Keech Hospice Care

Keech Hospice Care

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?	Outstanding
Are services well-led?	Good

Summary of findings

Overall summary

We carried out a comprehensive inspection of this service as part of a follow up for concerns raised to Care Quality Commission.

It is the first time we have inspected the adults and children and young people elements of the hospice separately. We rated Keech Hospice Care as good because:

- Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information. Key services were available 7 days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and helped them understand their conditions. Staff took account of patients' individual needs and went out of their way to make sure patients living with a life-limiting condition could make the most of their time with their families and loved ones. 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. The service had a community connector to ensure the local population's needs were understood and catered to. They went above and beyond to work with local services, improve visibility of services and speak to people in a way they could understand. People could access the service when they needed it.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

Hospices for adults:

- The service did not have regular clinical pharmacy input which meant medicines reconciliation was not always done.
- The service did not have a system in place with the ability for leaders of the service to view the overall training completion rates for all volunteers.
- Audits were not always repeated frequently enough to use the findings to make improvements.

Hospices for children and young people:

- The service had staffing vacancies. In order to manage this, the service operated a flexible model of access which meant people could not always access the service when they needed it.
- The service did not have regular pharmacy input and had room for improvement in their processes of accountability of controlled drug stationary.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	Good 	See the summary above for more details. It is the first time we have inspected the adults element of the hospice separately. We rated this service as good because it was safe, effective, caring and well-led. We rated responsive as outstanding.
Hospice services for children	Good 	See the summary above for more details. It is the first time we have inspected the children and young people element of the hospice separately. We rated this service as good because it was safe, effective, caring, responsive and well led.

Summary of findings

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Summary of this inspection

Background to Keech Hospice Care

Keech Hospice Care is registered to provide treatment of disease, disorder and injury. At the time of the inspection there was a registered manager who had been in post since 2019.

The service was last inspected in June 2016, when it received a rating of good.

The service provides free specialist and holistic palliative and end of life care for adults with life-limiting illness and their relatives and carers in Bedford, Luton and South Bedfordshire. The Luton site has an inpatient unit that cares for up to 8 patients. There were 5 inpatients at the time of the inspection. The service also provides specialist palliative care for infants, children and young people who have a life-limiting condition and living within Bedfordshire, Hertfordshire and Milton Keynes.

- There were 8 adult inpatient beds, a cold room, several quiet rooms for friends and family, a room dedicated for families to stay overnight when patients were near end of life and a cold room. For adults, Keech Hospice Care offered a range of day services, which included rehabilitation, wellbeing and outpatient appointments. The service provided specialist palliative care assistance in the community and supported the local NHS trusts with specialist palliative care and end of life advice. The service offered a 24-hour,7 days a week support call line dedicated to adult patients and their families.
- There were 5 children's and young people's inpatient beds. The service also provided play and activity services virtually or at home. There were a wide variety of inpatient therapies and services to help control the child's symptoms, and to provide emotional support for both the child and family. The service had a children's community team which provided hospice care to children with a life-limiting condition in various community settings, including the family home, the child's school or in hospital. The service offered a dedicated 24-hour support call line to support families who have a child with a life-limiting condition.

In June 2023, Keech Hospice Care merged with Bedford Daycare Hospice. The Bedford site provides outpatient and day services, an extensive holistic assessment, tailoring of a treatment plan specific to each person and their loved ones. Patients and their families could access packages of care and support virtually and online and utilise support at the Luton site. We did not visit the Bedford site as part of this inspection.

How we carried out this inspection

We carried out a comprehensive inspection of this service as part of a follow up for concerns raised to Care Quality Commission.

It is the first time we have inspected the adults and children and young people elements of the hospice separately. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.

Summary of this inspection

- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information. Key services were available 7 days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and helped them understand their conditions. Staff took account of patients' individual needs and went out of their way to make sure patients living with a life-limiting condition could make the most of their time with their families and loved ones. 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. The service had a community connector to ensure the local population's needs were understood and catered to. They went above and beyond to work with local services, improve visibility of services and speak to people in a way they could understand. People could access the service when they needed it.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- The service did not have regular clinical pharmacy input which meant medicines reconciliation was not always done.
- The service did not have a system in place with the ability for leaders of the service to view the overall training completion rates for all volunteers.
- Audits were not always repeated frequently enough to use the findings to make improvements.

Outstanding practice

We found the following outstanding practice:

Hospice care for Adults:

- There was a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that met these needs, which are accessible and promotes equality. This included people with protected characteristics under the Equality Act, people approaching the end of their life, and people who were in vulnerable circumstances or who had complex needs.
- Staff in the service went above and beyond to be responsive to their local community. Staff acknowledged the diverse community they served and sought ways to understand and improve services for them. They employed a community connector who worked to destigmatise hospice care in the local community and to build links between the area's community and hospice services. They held multiple events within the community to increase awareness and made changes to improve access to services.

Hospice care for Children and Young People:

- Staff supported the needs of refugee families by accessing sign language translators from a local authority sensory team offering the family and child a voice for the first time since accessing care in the UK.

Summary of this inspection

Areas for improvement

Action the service SHOULD take to improve:

Hospice Care for Adults:

- The service should ensure appropriate medicines reconciliation and pharmaceutical input for all patients.
- The service should ensure consistent monitoring of all refrigerators being used for patient samples.
- The service should have clear and consistent monitoring of completion of volunteer training records.
- The service should consider review of the clinical audit schedule to ensure audits were completed frequently enough to be used to improve care and treatment.

Hospice care for Children and Young People:

- The service should continue to recruit to vacant nursing staff posts and monitor the staffing establishment to ensure they are able to meet patient's needs.
- The service should offer a consistently accessible opportunity to use the facilities and resources.
- The service should ensure appropriate medicines reconciliation processes for medicines including controlled drugs.

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	☆ Outstanding	Good	Good
Hospice services for children	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	☆ Outstanding	Good	Good

Good

Hospice services for adults

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

Is the service safe?

Good

It is the first time we have inspected the adults element of the hospice separately. We rated safe as good.

Mandatory training

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

Staff, including nurses, doctors, and specialist carers received mandatory training. Managers supported staff to complete their training both through eLearning and face to face learning. Managers monitored training completion for all staff working in their area, for example in the inpatient unit or in therapies.

Mandatory training completion was generally good. Where staff were not meeting the target completion rate, the service had put action plans in place to improve compliance. For example, the domestic abuse level 2 training was new in the last 12 months and had 80.2% compliance across all care staff with training target completion of 95%. Leaders put in place a train the trainer programme and had additional training sessions scheduled in November 2023 and February 2024.

The mandatory training was comprehensive and met the needs of patients and staff. Training covered basic life support and anaphylaxis, domestic abuse, health and safety, fire awareness, infection control and moving and handling.

The service recently introduced the Oliver McGowan mandatory training to support staff in recognising and responding to patients with learning disabilities and autism. The service was rolling out this training via elearning and was on target with the national deadline to complete this by March 2024. Leaders of the service worked with local partners to deliver further face to face training for staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. When training was due, staff would receive an email with reminders of what training to complete. The service had a learning and organisational development manager to oversee training for staff and volunteers.

Managers provided and supported volunteers in the relevant area they were volunteering. Line managers were responsible for overseeing completion of mandatory training and induction. At the time of our inspection, leaders of the hospice were not able to view compliance rates for volunteers training. However, as part of the service's plan to review and make changes to their learning management system this was a specification they planned to implement.

Safeguarding

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

All staff, including volunteers, received training specific for their role on how to recognise and report abuse. The service provided a combination of e-learning and classroom safeguarding training and staff completed training within 3 months of joining the hospice. Managers ensured staff completed safeguarding training. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There was a named safeguarding lead for the service who had completed level 4 safeguarding of children and adults. The social work manager supported staff in raising lower levels of safeguarding concerns to ensure issues were picked up early. These concerns were reviewed by a safeguarding social worker and MDT meeting within 24 hours. The service had a clear process for escalating safeguarding concerns and we observed a flowchart displayed in staff areas with contact details for local safeguarding teams.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. The social work manager had completed best interest assessor training and was the domestic violence lead.

The service had up-to-date Disclosure and Barring Service (DBS) checks for all staff in the service including nurses, specialist carers, volunteers and the leadership team. They kept up to date logs of staff's professional registrations.

Cleanliness, infection control and hygiene

Staff used infection control measures when visiting patients on the inpatient unit and transporting patients after death.

Clinical areas were clean and had suitable furnishings and were well-maintained. The service performed well for cleanliness. A patient led assessment of the care environment (PLACE) survey was carried out on the same day as our inspection in November 2023. The hospice used the PLACE survey to assess the quality of the patient environment and assessors reviewed cleanliness of the facilities. The outcome of the survey was overall positive, and the assessors commented they would feel confident bringing their family to the hospice.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. The service undertook a monthly audit of cleanliness based on the NHS's National Standards of Healthcare Cleanliness 2021. The service had a structured cleaning chart with designated task, frequency and staff responsibility. During the period of April 2023 to September 2023, audits showed an overall compliance of 96% on the adult inpatient unit.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff were bare below the elbow and used good hand hygiene practices. Staff regularly audited hand hygiene. The service provided 11 hand hygiene audits between May 2023 to October 2023 which showed no missed opportunities for hand hygiene.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We observed 'I am clean' stickers on equipment after it was used.

Between October 2022 to September 2023, the service had no incidents of hospital acquired infections.

Environment and equipment

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

Patients and their families could reach call bells and we saw staff responded quickly when called. The unit had accessible bathrooms with emergency call cords available at a reachable height.

Staff carried out daily safety checks of specialist equipment. Staff had enough suitable equipment to help them to safely care for patients. All mattresses were pressure relieving and were regularly checked to ensure they were in good working order.

The design of the environment followed national guidance. The service had suitable facilities to meet the needs of patients' families. Clinical rooms were spacious and were designed with patients and families in mind to make them feel more at home. Patients and their families commented in the November 2023 PLACE survey that the hospice 'doesn't feel clinical' and that the area was welcoming, bright, spacious and clean.

Staff disposed of clinical waste safely. Waste bins were not overfilled and were clearly marked for their purpose and information was displayed in each room about waste procedure.

Staff were assigned fire safety as part of their health and safety mandatory training. Compliance rates for this training were 83.9% for nurses, 81.3% for doctors and 80% for support workers which was below the service's target of 85%. Health and safety training was being reviewed to provide an eLearning offering staff access to complete the training more easily. There were plans for 3 training days over the 3 months following our inspection with 32 staff booked onto the training. There were clear and visible fire safety evacuation signs throughout the service.

The service had a refrigerator in the sluice to store laboratory specimens. Although staff did not regularly use the refrigerator and did not normally leave specimens there for a long time, there was no temperature monitoring to ensure safe storage. Following our inspection, managers purchased equipment to monitor refrigerator temperatures.

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 life.

Shift changes and handovers included all necessary key information to keep patients safe. We observed the morning handover from the night shift staff to day shift staff. The handover demonstrated staff provided a thorough, informative exchange of patient information to ensure each patient had individualised care and continuity of care. Nurses and doctors had handovers at the start of shifts. Where an on-call staff member assisted staff out of hours, a handover was done to daytime staff.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff followed clear processes to escalate any concerns. Designated staff were alerted to emergency locations using emergency pagers. Staff used emergency buzzers, panic alarms and poolside alarms to alert the team of medical concerns and emergencies throughout the service.

