Garden House Hospice Care

# Garden House Hospice

**Inspection report**

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

## Ratings

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

# Summary of findings

## Overall summary

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

- The service had enough staff to care for patients and keep them safe. Staff had 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. They managed medicines well. 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 seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could 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:

- Managers did not always ensure that actions from patient safety alerts were implemented and monitored.
- The service used systems and processes to safely prescribe, administer, record and store medicines, but there were improvements that could be made.

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| **Hospice services for adults** | Good  | Our rating of this service stayed the same. We rated it as good because:<br>Refer to the overall summary above. |

# Summary of findings

## Contents

# Summary of this inspection

## Background to Garden House Hospice

Garden House Hospice is registered to provide diagnostic and screening procedures, personal care, and treatment of disease, disorder and injury. At the time of the inspection there was an application in progress for the Chief Executive Officer (CEO) to become the Registered Manager.

The service was last inspected in March 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 North Hertfordshire, Stevenage and parts of Central Bedfordshire and Cambridgeshire. There is an inpatient unit that could care for up to 12 patients, but was currently able to provide six beds. There were two inpatients at the time of the inspection. The service also provided day services which included rehabilitation, wellbeing and outpatient appointments, and community services in the form of Hospice at Home. There were family services that provided emotional, psychological and practical support to families and friends. The service offered support for children and young people who were bereaved or lived with an adult with a serious condition. In addition, the service ran a 24 hour palliative care advice line for patients, carers and healthcare professionals. There were a variety of staff employed at the service to deliver care, which included doctors, nurses, a pharmacist, a social worker, counsellors and therapists.

## How we carried out this inspection

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

## Outstanding practice

We found the following outstanding practice:

- The service collaborated on a variety of quality improvement initiatives and innovative approaches designed to address the needs of their region, as well as the sector in general, and to have a lasting effect on the way palliative and end of life care was delivered, and the equity with which it was delivered. For example, the service ran a frailty programme in care homes, a programme to provide palliative support for homeless people, a compassionate neighbours programme and a palliative heart failure service.

## Areas for improvement

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

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

- The service should ensure that staff have the appropriate level of safeguarding training for their role.
- The service should continue to maintain pace with the review of policies to ensure these are up to date with the latest guidance and recommendations.

# Summary of this inspection

- The service should ensure that all staff and volunteers have a disclosure and barring service (DBS) check.
- The service should ensure that all staff and volunteers have an induction.

# Our findings

## Overview of ratings

Our ratings for this location are:

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

Good

# Hospice services for adults

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

## Are Hospice services for adults safe?

Good

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

### Mandatory training

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

Staff employed by the service received and kept up-to-date with their mandatory training. The mandatory training was comprehensive and met the needs of patients and staff. The overall compliance for mandatory training completion was 94%. However, some of the individual modules had lower compliances, for example 79% for fire evacuation training, 89% for fire safety and 85% for information governance.

Clinical staff completed training on recognising and responding to patients living with learning disabilities and dementia. These subjects were not part of the service mandatory training programme but the East and North Herts Palliative and End of Life Education programme offered dementia training which was open to all staff. Staff completed Purple Star training in learning disabilities. We did not see staff completion records for these subjects therefore could not confirm completion rates. It was unclear what training staff received on mental health and autism.

Managers monitored mandatory training and alerted staff when they needed to update their training. The education department kept a record of staff training dates and when updates were due.

### 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.**

Nursing staff received training specific for their role on how to recognise and report abuse. Nursing staff received level two adults and children safeguarding annually.

Medical staff received training specific for their role on how to recognise and report abuse. Medical staff received level three adult and child safeguarding training annually.

There were two safeguarding leads at the service, one of which was the Trustee safeguarding lead. The service lead was trained to level four safeguarding for adults and level three for children. However, the Trustee lead was only trained to level one and planned to complete level two. There were also separate adult and children safeguarding champions. The adult champion was trained to level four safeguarding for both adults and children. It was unknown to what level the children's' champion was trained.

The Practice Development Lead had level three safeguarding for both adults and children and was booked to attend level four training, and the Schools & Colleges Coordinator had level three safeguarding for children.

