, monitored, and improved good working practices. There was daily communication between the nursing team and facilities team to ensure all needs were met and staff were informed of any infection risks.

The service provided the local service commissioners with a formal report detailing performance key indicators every 3 months.

Hospice services for adults

The service provided evidence of service level agreements with other organisations, including the local hospital for the provision of blood components, clinics being held on site and for the management and maintenance of equipment.

The fit and proper persons files for the chair of the trustees and 3 of the senior leadership team were reviewed. This included a review of their qualifications, references, and checks regarding past criminal or financial irregularities.

Staff recruitment files for 1 nonclinical member of staff, 6 clinical members of staff from the inpatient and hospice at home service and 2 volunteers were also reviewed. We found suitable checks had been completed in the files we looked at. The files included identification checks, references, professional body registrations and revalidations and DBS checks.

Staff at all levels were clear about their roles and accountabilities. There were clear lines of accountability in the service. There were nominated leads for most key areas such as safeguarding. The leads reported on these areas during board meetings.

The service did not always have sufficient oversight of their policies and procedures. Not all the policies were up to date, and some were awaiting ratification.

The senior leadership team provided information which stated training was offered on an ad hoc basis to support the needs of complex patients who attended the hospice. The training was delivered by clinical staff from where they had been admitted from or by the practice-based educators. The service did not have a fully developed system for recording ad hoc/'on the job' training for contracted staff. The service leads acknowledged this and had plans to record all ad – hoc training completed from then onwards.

Management of risk, issues, and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The service had a risk management policy which provided detail on how risks within the service would be assessed and the process of escalating risks based on their classification. Managers for services were responsible for following up on risks identified and dependent on their classification would either mitigate the risk or escalate the risk further to the sub committees.

The hospice held 2 risk registers, one related to financial risks and the other, safety risks. The risk register was monitored by the health and safety committee and the quality and governance committee on a quarterly basis. Risks that scored 16 or over were escalated to the Board of Trustees.

Risk registers clearly identified the risk, its likelihood and potential impact, measures to mitigate the risk and further actions required. The risks included the financial sustainability of the service, the additional staff required to ensure safe staffing levels and more specific risks including the evacuation of bariatric patients from the inpatient unit as the bed was unable to fit through the door.

Senior leaders and board members acknowledged that a main risk for the hospice was a financial threat. The total incoming resources for 2023 fell, mainly due to the withdrawal of additional COVID-19 funding and a reduction in legacy income. The grants for core funding of the hospice, which remained 1 of the main sources of funding had not kept up

Hospice services for adults

with inflation and had significantly reduced over the last 10 years. In addition, expenditure had increased. The risk was listed on the services risk register, the senior leadership team have met to discuss an action plan relating to the risk and actions are in progress including further fundraising challenges and an intention to build further 'major relationships' with potential supporters.

The service had a major incident response policy which clearly detailed the response expected from staff during normal working hours and out of hours if an event was to occur which threatened personnel, premises or services and required special measure to restore to normality.

The service reported deaths in a timely manner. We found there had been no delays regarding referrals to the medical examiner when reporting deaths from the inpatient unit.

The service had a staff recruitment policy which clearly defined the pre and post-employment checks including proof of identity, disclosure and barring checks, qualifications and eligibility to work in the UK.

The service completed routine audits and monitored key processes. There was a programme of audit covering key processes such as infection control, patient records and medicines management.

Information Management

The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff completed information governance training as part of their mandatory training for the service. The completion rate for training was 89%. Staff we spoke with understood their responsibilities regarding information management.

The information technology systems were protected by security measures. Staff had individual log on details. Computer screens were locked when staff were not sitting at their desks to prevent information breaches.

The service had reliable measures in place to ensure information systems were integrated and secure. They had an informatics committee and quality and governance committee which was accountable to and reported to the Bolton Hospice board of Trustees.

Information governance was an agenda item on the management team leaders monthly meeting and the quality and governance committee bimonthly meeting.

The service had a Caldicott Guardian (protect the confidentiality of people's health and care information), a senior information risk owner (ensures information risks are treated as a priority for the service), a data lead protection officer, information asset owners, a governance lead and a data and information technology manager.

An audit from August 2023 reviewed a sample of 50 entries on the services electronic system and found no unauthorised access. The sample covered a comprehensive wide selection of data entry including allied health professionals, bereavement support, clinical input and non-clinical input.

The service had a business continuity checklist and plan regarding data and cyber security which clearly outlined the potential situations which could occur and the services mitigations to manage them. The service had reviewed and tested their action plans in August 2023 and found all plans to be effective.

Hospice services for adults

The service consistently submitted data or notifications to external organisations, including the Care Quality Commission.

Engagement

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

The education team put on education sessions which were hosted at the Hospice for a variety of professionals including care home staff, paramedics, and carers. One of the courses offered is called a palliative care passport which covers various modules to help professionals become more confident in supporting palliative patients.

The service had completed work with community service providers, social prescribers, GPs, and further support groups to promote the hospice services.

The service completed a survey for relatives of those who had died for the inpatient service and the hospice at home service. The service provided data between April and September 2023. The inpatient service received 34 surveys from 76 that were sent out. The hospice at home service received 5 responses from 44 surveys sent out. Overall, the surveys provided favourable comments for the service. Patient feedback was also captured via social media which was circulated quarterly to staff. We also observed a number of cards from loved ones throughout the hospice.

The service had been engaging with local communities, who may not have previously engaged with the hospice service to raise awareness of the care offered to promote referrals.

The spiritual lead had close links with the interfaith community including the council of Mosques and the Christian Cohesion community in the local area.

The service had recently worked with trainee interpreters to ensure they were aware of what the service offered for when they are asked to interpret for patients in the community or on the inpatient unit.

The Wellbeing Hub supported carers by hosting a carers support group monthly.

The service worked closely with partner organisations to improve services. They worked closely with cancer charities as well as local hospices to improve services for the local population. For example, the service had been working closely alongside other hospices, attending learning disability and autism steering groups and health and social care professionals in an attempt to develop a pathway for young adults into the service.

Learning, continuous improvement and innovation

Leaders encouraged innovation and participation in research.

The service was collaborating with a local children's Hospice to develop a service to support young adults with life limiting conditions to transfer into adult specialist palliative care services within the Hospice. The initial governance for the project had been completed and a project lead had been appointed. The service has supported 3 young adults through their Wellbeing Hub.

Hospice services for adults

The service was involved in a national, multi-centre cluster randomised trial of clinically assisted hydration in patients in the last days of life (CHELsea II). The service had recruited 14 out of 20 patients when we inspected and were awaiting the next phase of the project.