Staff completed risk assessments for each patient on admission/arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff regularly reviewed care planning to ensure care delivered was specific to the patient's status and condition. The care plans and assessments were documented on the electronic medical record which meant all relevant staff could view a live account of the patient record.

Staff knew about and dealt with any specific risk issues. There was a lone worker policy in place for all staff and volunteers visiting patients in their homes and community. Staff undertook home risk assessments as part of the initial assessment to identify any concerns for staff visiting patients at home. Staff undertook risk assessments so patients could receive individualised care. For example, staff planned for a risk assessment for a patient with a back brace so they could explore physiotherapy and hydrotherapy.

Staff shared key information to keep patients safe when handing over their care to others. There was a board in the staff room where handover took place which displayed ongoing risks, as well as resuscitation orders, stage of care, fall risk, and nutrition status.

The adult inpatient unit had a safety noticeboard which listed the fire marshals, health and safety representatives and emergency contacts. There was a first aid box and an emergency grab bag on the inpatient unit. There were additional first aid and emergency grab bags in the wellbeing centre.

Nurse staffing

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

The service had enough nursing and support staff to keep patients safe.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Managers acknowledged staff provided speciality care to patients with highly complex symptoms, emotional, physical and spiritual needs. The service only opened enough patient beds that staff could care for in a safe manner. For example, the service told us that in the months prior to our inspection, an average of 5 to 6 beds was open for inpatient care.

Managers reviewed bed occupancy, staffing, capacity and demand of services in a daily meeting. Managers worked to support the local organisations. They met 2 times a week with all hospices in the Bedfordshire, Luton and Milton Keynes area, along with the NHS community specialist palliative care team, NHS hospitals' specialist palliative care team and with discharge planning teams. This meant managers could ensure patients received safe care managing patient demand against staffing level across all organisations. Managers took a dynamic approach to staffing and were constantly reviewing based on urgent referrals, patient condition and staff availability.

The service managed their vacancy rates. The number of planned staff had grown in the 12 months prior to our inspection. The establishment numbers increased with the merger of Bedford Daycare Hospice in June 2023. In September 2023, following a review of services in Bedford, there was a further need for increased nurse and support workers. From September 2022 to October 2023, there had been a steady number of staff at the service, however increasing the number of new staff to fill the higher establishment needed was a challenge.

The service used bank and agency staff to fill gaps due to sickness, leave and vacancies. The use of bank and agency staff remained steady over the 12 months prior to our inspection.

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 service had enough medical staff to keep patients safe. The service had access to medical advice 24 hours a day, 7 days a week when required. The service had a service level agreement with a local NHS trust to provide virtual consultant ward rounds twice weekly. They were also able to access out of hours consultant coverage as needed.

Records

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

Patient notes were comprehensive, and all staff could access them easily. Staff used an electronic record system to record patient information and care plans. Records were stored securely.

When patients transferred to a new team, there were no delays in staff accessing their records. The electronic record system was also used widely in the community which meant they were able to share information with other providers easily.

The service last conducted an adult inpatient records review audit in October and November 2022 looking at 30 records from January 2022 to July 2022. The overall compliance was good at 96% which had increased 3% from the previous audit in November 2020. The results of the audit were shared with the staff and actioned where appropriate. An audit bulletin was produced and shared with staff to share what they were doing well and where they could make improvements.

Medicines

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

The service had systems and processes in place to safely prescribe, and administer medicines, including complex medicines administered via a syringe driver. A syringe driver enabled medicines to be given via a small portable battery-operated pump and supplied a continuous dose of medicine. Nurses received medicine training and competency reviewed to administer medicines correctly using a syringe driver.

Medicines, including controlled drugs (CD) and medical gases were stored safely and securely. Controlled drugs are "drugs that are subject to high levels of regulation as a result of government decisions about those drugs that are especially addictive and harmful." Staff managed all medicines and prescribing documents in line with the provider's policy. Staff followed safe systems to manage stock of controlled drug stationaries, such as FP10s.

The associate director of care for adults, who was also the hospice's CD accountable officer described the arrangements for handling CDs. The accountable officer had a legal responsibility to ensure that controlled drugs were kept secure and safely managed. We found controlled drugs were managed safely. The accountable officer engaged in local meetings and submitted reports to the controlled drugs local intelligence network (CDLIN). The CDLIN was made up of partners to share good practice and learning from incidents and included representatives from the local NHS trusts and the police.

Staff checked ambient room temperature and refrigerator temperatures daily.

The service had medicines policies and procedures covering the various aspects of medicines management. Medicines were ordered from the local pharmacy. Nurses could obtain medicines 7 days per week as needed, however at the time of our inspection there was no regular clinical pharmacist support to the service. Staff told us that they were in a process of securing regular clinical pharmacy support.

We reviewed 3 medicine charts which showed that patients received their medicines as prescribed. Doctors followed the hospice's prescribing policy when writing on charts to minimise the risk of misunderstandings. However, records showed that staff did not always follow national guidance to check that patients had the correct medicines when they were admitted or moved between services known as medicines reconciliations. Following our inspection, the service provided evidence there was a new contract in place for regular clinical pharmacy input.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. However, staff were unable to recall any specific incident details.

Incidents

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

The service had no never events or serious incidents in the twelve months prior to our inspection.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with the service's policy. Managers investigated incidents thoroughly.

We reviewed incidents from the time period between July 2023 to September 2023. There was evidence staff regularly reported incidents, including those from patient falls, discrepancies in medicines stock balances, patient transportation delays and equipment failure, for example. All incidents raised, had immediate actions and learning documented. Incidents were regularly reviewed and monitored through the quarterly quality report. The quality report was shared with staff across the organisation, senior leadership team, trustees and commissioners.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. We saw evidence of managers being open and transparent and gave families a full explanation if and when things went wrong.

Good

Hospice services for adults

Staff met to discuss the feedback and how they could improve patient care. For example, the hospice shared with us a near miss incident reported around medicines administration. Staff learned from the incident and offered recommendations and as a result, new processes were put in place in the electronic medical record to avoid similar incidents.

Leaders were signed up to receive patient safety alerts and there was a central system to collect all patient safety alerts. Managers took action in response to patient safety alerts within the deadline and monitored changes.

Managers monitored trends to identify themes from incidents, for example from falls. Following investigations, managers updated risk assessments and provided additional training if needed. Managers created action plans and followed up to ensure changes had taken place.

Is the service effective?

Good

It is the first time we have inspected the adults element of the hospice separately. We rated effective as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

The service provided care and treatment based on national guidance, for instance from the National Institute for Health and Care Excellence (NICE) and National Institute for Health Research (NIHR). Staff worked closely with hospice networks, such as Hospice UK to receive updates in palliative care and end of life practices. The service developed their 2022/23 priorities based on updates on national guidance. For example, the new patient safety incident framework to facilitate in learning from incidents.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Compliance department staff notified policy holders of review dates which staff recorded on the master policy list. Staff updated best practice and reviewed policies in response to new guidance, legislation and new or changed working practices. Staff discussed policies which had exceeded their review period at the monthly operational performance and assurance committee (OPAC). The OPAC would identify and support the timely updating of policies.

The service had strong connections with the local NHS trust, including specialist palliative care staff both in hospital and in the community. Patient feedback demonstrated the benefit of the strong relationship between the hospice and NHS services. For example, providing patients with timely access to services, and continuity of care, such as with repeat blood tests and transfusion services.

The service provided evidence based holistic therapies such as music therapy, art therapy and play therapy.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients and their families had enough to eat and drink, particularly those with specialist nutrition and hydration needs. Staff used the nationally recognised malnutrition universal screening tool (MUST) to identify adults who are malnourished or at risk of malnourishment.

Visitors, staff, patients and their families could access an on-site canteen. The canteen was able to accommodate for a wide range of nutrition needs, including cultural and religious preferences. We observed staff considering individual preferences and relaying this to kitchen staff. Staff supported patients to provide meals during a suitable time.

Staff noted patient's dietary needs. Staff documented patients' food allergies on the electronic record system. Staff provided patients with an environment to enjoy their food, even when they were very poorly. Patients were supported by staff to eat foods of their choice. Patients visiting the wellbeing centre were offered a meal of their choice in line with their cultural and religious preferences where appropriate.

Dietitians, occupational therapists and speech and language therapists offered specialist support to patients who needed it. These specialist staff provided training and education on the international dysphagia diet standardisation initiative (IDDSI) food classification system. The IDDSI framework provided a common terminology for describing food textures and drink thicknesses to improve safety for individuals with swallowing difficulties.

Patient's food and fluid intake was observed at mealtimes so staff could respond promptly to concerns. Staff followed a nutrition and hydration framework when there were concerns regarding food and fluid intake. We did not observe any concerns on inspection. However, staff had not completed a nutrition and hydration audit since 2019. Staff did not regularly audit nutrition and hydration as part of patient record reviews. In the 2019 audit there were several areas for improvements highlighted. Additional audits could have provided assurances that improvements were made and embedded into normal practice.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff used the concept of 'total pain' to aid a holistic approach to managing pain. 'Total pain' was a concept characterised by the multidimensional nature of the palliative patient's pain experience. The concept worked with the patient's physical, psychological, social and spiritual domains. Staff used the palliative outcome score (POS) and distress thermometer to support the assessment of the experience of pain.

Patients received pain relief soon after requesting it. Staff prescribed, administered and recorded pain relief accurately. The service took guidance from best practice from the Palliative Adult Network Guidelines and the palliative care formulary to ensure safe, effective doses of pain medicine was given. Staff considered patient and family input at every step of the decision-making process.

Staff discussed pain management at handover, multidisciplinary team meetings and the consultant board rounds. Staff reviewed and documented effectiveness of pain relief medicines. On inspection, we observed there was regular monitoring with extra pain relief or increased doses to ensure effective pain relief. Specialist pain management was available to support in more challenging cases. For patients not able to engage with the distress thermometer assessment, staff could access a supportive care referral to help reduce anxiety and explore complementary therapies.

Good

Hospice services for adults

Patient outcomes

Staff monitored the effectiveness of care and treatment through a series of audits. However, audits were not always completed at frequent enough intervals to use the findings to make improvements. The service monitored data, such as preferred place of death to make sure they achieved good outcomes for patients.

The service had a programme of repeated audits. Not all audits were completed frequently enough to ensure findings were used to improve care and treatment. For example, the audit of adult inpatient records was completed once every 2 years which meant there was not frequent oversight to ensure actions taken for improvement were embedded and observed.

Local commissioners were provided with regular data outcomes through the service quarterly quality report. For example, shared preferred place of death data, response time targets for referrals to adult services, hospital attendance avoidance as a result of care and treatment and provision of specialist treatments, such as venepuncture and transfusions. Between October 2022 to September 2023, My Care Coordination Team recorded 361 hospital avoidances as a result of care and treatment from hospice services.