Staff in trading, fundraising, HR and community engagement, finance, quality and gardening, and trustees, received adults and children safeguarding level one.

Compliance for safeguarding training for clinical staff for April 2021 to March 2022 was over 95%, which met the target of 95%. Compliance in safeguarding training for patient facing volunteers met the target of over 85% in all three month periods for the year April 2021 to March 2022.

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 were two safeguarding leads, and champions for adults and children. The incident reporting system also included a prompt about safeguarding for incidents reported.

The service monitored safeguarding incidents and we saw a safeguarding risk report for October 2021 to March 2022 which gave details of safeguarding incidents, reporting and outcomes.

Staff followed safe procedures for children visiting the ward.

We reviewed three online staff records and found that all included evidence of right to work, signed contract, DBS check and professional registration where appropriate. However, data we saw showed a DBS completion rate of 98% for employees and 90% for volunteers.

### Cleanliness, infection control and hygiene

**Staff used infection control measures on the ward and when transporting patients after death.**

Ward areas were clean and had suitable furnishings which were clean and well-maintained. The areas we saw were visibly clean.

The service generally performed well for cleanliness. We saw the results of fifteen Hospice UK infection prevention and control (IPC) audits, 10 of which showed 100% compliance, and five of which showed compliance ranging from 83.9% to 99.3%. The service audited hand hygiene for community, day and inpatient services. We saw the monthly audits for this for January to April 2022. Community and day services showed 100% compliance for all four months, and inpatient services showed 100% compliance for January and February 2022, and 98% and 99% for March and April 2022 respectively. The service had no incidents of patients contracting Clostridioides difficile (*C.difficile)* or blood stream infections or acquiring MRSA over the last 12 months.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE). There was PPE, hand gel, disinfectant wipes and masks available around the building, and the receptionist checked our lateral flow test results on arrival.

The service carried out a monthly PPE and isolation audit for the inpatient service. This showed compliance of 98% for January and February 2022, and 100% and 95% for March and April 2022 respectively.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw clean confirmation stickers on equipment showing the date of the last clean.

The cold body storage area was listed on a daily cleaning schedule but was not always cleaned on a daily basis on the weekly cleaning records. The most recent deep clean for this area was February 2022.

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

The design of the environment followed national guidance. The unit was accessed through a private entrance within the hospital grounds and the reception area was staffed throughout the day. Visitors signed in and wore visitor badges when on the unit.

Staff carried out daily safety checks of specialist equipment. This included daily checks of emergency equipment, including the defibrillator and suction. There were no expired items found during the inspection. We saw service and maintenance agreements for medical and other equipment.

The service had suitable facilities to meet the needs of patients' families. This included a wide range of seating, a hoist and standing aids for safe moving and handling of patients requiring assistance and medical infusion pumps.

There were policies and procedures for monitoring and managing cold body storage temperatures, including a procedure to follow if temperatures were out of range.

The service had enough suitable equipment to help them to safely care for patients. PPE was available. The equipment we saw had been portable appliance tested (PAT) and testing was in date. The service had a PAT testing schedule for 2022.

Staff disposed of clinical waste safely. The waste bins we saw were clean and had foot operated lids in working order. They were colour coded for the category of waste. There was a designated storage area with waste bins for waste bags awaiting collection and this was only accessible through locked doors. Waste bags were then moved from this area into locked containers further from the building for removal from the site. We saw a service agreement with a commercial healthcare waste management company dated May 2022 and evidence of collection of waste by this company.

### 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.**

Staff completed risk assessments for each patient on admission using a recognised tool, and reviewed this regularly, including after any incident. Staff completed risk assessments for patients. There were two patients on the ward at the time of the inspection. We reviewed the record of one inpatient, which showed that a moving and handling score had been completed. We reviewed the record of a previous inpatient, which showed that Waterlow (skin assessment) score and falls risk assessment had been completed. Staff used care plans to identify and manage patient needs and changes in needs.

The service held a multidisciplinary team (MDT) meeting where the individual needs of each inpatient were discussed. This involved consideration of a broad range of needs, such as symptoms and efficacy of treatments, capacity, mobility, spirituality, delirium screening, relatives, discharge planning and so on.