The service collected data around preferred place of care and death. In Luton, the My Care Coordination team (MCCT) was composed of NHS acute and local community services. The MCCT coordinated the care packages for adults receiving palliative care and oversaw and managed the electronic palliative care coordination system. The patient's preferred place of death was identified by the (MCCT) of the hospice or community service team, including GPs. In quarter 1 and 2 of 2023, 81% of patients died in their preferred place of death. In staff handover, we observed staff discuss all patients' preferred place of death and preferred place of care.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers made sure staff received any specialist training for their role. The service provided learning and development opportunities through scheduled classroom learning from their internal training and education plan.

The clinical educators supported the learning and development needs of staff. There was a clinical development lead and practice educators to ensure staff received practical and on-the-job training to develop staff's clinical skills.

Managers gave all new staff a full induction tailored to their role before they started work. In 2022, the clinical development lead reviewed and updated all staff core competencies, specific to each staff role. Leaders of the service supported managers and staff to roll out the updates to clinical staff. Staff told us the induction was thorough and they felt supported throughout.

Managers supported nursing and medical staff to develop through regular, constructive clinical supervision of their work. Managers supported staff to develop through yearly, constructive appraisals. Annual appraisals took place from May to June where managers reviewed and signed off competencies. Of eligible staff, 95% had completed their appraisals.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The service had a staff library with up-to-date information on palliative and end of life care. There was also a quiet area for staff to undertake their mandatory training or any other virtual training.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff told us their managers were supportive for them to pursue additional training and education, in line with their goals and objectives. The service had supported a palliative care support worker to train as a nursing associate and were further being supported to undertake nursing training.

Managers identified poor staff performance promptly and supported staff to improve. Managers identified gaps in knowledge of staff through the use of reflective accounts completed after incidents.

Managers trained and supported volunteers to support patients in the service. Each local service manager oversaw completion of volunteer competencies.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. A multidisciplinary team (MDT) meeting was held weekly for the adult inpatient unit, which included staff from nursing, medical, therapy and social work. We reviewed MDT meeting notes which showed the team considered a holistic approach for each patient and discussed patient needs and actions.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff from the MDT worked closely with the local NHS hospital and community teams to provide specialist palliative care. A Community Liaison Team provided support, guidance and information to individuals and professionals regarding access and referral pathways. As part of the MDT, the hospice provided specialist input for complex palliative care patients and new patients and recommended therapies that may benefit patients.

Seven-day services

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

The adult inpatient unit was open 7 days a week, 24 hours a day. Medical input was available on site 7 days a week from 9am to 5pm with out of hours, on-call coverage. Patients were reviewed by consultants twice a week, virtually and as needed.

The service offered a help line 24 hours a day, 7 days a week which patients or their families could contact for advice and support. The help line was also accessible to other local service offering palliative and end of life care in the community.

As part of the My Care Co-ordination Team (MCCT), the service had palliative care support workers in the community. This team was available in Luton from 5pm to 10pm Monday to Friday, 9am to 9pm on Saturday, Sunday and bank holidays. In South Bedfordshire, MCCT support was available from 9am to 10pm, 7 days a week.

The community liaison team was available Monday to Friday from 9am to 5pm and was covered by the duty clinical nurse specialist out of hours.

Health promotion

Staff gave patients practical support to help them live well until they died.

The service had relevant information promoting healthy lifestyles and support. The service had leaflets on display for other local and national agencies and charities that patients and their families could use for support.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff supported and educated patients on how to take their prescribed medications to benefit them in symptom management and pain control. The service offered various therapies through the wellbeing centre. Staff worked with patients with a progressive palliative diagnosis to understand their needs and support them to achieve their goals so they could live well independently.

Staff supported patients to be as mobile as possible and therapy staff evaluated patients of their energy conservation and activity modification to help patients reach their goals. Outreach work enabled timely assessments at home, this meant that patients could have direct admission to the hospice and avoid a potentially lengthy referral process.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty. However, at the time of our inspection the service did not regularly audit do not attempt cardiopulmonary resuscitation (DNACPR) documentation.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. We reviewed 2 sets of records and saw staff had evaluated and documented the patient's mental capacity.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff clearly recorded consent in the patients' records. We saw evidence that staff had gained consent to mobilise a patient in the patient's medical record. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions and documented this.

Staff made sure patients consented to treatment based on all the information available. Staff documented consent with associated risks and benefits so that patients were informed before making decisions.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. The lead social worker oversaw the DoLS applications and followed up with the local authority. Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. On inspection we were able to review 1 patient record with a DoLS application, which was filled out to a high standard.

Of the 2 records we were able to review on site, both patients had a do not attempt cardiopulmonary resuscitation (DNACPR) order which we saw was completed to a high standard. The DNACPR audit was not part of the audit plan at the time of our inspection and the audit we received was noted to be the first completed. The November 2023 audit showed overall compliance of 86.4%, with 100% compliance in 7 of the 11 measured topics across the adult's and children's service. Following the audit results, staff devised a plan to improve compliance with immediate actions. The action plan would be monitored through the clinical safety and assurance group. Recommendations for improvement were mostly around ensuring all electronic medical records were accurately and thoroughly completed.

Good

Hospice services for adults

Is the service caring?

Good

It is the first time we have inspected the adults element of the hospice separately. We rated caring as good.

Due to the nature of the service, we were not able to speak with patients on inspection, however Keech Hospice Care provided feedback from patients and/or their family or carers.

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 used discreet signs in the unit and doors to the building following the death of a patient to be mindful and respectful of grieving family. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness. Patient feedback was overwhelmingly positive about staff and services offered by the hospice in the inpatient unit, wellbeing centre and in the community. Examples of positive feedback included:

- "I feel well looked after. The staff take the time to make me feel at ease."
- "You all do everything very well and are caring."
- "Very good at listening to their patients and carers. Extremely supportive and offers many opportunities to us."
- "The level of care and the way they make you feel so welcome and look after you the minute you step through the door, whether you are a patient or relative to the patient."
- "Make me feel welcome and relaxed."
- "Respect and encourage independence."

Staff followed policy to keep patient care and treatment confidential. Staff ensured rooms were closed when performing care. Staff logged off computers when not in use to ensure records were kept private and confidential.

Staff understood and respected the individual needs of each patient and their family. Staff often went above and beyond for patients. The hospice provided a case study of a patient who was supported in the community by the palliative care support workers and later benefitted from time in the inpatient unit for symptom control. Staff in the hospice arranged for a special afternoon for the patient and their children to spend time together to make memories. They used the cuddle bed so the children and the patient could watch movies together. The team at Keech worked together to help support the whole family during the patient's illness, deterioration and death.

Staff worked to make the difference to patients when it mattered the most. For example, staff went above and beyond to help a patient make the most of the time with their spouse near the end of their life by setting up themed date nights. As a result, they commented how these moments in the hospice made lasting memories and helped them to reconnect. Staff at Keech Hospice Care recognised that palliative care doesn't always need to be sad. Staff supported patients by walking the journey with them and by helping to make special moments and lasting memories.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff completed a needs assessment for each patient, including the patient's wishes and goals. Data provided by managers for the 12 months prior to our inspection showed 100% of respondents agreed their personal needs had been assessed.

The service provided results from the friends and family test from the 12 months prior to our inspection which showed 100% of respondents would recommend the service to a friend or family member. In the same survey, 100% respondents agreed that staff respected their confidentiality at all times and were caring.

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. The hospice's community services had palliative care support workers who provided emotional support. The service had a social group for family and carers called 'Stepping Stones' that met in the community which provided support for anyone who had previously been a carer. Other carer groups including a weekly walking group, a twice monthly face-to-face carers group, a monthly zoom call with carers and a pre-arranged 1-to-1 support which could be arranged at home, at the hospice, online, via email or on the phone. All of the groups were offered free of charge.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. There was a comfortable seating area in the middle of the inpatient unit which had memory jars on display, 'from me to you' bracelets and hearts that could be shared with patients and their families. The service's family lounge in the inpatient unit was available for families or meeting with staff and families.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. The service employed a chaplain, and we observed on inspection that the chaplain was visiting a patient. In line with the patient's wishes, the chaplain would come and pray for the patient while they were sleeping.

As part of the multidisciplinary team, staff discussed emotional care needs. We were told of how a patient was anxious about coming into the service and staff discussed how they could support the patient, so they were comfortable enough to be admitted in the inpatient unit. One patient provided feedback saying, "I was very scared being under Hospice care but everyone was friendly and supportive."

Staff continued to support the whole family following a patient's death and for as long as needed. Staff offered pre-bereavement support to help families come to terms with death. Following a patient's passing, the service made an automatic referral for bereavement support to the supportive care team. The service's 'Silver Lining support group' was available for anyone whose loved one had died and used Keech Hospice services. This meant family and/or carers could share their feelings with others who had been through a similar experience.

Staff supported practical matters, such as registering the death and arranging a funeral. The service held a yearly remembrance service in December called 'Light Up a Life' to dedicate a light on the hospice's tree in memory of a loved one. The hospice also worked with a web-based charity to help people create a tribute site on the internet to remember their loved one.

Good

Hospice services for adults

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. The hospice provided examples where patients and their families together discussed possible choices of care. Staff supported them by answering any questions and providing information so they could make well informed decisions. The service also supported patients and their families to understand their access to social services and benefits.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. As part of the staff handover, all patients were discussed in relation to next of kin and close family members, where they lived and how often they visited.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. There was a QR code on the inpatient unit that patients, their families or carers could scan to provide feedback. Patients gave positive feedback about the service. For example, “They are supportive, friendly, caring, give confidence, welcoming and encourage physical wellbeing.”

Staff supported patients to make advanced decisions about their care. The service provided a case study of a patient cared for under their care for several months. The patient and their family accessed a variety of services at the hospice in an outpatient setting. As the patient’s disease progressed, the hospice agreed to see the patient at home. The hospice supported the patient and their family to make decisions about preferred place of death and treatment. Staff provided information and the patient and their family were given time to ask questions. The hospice supported the patient and their family to make well-informed decisions.

Responses from the service’s patient survey were provided from the 12 months prior to our inspection. Feedback was positive with most people strongly agreeing they had been involved in discussions of their care and treatment. Feedback highlighted feeling supported to make decisions, being asked if they consented to care or treatment, and 100% of patients and their families felt their cultural and religious needs were met.

Is the service responsive?

Outstanding ☆

It is the first time we have inspected the adults element of the hospice separately. We rated responsive as outstanding.

Service delivery to meet the needs of local people

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

The service was available to all adults with a life-limiting condition and to those affected by death and dying, to help lead them to a purposeful and fulfilling life.

Good

Hospice services for adults

The service worked flexibly to accommodate needs of patients and families who needed it the most. They offered a self-referral process for any adults to the wellbeing centre, including for therapies. For adults needing additional care services in an inpatient setting, they gave priority to those with the greatest need. On the day of inspection, we were told of a patient who had been referred to the service 1 day and the next day they were admitted to the inpatient unit for symptom control.

Managers planned and organised services so they met the needs of the local population. Patients using the service told us they had timely treatment and support from the hospice. The hospice was able to support patients with ongoing monitoring through regular blood tests. Patients said they often saw the same staff which helped ensure continuity of care and by helping patients to feel comfortable with the regular contact. Staff supported patients through a wide variety of therapy services, such as physiotherapy, occupational therapy, massage therapy, hydrotherapy, and music and art therapy. Staff supported patients through the social work team.

The service had systems and equipment to help care for patients in need of additional support or specialist intervention. Patients with mobility concerns could use ramps into the building. Clinical areas were on the ground floor for ease of access. The inpatient rooms were all equipped with hoists and hoist tracks which meant patients were able to access the bathroom, specialist bathtub and be safely moved to recliner chairs.

Patients could use the hydrotherapy pool and wellbeing centre, where there was a gym, rooms dedicated to alternative therapy services, a library, quiet areas and a restaurant with seating. Families could use an ensuite room to freshen up and stay over. There was a cold room with a dedicated quiet space with outdoor access to a garden and an alternative route to the rest of the hospice.

Facilities and premises were appropriate for the services being delivered. The hospice in Luton had a significant footprint which was accessible for patients with all abilities. The hospice was set back in a quiet area, surrounded by nature and gardens. All patient rooms had access to a quiet outside garden area. The service designed and decorated the inpatient rooms so they felt more homely and less clinical.

Staff identified the need to enhance the wellbeing of patients through intimacy and touch. Staff fundraised for 2 cuddle beds in the adult inpatient unit. Cuddle beds had the features of a hospital bed, but with the ability to extend. This meant the patient and their loved ones had the opportunity to hold each other and be together.

Staff collaborated with local hospitals to help relieve pressure on NHS services. The hospice worked with the local NHS trust's specialist haematology team to establish a pathway for transfusion dependent patients. The service provided a satellite unit for blood transfusions, which the NHS trust monitored and audited. This pathway was established to help identify patients earlier in their needed for transfusions so that they could get the most benefit from treatments.

Staff supported patients when their preference was to avoid hospital admissions and ensured patients could receive care in their preferred place. Between October 2022 to September 2023, the service helped with 74 patients avoiding hospital admission.

The service held a consultation between staff, volunteers, patients and carers. The consultation identified the need for a more flexible approach of supporting patients in the community. The service used Compassionate Neighbours, which was a social movement of local people enabled and supported to be more compassionate in their local communities. This meant the service was able to provide social and emotional support to people towards the end of their life due to a life limiting illness.

At the Bedford site, there were support services 5 days a week. They offered a new patient clinic for assessment and education on welfare benefits. They also offered health and wellbeing days, peer education programme days and cancer drop-in days. They had sessions of 'stories for life' which was a programme to record stories of patients with compassion and care, capturing memories to leave an audio recording legacy for families and friends. The cancer drop-in days were supported by a cancer charity and had therapists available to offer reiki, massage and reflexology. The cancer support group offered a calm environment for patients and their families to speak and support each other.

The service's lead nurse for supportive care and social work set up and co-chaired a Bereavement Alliance group for Bedfordshire, Luton and Milton Keynes (BLMK). Bereavement leads across the region were invited to the group, to share reflections and learning, update on services offered and create an annual work plan. They produced a bereavement services directory which they sent to local services, such as hospices, commissioners and healthcare professionals. The directory assisted to signpost people to the many bereavement services in the region.

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.

The service had a strong commitment to reach people and communities who seldom accessed hospice services. The service's palliative care inclusive health nurse had completed a comprehensive course on homeless and inclusion health. This meant that the palliative care inclusive health nurse could support the care team to continue to develop their health inequalities offer, establish further links and knowledge base of working with local homeless populations. Further, the service offered 2 sessions to local homelessness partners in the community focussing on the advanced illness and raising awareness. The service continued to have a strong commitment to having a partnership with local homelessness groups.

All staff completed equality, diversity and inclusion training part of their mandatory training. Leaders of the organisation were supporting 2 staff members to complete a foundation certificate in equality, diversity and inclusion for palliative care and end of life care with Compassionate Communities UK. This learning was to be shared with the service's equality, diversity and inclusion group to consider changes they could make to improve the service.

The service acknowledged the diverse community they served; Luton had a 55% Black, Asian and minority ethnic (BAME) population. The service employed a 'community connector' who had strong links to the local population and community. The staff member completed a training through 'No Barriers Here' on addressing systematic barriers to accessing care and to improving palliative and end of life care for all people. Following this training, the service planned to share the learning with all staff through workshops in 2024 to ensure there would be genuine inclusion and equity for all people.

The community connector worked with local faith groups and supported the local population to understand the hospice's services and offerings. The community connector helped support the hospice to ensure they were able to provide suitable prayer spaces and wash facilities. They also supported other staff to be culturally sensitive and offering equitable experiences for all patients.

The service provided several examples where the hospice collaborated with other local teams, such as patients' consultants, GPs and community nurses to provide individualised care and treatment whilst respecting patients' wishes. The service provided placed importance on teams being integrated regardless of where the patient was receiving treatment, whether it be the home or at the hospice.

The inpatient unit and other services were designed to meet the needs of patients living with dementia. Staff used discreet signs to signify patients living with dementia.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. A local charity, which helped those affected by a disability or long-term health condition, delivered disability awareness training in May 2023 to staff. The training gave delegates an introduction and understanding of a range of different disabilities, attitudes to, and the legal requirements around service provision for people with disabilities. The service had a hearing loop system to help people living with hearing loss to hear conversations more easily.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff explained how they could access interpreters and that they used interpreters regularly. The service had information leaflets available in languages spoken by the patients and local community. The service was able to provide leaflets in additional languages, as needed.

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

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.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The service collected data for all referrals received. The service's referrals were triaged by the lead palliative care clinical nurse specialist (CNS), the CNS team and the My Care Coordination Team. This meant staff processed and reviewed referrals 7 days a week.

The service accepted self-referrals to the outpatient services and could be accessed at any time of day through the service's website. The self-referrals meant that patients, families, carers and friends could refer themselves to hospice services even if they did not have professionals currently involved in their care. The self-referral allowed for people to decide what was important to support them and how and when they would like to receive care. The service's self-referrals to the hospice had increased. Between October 2022 to September 2023, the service had nearly 170 self-referrals, which was an increase of about 100 self-referrals compared to the previous year.

Managers monitored waiting times and made sure patients could access services when needed and received treatment. The service aimed to achieve 90% compliance for all new referrals. The service's response time for inpatient referrals was up to 24 hours and they have achieved 93% compliance in the 12 months prior to our inspection. The service's response time for outpatient service referrals was 5 days and they had achieved 91% compliance in the 12 months prior to our inspection.

Managers and staff completed assessment planning for all patients, which included preferred place of treatment and preferred place of death. If the preferred place of death was at home, the service planned for a safe and comfortable discharge as early as possible.

Good

Hospice services for adults

The service held a monthly 'thinking ahead' clinic. Staff developed this liver clinic alongside the hepatology consultant at the local NHS trust. The clinic was collaboratively created to identify patients with liver disease who had not been recognised with a palliative condition and therefore not accessing services to provide support and advice. The 'thinking ahead' clinic was available to monitor symptoms, provide emotional support, advanced care planning and to improve access to additional hospice services.

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. Patients and their families told us they felt comfortable raising concerns. The patient survey provided by the hospice from the 12 months prior to our inspection showed 100% of those survey would feel confident in making a complaint or raising a concern. From October 2022 to October 2023, there had been 5 complaints made about adult's services.

The service received a complaint from a patient regarding a long wait of 6 months for counselling and wellbeing support. The service acknowledged there were delays due to other projects taking place at the hospice. In response, they put in place a more robust referral pathway into supportive care with assessments to be completed within 2 to 3 weeks from referral. Leaders of the service put together a business plan, which was accepted and agreed by the board of trustees, to expand the supportive care team to better manage the number of referrals coming in.

The service clearly displayed information about how to raise a concern in patient areas. In the hallway of the inpatient unit, there was a drop box for anyone to raise complaints, concerns and compliments. Additionally, there was a QR code displayed through the unit which could be scanned to provide feedback.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers shared feedback from complaints with staff and learning was used to improve the service. For example, following an investigation into a complaint, the service looked at how they could improve communication in the discharge process. They identified that conversations with patients and their carers regarding discharge must be in person, if possible. Staff must explain the reasons for the possible discharge, the discharge plan must be mutually agreed and at the time of assessment and offering of services there would be a regular review of needs of services. Managers reflected with staff member involved in complaints to support them.

Is the service well-led?

Good

It is the first time we have inspected the adults element of the hospice separately. We rated well led as good.

Good

Hospice services for adults

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The service senior leadership team was made up of a chief executive officer, deputy CEO and clinical director, finance and corporate services director, executive director of innovation, and digital and engagement. Additionally, there were associate directors of patient services for adults and children, people and human resources, commercial and trading and supporter engagement. The senior leadership team brought a wealth of knowledge and experience in palliative and hospice care, and several had been at Keech Hospice Care for more than 10 years.

Keech Hospice Care was governed by a board of trustees whose role was to take overall responsibility for the hospice. Trustees had backgrounds in management, finance, law, strategic planning, clinical and corporate governance, human resources and lived experience of having family member with life-limiting conditions. At the time of our inspection, senior leaders acknowledged the board was not as diverse as they would like and completed a gap analysis. They were in the process of recruiting more diverse board members to be representative of their local community. In addition to trustees, leaders recruited Keech ambassadors to be a gateway to parts of the community, provide feedback on ambition and governance of the service.

Leaders actively worked to be visible to all staff. The CEO posted a weekly blog to highlight activity at the hospice and positive work by the hospice and its staff. The deputy CEO continued to work in a clinical setting to maintain skills and support staff. Staff told us the senior leadership team was visible and that they felt supported by their line managers.

Vision and Strategy

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

The service had a strategy for 2023 to 2026. Within this, the service had a vision of 'making a difference when it matters the most.' It was their mission to 'lead the way in providing excellent care, supporting children and adults with life-limiting conditions and those affected by death and dying, helping them to live well and make every day count.'

Leaders of the service included the views of staff, patients and carers when developing the vision and strategy. The service had worked with the board of trustees to develop the vision and strategy. As well, leaders of the service had plans to further work with the board of trustees to develop a 10-year strategy in December 2023 to look at the future of their services. The service engaged with key stakeholders, such as Healthwatch to develop the strategy to reflect the needs of the local community.

The service had a set of values as follows:

- We deliver better outcomes by working today.
- We take care of each other.
- We can be trusted and respected for our professionalism.
- We are committed and innovative.

Staff we spoke with were able to share the vision and values of the hospice. Staff told us they felt engaged with the development of the values and that they reflected the organisation. We saw staff display these values during our inspection. The service had embedded the values by linking job descriptions, interviews and appraisals to the values. Managers were committed to embedding the values and mapped the action plan from the staff survey to the service's values.

Leaders had a clear commitment to sustainability of services and worked closely with the local community and wider health economy. The service worked with local NHS services to improve continuity of care and access to services earlier in the palliative care journey. The service worked with local communities to understand their needs and make care more accessible.

Culture

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

All staff we spoke with described leaders and their managers as open and approachable. Staff were proud of the organisation as a place to work and spoke of the culture as having good teamwork and support from others.

Staff of all levels were encouraged to speak up and raise concerns. The service had an up-to-date whistleblowing policy. The service had a Freedom to Speak up Guardian, who was a trustee and had an open email for staff to raise any concerns. The freedom to speak up guardian had not received any concerns in the 12 months prior to our inspection. The service was exploring expanding their speak up programme to include speak up champions.