Staff knew about and dealt with any specific risk issues. We saw four patient records. We saw evidence of falls risk assessments and Waterlow scores. Individual needs were identified and discussed at the MDT meetings.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). The service had access to the mental health crisis team.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. The service employed a social worker and provided counselling sessions. We observed staff discussing the psychological and mental health needs of patients at the MDT and at handover between staff on the inpatient unit.

Staff shared key information to keep patients safe when handing over their care to others. We observed the handover on the inpatient unit.

### Nurse staffing

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

The service had enough nursing and support staff to keep patients safe. The service had reduced the number of inpatient beds from 12 to six, which was in line with current staff numbers.

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.

The number of nurses and healthcare assistants matched the planned numbers. We saw the data for planned versus actual staffing levels for the last three months before the inspection. This showed that actual levels either matched planned levels or were close to planned levels on the majority of days. Where planned levels were not met, this was most often due to staff sickness.

We did not see data for vacancy rates. The service advised the vacancy rate for clinical staff was 8.2 on the day of inspection. When we spoke with staff from Human Resources, they reported they had just appointed three people to seven of their care vacancies.

There was no trend in clinical staff turnover rates. We saw staff turnover data for clinical staff from April 2021 to March 2022. This was not broken down into types of clinical staff. This was 6.62% for January to March 2022.

Managers limited their use of bank and agency staff and requested staff familiar with the service. It was procedure for the service to use one agency to try to ensure the consistency of staff working at the service. Where possible the service would try to use the same agency nursing staff.

Managers told us they gave bank and agency staff a full induction and made sure they understood the service. It was procedure for all bank workers to attend mandatory training, complete e-learning and medicines competencies, attend the medicines management course, and complete supernumerary shifts.Bank workers were also encouraged to attend the service education days and additional training.

Regular agency workers were given an induction and required to complete the service's in house medicines management training. It was procedure for bank and agency staff to work alongside a regular member of staff and to not be in charge of a shift.

### 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 medical team was made up of two GP trainees, one specialty doctor, a specialist registrar, bank doctors and two consultants.

The medical staff matched the planned number. We saw data for actual versus planned staffing levels for the last three months before the inspection. There were only four days during this period when actual staffing numbers were less than planned numbers, and on all occasions, this was only one staff member less than planned.

We did not see data for vacancy rates for medical staff. One of the two consultants was leaving the service. The service had a medical bank which was made up of doctors who were currently working, or who had previously worked at, the service, local GPs with a special interest in palliative care and a palliative care consultant.

There was no trend in clinical staff turnover rates. We saw staff turnover data for clinical staff from April 2021 to March 2022. This was not broken down into types of clinical staff. This was 6.62% for January to March 2022.

Managers made sure locums had a full induction to the service before they started work. The majority of bank doctors were doctors who were currently working, or who had previously worked at, the service, therefore had completed the service induction. Bank doctors with experience gained elsewhere underwent an individualised induction based on their needs. Bank doctors were required to complete the service mandatory training programme but may be able to demonstrate compliance with the mandatory training requirements through completion of training in other healthcare organisations.

The service always had a consultant on call during evenings and weekends. The service was part of the regional Hertfordshire specialist palliative care Consultant on call rota.

Good

# Hospice services for adults

## 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 relevant staff could access them easily. At the time of the inspection there were two patients on the inpatient unit. Medicines records were completed, and specific monitoring charts were in place, for example for glucose monitoring and patch (a mode of pain relief delivery) monitoring. The care plans we saw were comprehensive and accessible.

The service used a combination of paper and electronic records for patients.

When patients transferred to a new team, there were no delays in staff accessing their records. Staff could access patients' Summary Care records on admission, and as part of the medicine's reconciliation process, consent from the patient was sought to access GP records. Discharge documentation for medicines was provided.

Records were stored securely. Paper records were stored in a locked trolley and electronic records had appropriate staff access.