The CEO published a weekly blog displaying the past week's accomplishments and relevant events taking place. The blog highlighted equality and diversity. For example, in October 2023, there was a celebration evening for Black History Month. The event welcomed local speakers and discussions. The blog also brought awareness for international pronouns day with information on how to respectfully understand and use pronouns. The CEO welcomed challenge and response from the blog and said that there was regular feedback and suggestions that arose from the blog.

Staff we spoke with reported they were encouraged to raise concerns at all level and leaders valued the opportunity to make improvements.

The service supported the wellbeing of staff through the use of an employee assistance programme and staff wellbeing events. A room on site, called the Sanctuary, was donated as a place for staff wellbeing. The Sanctuary was a quiet space with music, 1-way windows overlooking a green space, a massage chair and other wellbeing activities.

The service's last staff survey took place in September 2022. Results from the survey were largely positive and showed that most people felt supported by their managers and enjoyed working for the service. Managers reviewed the survey results and created an action plan to address areas where improvements could be made. For example, managers looked at how they could improve internal communication for all staff. Managers met with staff through the operational performance and assurance committee to understand how communication happened between teams and received feedback from staff. Following a review, the service put in place an organisation-wide electronic communication tool so that staff could have a more consistent place to review information and updates.

Good

Hospice services for adults

Governance

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

The service had governance processes in place to manage risk, make improvements and keep patients safe from harm. The service's governance processes were overseen by a board of trustees. Trustees were on various subcommittees, including on the audit and risk committee, remuneration committee and investment committee. Board meeting minutes showed that trustees were challenging and committed to the improvement of services.

Staff from all levels were able to contribute to governance of the organisation. The clinical safety and assurance group (CSAG) met monthly and consisted of representatives from clinical areas and staff groups. The group reviewed and contributed to audits, scrutinised incidents, considered additional training for staff and contributed to updates on policies. A number of groups, along with CSAG, the clinical education group, clinical management team, management of medicines group and the infection prevention and control group fed into and were accountable to the clinical effectiveness group (CEG). The clinical effectiveness group provided assurance to the audit and risk committee, which was responsible to the board of trustees. The CSAG was responsible for following up on actions and to share learning with teams.

There were processes to ensure learning from groups and committees was fed back to staff. This was done through the hot topics board and staff handover. Staff told us there were opportunities to make changes in their areas. For example, we were told about medicines incidents relating to patient's own medicines.

The service produced an annual quality report and impact report highlighting the years performance including performance of care, operations and financial status. This report was available publicly online.

The service had service level agreements (SLA) with partner organisations. For example, SLAs were in place for consultant coverage, supply of blood and blood products, pharmacy supply of medicines, and information and communication technology, amongst others. The SLAs were reviewed regularly and there was a clear governance structure to monitor agreements.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. However, the audit programme had some audits which were not done frequently enough to ensure action plans were making improvements.

The service had systems in place to record, mitigate and monitor risks. Following our inspection, we reviewed the clinical risk register and a corporate risk register from November 2023. The top 3 risks on the clinical risk register were nurse staffing, funding, and incidents relating to medicines management. Each risk on the register included a category, description of risk, effect, inherent risk rating, controls or mitigating actions, residual risk rating and further controls in place. The risks staff told us about were on the risk register.

The risk register, which was reviewed after the inspection, did not list dates the risks were added and when they were next due for review. It did not have dates for when each action should be completed, and risks did not show who was responsible for ensuring actions were completed. Leaders of the service told us that although risks were not dated, they

had a system for highlighting any additions or changes so they were easily recognised. The front-page summary for the risk register was dated and provided a description of changes to the risk register. Leaders recorded actions from the risk register on a separate action plan with dates of when these actions were due for completion. Relevant committees monitored the action plans.

The top 3 risks on the corporate risk register were being unable to meet the demand for care services and delivering their purpose, risk of failing to comply with safety regulations, and financial risks. This showed that the corporate risk register took into account the top clinical risks. The corporate risk registers also had controls and mitigating actions in place, however there were no dates pertaining to when risks were added to the register and when they were due for review next.

The risks we identified through our inspection were already identified by the service. The service had a business case to procure clinical pharmacy support and we saw evidence this was identified prior to our inspection. However, the service had not identified the need to audit DNACPR and some audits were not done frequently enough to ensure action plans were making improvements.

Following our inspection, the service provided evidence that they had amended their audit schedule for 2024/25 to include a DNACPR audit annually. Additionally, some audits were increased in frequency compared to the 2023/24 audit schedule. For example, the adult service notes audit had gone from once every two years to an annual audit.

Information Management

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

The service provided information governance and data security as part of their mandatory training, and this was refreshed annually. The service carried out regular audits and inspections to ensure their security controls were effective and reliable and we saw this was discussed and challenged at trustee board meetings.

The service had clear responsibilities and accountabilities for information security. There was a Caldicott Guardian in place whose role was to protect patients' confidentiality in line with NHS information sharing rules. There was a senior information risk owner (SIRO) who was responsible for promoting and raising awareness of information governance issues. Additionally, there was an information governance lead responsible for fostering a culture of information security throughout the organisation.

The service collected data through audits, surveys and feedback. The service provided structured data that was easy to understand as part of our evidence review following the inspection.

Engagement

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

The service had an Equality, Diversity and Inclusion (EDI) group which was formed in the beginning of 2023. The groups goals were to represent the voice of staff and volunteers on EDI issues and to provide a way for people to raise issues or areas for development. The hospice was dedicated to being a place where everyone felt welcome and to celebrate their

diversity. The EDI group was exploring 3 areas: date, education and training and awareness raising. The group produced an awareness calendar which highlighted areas for celebration, such as Ramadan and Eid, Pride month, South Asian Heritage month, Black History month and Diwali. The service continued to be dedicated to developing further areas in 2024, such as looking at support for neurodiversity.

Following the hospice's success of collaborative working with the local NHS trust's haematology team, they also had started to work with the heart failure team to develop a similar pathway for patients requiring intravenous treatment. This meant the service would be able to help patients receive treatments in a timelier manner, to help manage their symptoms better and to reduce the need to attend hospital.

The service had a research partnership with a local university which organised 3 expert by experience workshops. Following feedback, the service recruited a community connector for the south Asian community. In addition, the service made changes to make Muslim patients more comfortable using hospice services. For example, the service ensured they had appropriate prayer and reflective facilities, do not disturb and 'I am praying' door signs. They offered training for staff, gift boxes for Muslim patients with items they might require such as head scarves and prayer mats. Leaders also worked to develop a more diverse workforce to represent the local population. Leaders noticed the local south Asian community had increased uptake of the hospice's services following these changes.

Leaders of the service were dedicated to collaborating with partner organisations to improve services for patients. They had a masterclass on end-of-life care needs of the LGBTQIA+ community which offered insight into the unique needs and barriers that may be encountered by people in the community. The masterclass was attended by 52 people and staff found it thought provoking.

Two members of staff actively collaborated with Hospice UK to develop the 'I Just Want to be Me' report which was released in February 2023. The report focussed on access to palliative and end of life care for those in the trans and gender diverse communities. Keech Hospice Care was mentioned in the report regarding the work the education team had done to deliver workshops addressing the needs of the LGBTQIA+ community. The hospice was looking at recommendations made in the report to develop future offerings of care.

There was engagement between the hospice and a local community group for those living in Bedfordshire who were hard of hearing or deaf. Following this engagement, the hospice adjusted their facilities. For example, introducing a hearing loop at reception, training for staff and the procurement of an IT package which allows people to make a telephone call accessing a translator.

In 2023, the hospice worked with a local charity who worked to make Bedford a more accessible place for the deaf and hard of hearing community. In early 2023, the charity held a session to introduce British Sign Language (BSL) to staff. There were plans for a 2-hour BSL workshop for staff and volunteers to take place in January 2024.

The service was a Disability Confident Employer (level 2). The Disability Confident Employer scheme is a government campaign to create a movement of change and encourage providers to think differently about disabilities. The service was taking action to improve how they recruit, retain and develop disabled people.

The service took part in an annual external staff survey. The service achieved high marks from the survey due to high staff engagement scores and staff reporting that they felt proud to work for the hospice. The external survey also highlighted staff satisfaction with their managers.

Good

Hospice services for adults

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation.

Leaders of the service adapted their approach to completing training during the pandemic. As a result, the service supported staff, who were subject matter experts in their field, to author and host eLearning appropriate to the diverse hospice staff and volunteers at the hospice.

The hospice was committed to their own learning journey and to improve other services' approach and understanding of palliative and end of life care. The hospice's clinical education team delivered training on palliative and end of life care courses both to their own staff and volunteers but also to other organisations and professionals. The service also supported clinical student placements across the specialist care services from various disciplines, including pre-registration adult and children's nursing, paramedic science and social work.

The service funded external training and paid for staff to attend national conferences to develop staff. Staff who attended conferences cascaded best practice training and knowledge to other staff.

Managers supported staff to improve services. At the time of our inspection, the service did not have a children's occupational therapy service. Managers supported therapy staff to meet with other hospice providers on how they might be able to adapt their services to be able to provide additional therapy services at Keech Hospice Care.

The service introduced a self-referral option for patients and their family to use outpatient services. The hospice found that by being able to complete the self-referral early on in the patient journey, it meant patients were able to live well for a longer period of time. It also gave patients' family members longer to access support services and enabled patients to have more control and choose which care and support they needed.

Staff were committed to the service's values, vision and strategy, including to improve services for all patients. Staff fundraised with the local community to procure the cuddle beds which leant themselves to patients and their families to spend valuable time together at or near the patient's end of life.

Good

Hospice services for children

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

Is the service safe?

Good

It is the first time we have inspected the children and young people element of the hospice separately. We rated safe as good.

Mandatory training

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

Staff including nurses, specialist carers and volunteers received and kept up to date with their mandatory training. The service undertook quarterly audits to ensure training was up to date. The mandatory training completion rate for a 4-month period before the inspection was 92%. Managers told us they had plans in place for those staff who were below compliance levels. For example, we could see that intermediate domestic abuse training was at 80% and there was a dated plan in place to roll out this mandatory training for all staff.

The mandatory training was comprehensive and met the needs of children, young people and staff. Training covered a range of relevant topics and included, but was not limited to, safeguarding children, consent, and infection control training.

Staff had been introduced to the Oliver McGowan mandatory training. The training developed staff skills in recognising and responding to children and young people with learning disabilities and autism. At the time of the inspection, leaders were working on a plan with partners to deliver face to face training. There remained limited availability to non-NHS providers of this element of the training across the area and staff were working with partners to address this.

Managers monitored mandatory training and alerted staff when they needed to update their training. We saw the training compliance matrix that clearly detailed when staff where next due refreshers on the training subjects.

Safeguarding

Staff understood how to protect children and young people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Good

Hospice services for children

All staff received training specific for their role on how to recognise and report abuse. Staff who worked with children and young people received and were up to date with level 3 safeguarding training. Compliance levels were at 95%. Central Bedfordshire Safeguarding staff had been commissioned to deliver the training to all new and existing staff from September 2023.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff were trained to identify safeguarding issues and could describe the pathway to make a safeguarding referral. We looked at documentation relating to partnership working with other agencies to support the safeguarding needs of children and young people. We were given examples of staff supporting families with very sensitive and complex safeguarding needs. These sensitive supportive acts demonstrated over and above what would be expected of staff of this service.

Staff understood lone working and risk assessed community visits in advance. Staff told us they made decisions about lone working using risk-based information to determine whether lone working was appropriate. For example, if risks were identified staff attended community visits in pairs.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service had a designated safeguarding team who supported staff. The safeguarding team also worked with local authorities to help care for children and families who needed safeguarding support.

Staff documented joint working with local authorities safeguarding staff and other agencies to safeguard children and families. Staff documented safeguarding meetings and shared minutes and learning. We were provided with documentation that outlined working with partner agencies such as housing and social workers to rehouse children and young people and their families to safeguard people from harm. The safeguarding notes and records we looked at were comprehensive and staff documented all relevant information to help understand the safeguarding needs of the children.

Social workers saw an increase in face-to-face visits to provide emotional and other support work. Social workers reported an unprecedented number of safeguarding concerns over a four-month period which included concerns about children's weight loss, homelessness and family wellbeing and carer's ability to provide for children. Social workers workloads had increased resulting in more joint working with external agencies and the recruitment of additional social workers to safeguard those using the service.

Cleanliness, infection control and hygiene

Staff used infection control measures when visiting children and young people at the service and transporting children and young people after death.

Clinical and therapy areas were clean and had suitable furnishings which were clean and well maintained.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff documented completion of cleaning tasks in cleaning records in all clinical areas. Staff were seen to clean equipment after patient contact.

We observed staff following infection control principles including the use of personal protective equipment. The service lead had completed an infection prevention control degree module and acted as the service infection prevention control lead.

The service had suitable access to hand washing facilities. Staff working in the community had access to hand washing facilities in children and young people' homes. We observed staff washing their hands before and after patient contact.

Staff performed monthly infection prevention control audits on the effectiveness of cleaning processes including hand washing technique. The service scored 94% in their latest cleaning audit. Hand hygiene audit demonstrated 96% compliance. We saw recorded areas for improvement, for example, clinical area compliance was 96% because bags were found on the floor in changing rooms. The recommendations set out in the audits were for staff to report maintenance issues on the unit and to replace hand hygiene posters to remind staff and visitors of importance of hand hygiene.

Environment and equipment

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

People could access call bells in each room. There were no inpatients at the time of inspection, and we were unable to assess how quickly call bells were answered.

Accessible bathrooms had emergency cords available hanging at a reachable height.

The service had security card swipe access to each area. Staff had controlled access to different areas of the service to protect families and staff.

Staff carried out daily safety checks of specialist equipment including hoists. Staff completed weekly checklists of equipment including automated external defibrillator (AED) and grab bags. We looked at copies of the last 6 months. If equipment was found to be defective it was reported in line with the Equipment Management Procedure and taken out of use until corrective action had been taken.

The service had suitable facilities to meet the needs of children and young people's families. Clinical rooms were spacious and had equipment to meet the needs of the users. The bedrooms were suitable for children and young people of all ages with appropriate equipment including hoists. Young people who wanted their own space were accommodated away from the younger children's areas.

There were large open areas indoors and outdoors for play with age-appropriate equipment. There was a well-equipped sensory room and a room for young people to play computer games and other age-appropriate games. Staff told us they have the equipment to convert unused rooms at the back of the unit for young people who wanted space to spend time on their own.

The service had enough suitable equipment to help them to safely care for children and young people. Staff received role specific specialist equipment training. Staff were competency assessed for the use of equipment, for example, infusion pumps for delivering pain relief in end of life care.

Staff disposed of clinical waste safely. Waste bins were clearly labelled and there was information displayed in each room about the waste procedure. The service had contracts with external providers for the removal of domestic and clinical waste.

Good

Hospice services for children

Assessing and responding to patient risk

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

Staff were able to identify deteriorating children and young people and escalated them appropriately. Staff could describe what they would do if a child were to deteriorate. Staff had access to medical advice via an on-call system at the hospice. In case of emergency, staff would dial 999. Staff clearly documented do not resuscitate status in care records which included the wishes of the children and their families.

Staff completed risk assessments for each patient and recorded the information in care plans. Staff reviewed patient information regularly to determine if there were any changes. Care plans detailed risks and how to respond in an emergency, for example, children with allergic reaction risks and anaphylaxis. Staff ensured information from children's families and their doctors was up to date. We looked at six care plans, and all had up to date risk assessment information.

Staff knew about and dealt with any specific risk issues. We saw that themes around incidents were identified and actioned, for example within the falls audit information. There were environment risks audited and actioned, for example, concerns were identified in relation to fire doors which meant some rooms were not used as a result.

Staff shared key information to keep children, young people, and their families safe when handing over their care to others. Children's records included information from their care teams outside the service. Staff could access key information in relation to children's contact with other healthcare providers, including their GPs using a shared electronic record system.

Handovers included key information to keep children, and young people safe. We observed daily huddles where staff discussed each child individually, including risks. Staff demonstrated a good understanding of each child's specific needs, including their physiological needs.

Nurse staffing

The service operated a flexible model of care to ensure they had enough staff to keep people safe. There were nursing and support staff vacancies. Staff employed had the right qualifications, skills, training and experience to keep children and young people safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service did not always have enough nursing and support staff. However, leaders operated a flexible model of care to ensure that there was enough staff to safely care for children and young people. Families understood the need for the flexibility due to constantly shifting complex needs of each child and family. Leaders prioritised staffing for all end of life care and would call upon staff across the service to provide support. Staff shortages, for example due to sickness, meant visits or respite stays were rearranged with families.

Managers carried out regular recruitment campaigns to encourage staff to work at the hospice. Managers told us they had carried out recruitment open days to improve staffing levels however continued to find it difficult to recruit despite initiatives.

The managers could adjust staffing levels daily according to the needs of children and young people. Daily huddles were held with staff on the unit to discuss staffing levels and requirements for the care of children attending.

Good

Hospice services for children

Staffing was managed in a fluid and responsive way prioritising patient need. Nurses would be reallocated depending on increased demand for end-of-life care or symptom management in the community. Staff would be prioritised for an end-of-life child who required admission to the inpatient unit.

The main children's unit was opened weekends for short breaks and closed overnight Monday to Thursday. Staff told us this was what children and young people and their families preferred. Long day care and play services continued 9 am until 7 pm throughout the week. However, hospital transfers, compassionate extubating or end of life admission meant the unit remained open. The meadow suite, which was used after death, remained open.

Every morning there was a meeting which managed capacity and demand. Senior nurses and associate directors reviewed complexity, dependency, referrals, numbers in community, outpatients, and bed occupancy. Staffing needs were managed as a dynamic process.

The number of nurses and healthcare assistants did not always match planned numbers. We looked at staffing data and saw that from September 2022 to October 2023 actual staffing numbers did not match planned numbers. There had been increases to establishment due to increase in need for senior palliative children's nurses and the introduction of a further transition lead post based upon the success of the first. September 2022 planned for 29.5 staff to October 2023 where establishment had increased to 32.5 however remained on average across the previous 12-month period at around 27 staff. Staffing had been noted on the risk register and was consistently discussed as an ongoing risk in various meetings, for example, the audit and risk committee.

The service used regular bank staff who were familiar with the environment and families who visited the unit.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training, and experience to keep children and young people safe from avoidable harm and to provide the right care and treatment.

Staff could access 24/7 on call medical staff and advice. The service could access advice through contacting the child's GP or could liaise with paediatricians and their teams through an agreement with a local hospital.

A specialist paediatric palliative doctor, a paediatric speciality doctor and five adult palliative medicine doctors provided medical cover for the paediatric inpatient unit and for patients who used the facilities during the day. These doctors were available for reviewing patients, paediatric prescribing, and advice. The service had a standard operating procedure in place for specialist paediatric medical cover.

The service had working agreements with the East of England Managed Clinical Network and Regional Assessment and Facilitation team for children requiring palliative care services living within the geographical area of Bedfordshire and all of Hertfordshire.

The service had working agreements with specialist children's hospitals palliative care services. The specialist hospital team led on the end of life care for all children and young people with a cancer diagnosis who were treated at NHS hospitals regardless of where they lived or the setting in which the child received end of life care.

Records

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

Patient notes were comprehensive, and all staff could access them easily. We looked at six securely held children and young people electronic records and saw they were completed with all necessary information. There were alerts for allergies, the voice of the child was evidenced and family's views recorded. For example, one child told staff they did not like being left alone and the mum's views was recorded in relation to what their child was frightened of.

Staff accessed patient records and updated those records using service issued laptops. Using electronic records meant staff could access patient information while they were in the hospital or visiting children and young people in the community.

When children and young people transferred to a new team, there were no delays in staff accessing their records. Services who also used the shared electronic record system, for example, GP's and hospitals could find the most up to date patient information.

Records were stored securely. All electronic records were accessible only to those with codes, passwords, and approval. Staff told us that only relevant patient information was shared with those who needed to access it.

Medicines

Staff followed safe systems and processes for administration and recording of administration of medicines. However, we found areas for improvement in the service's systems and processes for medicines reconciliation and accountability of controlled drug stationary.

Staff did not always follow safe systems with regards to the stock management of controlled drug stationaries, such as FP10s, used for the prescribing of controlled drugs, to ensure a trackable accountability of stock as per national guideline. At the time of our inspection, staff were putting a new system in place for tracking of FP10s, however this was not yet fully embedded.

The service had systems and processes in place to safely prescribe, and administer medicines, including complex medicines administered via a syringe driver. A syringe driver enabled medicines to be given via a small portable battery-operated pump and supplied a continuous dose of medicine.

Medicines, including controlled drugs (CD) and medical gases were stored safely and securely. Controlled drugs are "Drugs that are subject to high levels of regulation as a result of government decisions about those drugs that are especially addictive and harmful."

There was a Controlled Drug (CD) accountable officer (AO) who had legal responsibility to ensure that controlled drugs were kept secure and safely managed. We found controlled drugs were managed safely. The AO engaged in local meetings and submitted reports to the controlled drugs local intelligence network (CDLIN). The AO worked with partners, included local NHS trusts and the Police within the network to share good practice and learning from incidents.

We looked at paediatric patients who were coming in for day care whose prescriptions were already written, however we did not see any records of previous medicines reconciliation. Medicines reconciliation is the process where staff check that patients have the correct medicines when they are admitted or moved between services. In review of the three medicine charts, they showed that patients received their medicines as prescribed. Doctors followed the hospice's prescribing policy when writing on charts to minimise the risk of misunderstandings.

Staff checked ambient room temperature and refrigerator temperatures daily.

Good

Hospice services for children

Staff used an up-to-date medicines policies and procedures covering various aspects of medicines management. Medicines were ordered from the local pharmacy. Nurses could obtain medicines seven days per week as needed. There was no regular clinical pharmacist input for the service, however there was an opportunity for staff to contact a pharmacist for ad hoc advice. Staff told us that they were in the process of securing regular clinical pharmacy support. Following our inspection, the service provided evidence there was a new contract in place for regular clinical pharmacy input.