## Medicines

**The service used systems and processes to safely prescribe, administer, record and store medicines, but there were improvements that could be made.**

Staff followed systems and processes to prescribe and administer medicines safely. Medicines were supplied by a local Trust. A pharmacist visited the hospice twice a week to review prescription charts, complete medicines reconciliation, provide advice and ensure any medicines issues were addressed. Pharmacists were contactable the rest of the time and there was a system of using FP10 prescription from a local chemist to supply anything needed urgently. There was a system for recording the issue of FP10 prescriptions, but the provider would not be able to identify if any were to go missing. Following the inspection, the service introduced additional measures to address this. Medicines administration charts were currently undergoing redesign.

Emergency medicines were available should they be required although anaphylaxis kits were in a locked cupboard and not quickly accessible. The provider was aware that they needed relocating and were in a process of identifying a more suitable place for storage so they could be accessed more quickly. Following the inspection, the service placed the anaphylaxis kit over a cupboard in the locked clinical room and ensured all the staff were aware of the change of location.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. We could see that people were involved in conversations such as the prescribing of medicines to prevent blood clots and whether they wished this to be part of their care. Prescribing was clear, safe and appropriate to be able to respond to symptoms that patients may experience during their stay.

Patients received prompt and adequate pain relief and there was a pain assessment tool in use.

People receiving medicines by syringe pumps (medicines delivered through the skin) were regularly monitored and the syringe pumps were regularly checked to ensure they were in working order.

Staff completed medicines records accurately and kept them up-to-date.

Staff stored and managed all medicines and prescribing documents safely. The medicine policy was currently being reviewed.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Staff followed current national practice to check patients had the correct medicines. Ideally this should be completed within 72 hours to ensure that people's normal medicines are continued appropriately, of the two patient records reviewed only one had been seen by the pharmacist within this timescale. Following the inspection, the service advised that medicines reconciliation occurred twice weekly, and that they were planning to embed a medicines reconciliation template into the patient electronic record, with a time and date stamp to allow for audit. This would be reviewed regularly to ensure medicines reconciliation was completed in a timely fashion.

Medicines were prescribed off-label (where a medicine is used for a condition or purpose other than for which it has been approved) and occasionally unlicensed medicines were used within the hospice. This means the use of these medicines is not covered by the manufacturer. This prescribing was guided by standard practice within palliative care and there was a leaflet available to inform patients.

Staff did not always learn from safety alerts and incidents to improve practice. Staff told us they received feedback from any incidents they had raised. However, the service had not actioned an alert advising that people who took steroids were adequately informed and carried an alert card. This should have been done by May 2021. Following the inspection, the service looked into this and found that most nursing staff were aware of steroid cards. They planned to remind staff of steroid cards in the newsletter and in medicines training and consider adopting steroid alert cards.

Following an alert about the risk of using mouth care swabs posing a choking hazard, the Royal College of Nurses (RCN) had issued best practice guidance which was not being followed. Following the inspection, the service discontinued the use of these mouth care swabs and introduced an alternative. They informed staff of the withdrawal of the old swabs and the new replacement. The provider worked closely with other hospices, the local NHS trust and the community to provide and update prescribing guidance including deprescribing.

The service conducted audits to assess compliance against the medicines policy including management of controlled Drugs. The service had identified that the controlled drugs audit was overdue but had actions in place to address this and a second medicines security audit was completed after our visit and an action plan drawn up. A Drugs and Therapeutics Committee reviewed incidents and medicine audits. A medicines matter newsletter was used to communicate with staff.

Medicines training was not mandatory but the staff we spoke with said they had done medicines training and their competency had been checked. They said the medicines induction training they had received was good.

There was clear guidance in place to allow patients visiting the day hospice to continue to administer their own medicines. There was also a provision for doctors to prescribe patients medicines and nurses to administer. Arrangements could be made for the community nursing team to administer medicines via a syringe pump whilst at the day hospice. The policy still referenced Nursing and Midwifery Council (NMC) medicines management standards that had been withdrawn in 2019.

Good

# Hospice services for adults

## 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. However, managers did not always ensure that actions from patient safety alerts were implemented and monitored.**

Staff knew what incidents to report and how to report them. The service used a specific incident reporting system. Staff received training on how to use the reporting system as part of their induction.