Incidents

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

Staff knew what incidents to report and how to report them. Staff were encouraged to report incidents. We reviewed incident data between October 2022 to September 2023 and saw four child related incidents. Staff recorded the incidents along with learning. For example, one incident related to an incorrect on-call doctor's rota leading to a delay in a family seeking medical advice. The learning was shared with the team.

There was a governance team who identified themes and learning from incidents which was shared in several ways. Learning from incidents was shared at huddles, in one-to-one meetings, at team meetings and through an in-house newsletter. Staff used an electronic reporting system which was overseen by managers for themes and learning.

Staff were introduced to a new Patient Safety Incident Response Framework (PSIRF). The new framework was a more flexible approach involving staff and focusing on improvements.

Staff reported serious incidents clearly and in line with the service's policy. Managers reviewed incidents quickly for safety. Incidents were shared at clinical safety assurance and clinical effectiveness groups. Staff used the learning to improve processes, update policy and develop training.

Staff understood the duty of candour. They understood the need to be open and transparent and gave children and young people and families a full explanation if things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. We saw incident information was gathered, recorded, and shared using various platforms which included online access to learning and themes or face to face discussions.

Staff met to discuss the feedback and look at improvements to patient care. Staff shared feedback in a variety of meetings and handovers.

Is the service effective?

Good

It is the first time we have inspected the children and young people element of the hospice separately. We rated effective as good.

Good

Hospice services for children

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies were based on national guidance such as Together for Short Lives and the Royal College of Nursing. All policies were accessible to staff; available online, reviewed, had version control and were in date.

Staff worked closely with other health and social care providers to provide wraparound and holistic care. Staff used a shared electronic care record system. For example, information recorded could be shared with the children's GP, physiotherapist, occupational therapist and speech and language therapist.

Staff worked closely with specialist children's hospitals. Staff carried out joint visits with hospital staff to offer continuation of care for children, and young people when they moved between the hospital and the hospice. Staff documented the joint working and joint home visits with hospital staff in care records.

The service employed a transition team to support young people moving to adult care. Transition staff worked jointly with staff across four local authorities. Transition packs were given to each family. There was a transition policy. Staff, families, and other professionals attended quarterly social groups, online evening workshops; topics for discussion were developed with families in transition or who had already transitioned. Staff attended a quarterly hospice transition network and young people delivered presentations to help professionals understand what young people want.

Qualified staff provided evidence based holistic and creative therapies such as music therapy, art therapy and play therapy.

Nutrition and hydration

Staff gave children and young people enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service adjusted for children and young people' religious, cultural and other needs.

Staff made sure children and young people had enough to eat and drink, particularly those with specialist nutrition and hydration needs. Staff worked alongside key professionals to support children and young people specific needs, for example working with a dietician and speech and language therapists.

Staff took a comprehensive approach to assessing and delivering nutritional and hydration needs, reflecting cultural and religious requirements. There were examples of this throughout the hospice. Restaurant staff marked religious festivals throughout the year, however they also offered alternatives and options for people if it was indicated in their personalised care plans or requested.

Pain relief

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

Staff assessed children and young peoples' pain using a recognised tool and gave pain relief in line with individual needs and best practice. We observed staff discuss and record pain relief in meetings and care records. Staff discussed pain relief daily and documented discussions with relatives.

Children and young people received pain relief soon after requesting it. Staff recorded pain relief needs and worked with other professional partners to support the needs of each individual.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements to care and treatment provided to children and young people.

The service participated in relevant national clinical audits. Staff attended an audit and risk committee to identify areas for improvement. Staff provided us with minutes from the meetings over a three-month period. Audit plans for 2023/24 had been formally approved by the committee. Staff discussed highlights from the previous quarter. Areas of concern from audits were discussed, for example, medication audits found an increase in medications incidents with low level harm identified and action points indicated.

Staff attended paediatric palliative care meetings to discuss children and young people's diagnosis and planning for their needs.

Staff worked with families, children and young people to agree expectations at the point of referral and reviewed them at regular intervals. Staff recorded discussions in relation to expectations and staff measured outcomes against these expectations. Examples of outcome measures included, emotional support to relatives, including siblings or provide respite for families.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of children and young people. Staff were trained and provided continuing care to children and young people in an inpatient and community setting.

Managers gave all new staff a full induction tailored to their role when they started work. One new member of staff had spent time being inducted to community and inpatient services.

Managers completed annual appraisals for staff. Data provided demonstrated 95% appraisals were completed. Staff and managers identified training needs through appraisals and opportunities to develop skills and knowledge. Staff attended external events such as training events and national conferences.

Volunteers were recruited, trained and supported to work with the needs of children, young people and their families. Volunteers told us they were supported in their role and had clearly defined roles in working with children and their families.

Clinical educators supported the learning and development needs of staff. The Clinical development nurse was responsible for providing clinical leadership and development to the adult and children service nursing staff in partnership with leaders, head of care and the medical team.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Managers held meetings online to improve accessibility and recorded meetings for those who could not attend. Minutes were shared using email and hard copies were made available for staff who preferred hard copy documents.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff training needs were agreed in appraisal meetings and additional training was provided throughout the year if a training need was identified.

Managers made sure staff received any specialist training for their role. For example, nurses received medicine training and had their competency to administer medicines correctly using a syringe driver.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss children and young people and improve their care. Staff worked regularly with professional staff, for example, family link nurses and clinical staff such as hospice doctors attended internal and external multidisciplinary meetings.

Staff worked across health care disciplines and with other services including social services and other charities when required to care for children, young people and their families. Each family had access to an emergency contact number to provide instant guidance and support.

Staff collaborating across teams to join up care for people who used the services. For example, the transition team helped create a collaborative approach to ensuring a smooth process at every stage, including movement across services and at point of discharge.

Seven-day services

Key services were available seven days a week to support timely patient care. End of life care was provided when and where required.

Clinical support from doctors was available 24 hours a day, 7 days a week. The service was able to access medicines through their pharmacy contract 24 hours a day, 7 days a week. End of life care provided by the service was provided as and when required. Short break stays were booked in advance with coordination between the families and service to provide care when best suited the family and spaces were available.

The service provided an on-call telephone access 24/7 for advice or urgent referrals and home visits as needed.

Health promotion

Staff gave children and young people practical support to help them live well until they died.

The service had relevant information promoting healthy lifestyles and support on the unit.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. All care records we looked at had included a review of dental care, immunisations, and links to other health care professionals.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported children and young people to make informed decisions about their care and treatment. They followed national guidance to gain children and young people' consent. They knew how to support children and young people who lacked capacity to make their own decisions or were experiencing mental ill health.

Good

Hospice services for children

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff were up to date with consent training and understood Gillick Competency

Staff gained consent for care and treatment in line with legislation and guidance. Staff provided families with Mental Capacity information based on My Adult Still My Child, a collaboration between Together for Short Lives, other partners and East Midlands parents. The initiative supported parents caring for young people who could not make some decisions for themselves.

When children and young people could not give consent, staff made decisions in their best interest, considering all involved people's wishes, culture and traditions. Staff documented children and young people's voices and that of their families in their care records. Staff clearly documented do not resuscitate in care records which included the wishes of the children and their families.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

Staff supported children, young people, and their families to make advanced decisions about their care involving all key people. Staff documented discussions in all records we looked at about family members preferences in relation to do not attempt cardiopulmonary resuscitations and the preferred place of death. Where there were disagreements, staff recorded this in care records, and worked with children and their families and other partner agencies to try to resolve the disagreements.

Is the service caring?

Good

It is the first time we have inspected the children and young people element of the hospice separately. We rated caring as good.

Compassionate care

Staff treated children and young people with exceptional compassion and kindness. All people who used the services were truly respected and valued as individuals and empowered as partners in their care.

Staff were discreet and responsive when caring for children and young people. Staff took time to interact with children and young people and those close to them in a respectful and considerate way. Staff were incredibly considerate to those with additional needs including learning and physical disabilities. Staff at all levels were observed to be caring and respectful to all. Children interacted with staff who spent time with them, demonstrating happiness, laughter and fun.

Families told us staff were 'incredible' and 'often going over and above when supporting them with their children.' Staff gave families confidence to care for their children and they felt safe leaving them to take time for themselves. Staff provided respite care and families told us that they were encouraged to take time for themselves, and staff were flexible in when and where they provided respite care.

Good

Hospice services for children

Families of children and young people said staff treated them well and with kindness. Families described staff as having an attitude of 'nothing was too much trouble.' One relative told us that staff volunteered to visit their child at home when they were discharged from a long stay at hospital. This was in response to the relative describing feeling exhausted. The relative expressed gratitude for the unexpected offer of respite at a challenging time.

Families told us that because of the service, they had time for themselves to carry out chores or take rest time and replenish their energy stores. Families shared examples of staff providing support in sourcing additional equipment. We observed a group event at the hospice where we saw staff giving children one to one attention, singing songs, playing games and demonstrating compassionate care.

Staff followed policy to keep patient care and treatment confidential. Staff were discreet when discussing patient information. We observed doors being closed to maintain dignity and afford a private space to maintain patient confidentiality.

Staff understood and respected the personal, cultural, social and religious needs of children and young people and how they may relate to care needs. Staff gave us examples of appreciating the needs of the diverse population they serviced. There were cultural and religious celebrations on display in the hospice. Staff told us of how they respected and facilitated differences in cultures and religions in dealing with death and end of life ceremonies. For example, facilitating religious customs of families who ritually washed and draped their child before burial.

Emotional support

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

Staff gave children and young people and those close to them help, emotional support and advice when they needed it. In addition to staff directly supporting families, the service offered a supportive care team who were available Monday to Friday from 9 am until 5 pm. Staff documented in care records when parents were low in mood and told us they did this so they could offer additional support if appropriate. Support groups were also available outside of normal working hours. The supportive care team offered groups, including separate groups for mums and dads. There was a group pre and post bereavement and a chaplain and volunteer spiritual support team who were available when required. The nursing teams could also access support.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. People who used the service left lasting memories of their loved ones after death throughout the hospice. There were memorials around the hospice to those who had used the service.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff and families worked together to develop innovative ways to promote wellbeing for all members of the wider family. The service offered creative classes, music sessions for families and the children and young people. Relaxation sessions were offered to parents and groups to meet and share experiences. One relative told us about the benefits of being together with other families to provide emotional support. We were also told of social media groups where families offered support to each other. Families told us how valuable it was to link with other families to reduce feelings of isolation.

Staff understood and respected the personal, cultural, social, and religious needs of children, young people, and their families and how they may relate to care needs. Families had access to a multifaith room which catered to all faiths. Local religious leaders engaged with staff and families to offer religious support if requested.

Staff encouraged families to personalise bedrooms with familiar and preferred items. The bereavement suite was a comfortable area which could be adapted to reflect the children's personalities. The bereavement suite was where families could stay with their child after they had died. Families gave examples of staff offering support when they were at the most distressed and vulnerable. We were told of numerous occasions where staff visited families in hospital when their child was acutely unwell, often at short notice.

Staff worked with families including children about what would increase their wellbeing and provide moments of happiness. Staff went out of their way to make the children's wishes come true. One young person had a birthday party where staff arranged a rapper to attend.

Understanding and involvement of children and young people and those close to them

Staff supported and involved children and young people, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure children, young people and those close to them understood their care and treatment. Staff took time to give information about what to expect from care and treatment. There were leaflets given to them to help with expectations of care and treatment. There were teams, for example, transition teams who provided support and detail in relation to transition from the service. Support staff, including bereavement counsellors, art and music therapists, young people and their families to understand their care and treatment in creative and comforting ways.

Staff talked with children and young people, families and carers in a way they could understand, using communication aids where necessary. Staff used a variety of communication tools, including an innovative and technologically advanced eye gaze-enable speech generating device for people who were not able to communicate verbally. Staff used toys and music to communicate with nonverbal children. In care records we reviewed, there were clear details of the children's preferred method of communication, including details of verbal and nonverbal cues for the staff, which highlighted how the child was feeling at the time.

Children and young people and their families could give feedback on the service and their treatment and staff supported them to do this. There were numerous ways for people to leave feedback. There were accessible hard copy feedback forms, and verbal and electronic options to feedback in relation to care and support.

Staff encouraged people to complete feedback. For example, a bereavement survey at the end of a support intervention, either pre or post bereaved. People who used the service where offered a QR code or link to the user feedback survey. We saw QR codes visibly accessible around the hospice and options to complete paper form feedback.

Staff provided us with numerous examples of how they used patient feedback to improve daily practice. For example, one person suggested it would be good to be offered flexibility in where relatives would meet. Staff recognised that entering the hospice might hold difficult memories and as such they arranged future meetings at a different location. Staff set up specific groups that were requested by relatives. For example, there was a request for a dad's group and an equivalent mums' group where relatives could share issues specific to them as a group.

Good

Hospice services for children

Is the service responsive?

Good

It is the first time we have inspected the children and young people element of the hospice separately. We rated responsive as good.

Service delivery to meet the needs of local people

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

Managers planned and organised services so they met the needs of the local population. Staff followed a RAG (Red, Amber, Green) rating system to plan and respond to referrals. Children and young people rated as red would be assessed immediately and a plan of care agreed. Children and young people identified as amber would be assessed within 48 hours and a plan of care agreed. Children and young people identified as green would be discussed at the next weekly multi-disciplinary meeting and a home assessment planned at a convenient time for the family.

Staff provided a range of therapies and creatives ways of working with children, young people and their families. Several therapies and creative interventions were offered to children, young people and their families. A bereavement service was available to support the whole family before and after death for as long as needed.

Staff worked flexibly to meet the needs of families who needed it most. Staff offered day and overnight respite care with space for families to stay as well. Priority was given to those families with the greatest needs. Families we spoke with told us they appreciated the limitations of the service and the flexibility. Families and staff negotiated arrangements that best suited individual family's needs.

Facilities and premises were appropriate for the services being delivered. Families had access to a large pool for hydrotherapy. There was a well-equipped sensory room. There was a music room and a music therapist employed to work directly with the whole family, including brothers and sisters, to explore and express feelings. The music therapist took the service to schools and patient's homes as well as an acoustically appropriate room at the hospice. The therapist carried out song writing sessions, making memories in the form of music recordings, or simply taking time to listen to music. The music therapist was British Association of Music therapy accredited.

Trained complementary therapists were employed to provide treatment to children, young people and their families. They offered infant massage to aid sleep, reduce pain and help children feel less anxious. The treatments were offered in a therapy room or at the bedside. There were trained and accredited art therapists offering expressions through art.

Families could use a playroom that was accessible to children of all needs. All areas were accessible with wheelchair access. Children and young people could use the service's vibrant and fun moulded specialist wheelchairs for improved accessibility and comfort. The service had a wheelchair friendly play area and access path to a sensory garden. The design of the building had been completed with input from users of the service, including a room for young people which was themed more appropriately for their age.

All people using the service could access specific areas, such as the bereavement suite avoiding the main areas. There were garden entrances and exits which meant families could avoid going through the hospice.

Staff understood the local populations complex needs. For example, due the high incidence of consanguineous (related by blood) in families in the area, a speaker was invited to attend the children's service care team meeting to present on the topic. This helped facilitate discussion and raising awareness in the team.

Meeting people's individual needs

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

Staff understood the diverse population they served. Staff also considered groups who were underrepresented. Faith groups were considered, and a community Iman was employed to encourage inclusion and accessibility. Staff facilitated ways of compassionately caring for people of different faiths at the end of life. Staff described their understanding of different traditions in relation to faith and caring for the loss of loved ones.

Staff understood and applied the policy on meeting the information and communication needs of children and young people with a disability or sensory loss. Staff used specialist sensory tools and equipment, there was a sensory room, there were staff qualified to be creative in the way they worked with people's sensory needs. For example, art and music therapy offered one to one or in groups for those with additional needs.

The service had information leaflets available in languages spoken by the children and young people and local community. This included providing translation support for advanced care planning to those with English as a second language.

Managers made sure staff, and children and young people, loved ones and carers could get help from interpreters or signers when needed. Staff gave us examples of co-ordination of initial meeting to support a refugee family where sign language in their language was used to communicate. Staff accessed a sign language translator from a local authority sensory team. The community care officer was able to translate to British Sign Language and via an interpreter they were able to converse.

Staff explained the role of palliative care services and signposted for additional social and financial support. Staff offered continued support to advocate for families, including highlighting their communication needs.

Children and young people were given a choice of food and drink to meet their cultural and religious preferences. Staff celebrated traditions and religious festivals with people who used the service. There were celebrations for Eid and Diwali. The canteen offered foods in celebration to those festivals. There was recognition of black history month, LGBTQ+, engagement group with staff from diverse backgrounds to make it feel like it is a place to work for everybody. Staff told us they aimed to encourage diversity to be representative of the local community.

A Community Outreach Worker was employed to engage with families of children with life limiting or life-threatening conditions, in particular families in Black, Asian and ethnic minority communities. Staff encouraged working with hard-to-reach communities, the underserved communities and those who may find it more challenging to access children's palliative care services. In addition, the service made changes to make Muslim patients more comfortable using hospice services. For example, the service ensured they had appropriate prayer and reflective facilities, do not disturb and 'I am praying' door signs, offering training for staff, and gift boxes for Muslim patients with items they might require such as head scarves and prayer mats.

Good

Hospice services for children

A Keech nurse and palliative care support worker were supported by the community outreach worker. These staff hosted a stall at an event in a local park where families could attend to meet local staff and learn about services. Activities were provided aimed at children of families meeting the cultural and social background criteria.

Access and flow

The specialist palliative care service operated a flexible model of care to help achieve people's preferred place of care and death. Waiting times were within agreed timescales and national targets.

Managers monitored waiting times and made sure children and young people could access services when needed and received treatment within agreed timeframes and national targets. Staff followed the RAG system to ensure children and young people were assessed and their plan of care started within agreed timeframes to avoid any unnecessary wait times. There were 393 children on the service caseload from October 2022 to September 2023. There had been 64 children using the inpatient facilities with the average length of stay being two nights. Most of the stays in the 12-month period was for short stays.

Children's outpatient care and play services from October 2022 to September 2023 saw 884 attendances making up most of the time spent at the service. The activities were mostly play activity, with some special play and sibling support.

Children's community care and families supported in the community saw 3103 community visits by staff. The visits were recorded as clinical interventions symptom control, end of life, psycho-social, multidisciplinary visits and assessment and care planning. Patient's homes were visited 931 times in the previous 12 months, hospital visits were 330, five school visits and 1673 hospice visits, 164 visits were described as 'other'.

Staff recorded calls as contacts when they were over 15 minutes by phone. Staff also recorded doctors' community visits as 40 in the previous 12 months.

Staff supported young people when they were referred or transferred between services. For example, when transitioning into adult services.

Managers monitored patient transfers and followed national standards.

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 children and young people in the investigation of their complaint.

Children and young people, relatives and carers knew how to complain or raise concerns. There had been no complaints for children's services in the previous 12 months. However, we did see five complaints dealt with appropriately for adult services by staff.

The service clearly displayed information about how to raise a concern in patient areas. Leaders told us they try to have open and transparent culture. Staff are encouraged to promote complaints and concerns and were open to learning from concerns.

Staff understood the policy on complaints and knew how to handle them. Staff could describe the process for complaints. Managers were responsible for investigating complaints and identified themes. Complaints and concerns

Good

Hospice services for children

were shared using various platforms, for example, in handovers directly or online with staff, in emails and bulletins. One family member shared with us that some of the parents were concerned about celebrating Halloween because of religious considerations. Staff reframed the festivity to be more inclusive by renaming and focussing on the autumnal aspects. We were told the celebration of autumn was in good spirit and enjoyed by the people who used the service.

Is the service well-led?

Good

It is the first time we have inspected the children and young people element of the hospice separately. We rated well-led 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 were visible and approachable in the service for children and young people and staff. They supported staff to develop their skills and take on more senior roles.

See information under this sub-heading in the adult hospice section.

The children and young people's leadership team demonstrated experience and capability to deliver high quality care. Staff were encouraged to progress to leadership roles and were supported in developing their leadership skills. The leadership team were accessible and there were leadership support networks across the service for escalation and support purposes.

Vision and Strategy

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

See information under this sub-heading in the adult hospice section.

Staff provided us with a vision of the service offered to children and young people. Their plans clearly aligned with the plans of the wider health and social care economy. Staff were integrated in their vision of providing joined up, personalised and person-centred system wide care.

Culture

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

See information under this sub-heading in the adult hospice section.

Good

Hospice services for children

Staff were proud to work at the service. Their focus was clearly on the needs of the people they worked with. Staff were encouraged to be innovative, creative and go over and above to support children, young people and their families. Staff spoke of being inclusive and being considered in working with the diverse needs of the people they supported.

Staff voiced a strong commitment to collaborative working, both locally and with external partners to benefit everyone's experience.

Governance

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

See information under this sub-heading in the adult hospice section.

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. However, the audit programme had some audits which were not done frequently enough to ensure action plans were making improvements.

See information under this sub-heading in the adult hospice section.

Information Management

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

See information under this sub-heading in the adult hospice section.

Engagement

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

See information under this sub-heading in the adult hospice section.

Leaders developed a youth voice project in partnership with a local youth engagement team. A local Healthwatch team attended the service with a group of young people to complete a review of the facilities. The review resulted in improvements which included a children outside space and play area and to the development of a youth trustee role.

Staff worked with other local providers to support children and young people. The service had a research partnership with a local university which organised three experts by experience workshops. Staff acted on feedback, for example the recruitment of a community connector for the south Asian community.

Good

Hospice services for children

Learning, continuous improvement and innovation

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

See information under this sub-heading in the adult hospice section.

The hospice was committed to learning to improve their approach and understanding of palliative and end of life care. The hospice's clinical education team delivered training on palliative and end of life care courses both to their own staff and volunteers but also to other organisations and professionals. The service supported clinical student placements across the specialist care services from various disciplines, including pre-registration adult and children's nursing, paramedic science and social work.

Managers supported staff to improve services. At the time of our inspection, the service did not have a children's occupational therapy service. Managers supported therapy staff to meet with other hospice providers on how they might be able to adapt their services to be able to provide additional therapy services at Keech Hospice Care.

Staff were committed to the service's values, vision and strategy, including to improve services for all patients. Staff fundraised with the local community to procure resources needed to spend valuable time together at or near children and young people's end of life.