Staff raised concerns and reported incidents and near misses in line with the service's policy. Staff we spoke with reported they were encouraged and supported to report incidents and initiate the learning process so that improvements to the service could be made. There had been 283 clinical incidents reported for the year April 2021 to March 2022.

The service had no never events on any wards.

Staff reported serious incidents clearly and in line with the service's policy. There had been one serious incident in the year April 2021 to March 2022, reported in June 2021, and none in the previous year. The serious incident was a patient fall resulting in a fracture. The service investigated the incident and found that the necessary risk assessments and actions had been put in place. Documentation showed that the serious incident occurring in June 2021 would be shared with staff in the Learning Lessons Bulletin and the fortnightly inpatient unit newsletter. The incident reporting system included prompts about whether an incident was a serious incident or not, and definitions of risk categories.

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. The service had a duty of candour policy. The incident reporting system prompted staff about duty of candour when reporting incidents. Documentation stated that the service had met with the family and provided a duty of candour apology letter in the case of the serious incident occurring in June 2021. A duty of candour audit in April 2022 showed that a record of a written apology was found in 100% of cases requiring it, and a verbal apology had been recorded in 91% of cases requiring this. This represented a significant improvement on previous audit results.

Staff received feedback from investigation of incidents. The service held weekly incident meetings which were attended by staff in leadership roles. The service was considering changing the time of this meeting to enable other staff to attend. We saw evidence of the discussion of incidents in other team meeting minutes, such as the community team meetings. A 'must read' folder was placed on the inpatient unit containing details of incidents which staff were required to read and sign to confirm reading. We saw that the signing sheet was completed. The incident reporting system also gave prompts about whether learning should be shared with other parts of the service, such as Hospice At Home. The monthly inpatient (IPU) newsletter contained information on incidents. Staff we spoke with reported that all staff involved were informed of the outcome of incident investigations either verbally or by email.

There was evidence that changes had been made as a result of feedback. For example, GP trainee prescribing errors had reduced by 50% due to changes to the induction programme.

Managers investigated incidents thoroughly. The incident reporting system emailed the relevant line manager when an incident was reported. The incidents policy allowed a period of four days for investigation.

Good

# Hospice services for adults

Managers did not always ensure that actions from patient safety alerts were implemented and monitored. The service had a system in place for processing and responding to safety alerts and recalls and recorded these on an alerts log. We saw the alerts log for November 2021 to April 2022. We saw an example of the plan of action distributed to staff in the case of a safety alert received in November 2021. However, we did not see the incorporation of safety alerts on steroid alert cards and mouth care devices (pink sponges) into practice. Following the inspection the service had addressed these alerts as described above in the medicines section.

## Are Hospice services for adults effective?

Good

Our rating of effective stayed the same. We rated it 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.**

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

The service had a clinical guideline resource which was available to all clinicians via the computer system. We saw a log of dates for when guidelines were published or last reviewed, and dates for when future reviews were due. None of the review due dates were overdue at the time of the inspection. The service was able to give examples of where they had developed clinical guidelines in response to needs arising.

The service also had paper copies of guidelines and policies in folders on the inpatient unit. We saw that some of these paper copies were out of date for review, this was escalated during our inspection and acted upon at the time to ensure all copies of policies were in date. We saw a master policy schedule which logged the issue date and review date for policies. This showed some policies were overdue for review, some of which were significantly overdue. In most cases, policies overdue for review were in the process of being reviewed, or awaiting sign off by, the Board of Trustees.

We saw that various care plans had been completed for different aspects of the individual patient's care needs, such as pain, sleep, personal care, pressure ulcers and mobility. We saw evidence of the use of Advance Care Plans which had been discussed with the patient and included decisions such as preferred place of care and preferred place of death, which were recorded and were also discussed at the MDT.

During our inspection we observed the use of the Outcome Assessment and Complexity Collaborative to identify a patient's phase of illness, and the Australian Karnofsky Performance Status to identify what level of assistance patients required with ordinary tasks. This meant that appropriate care could be put in place.

Treatment Escalation Plans (TEP) in case of a patient's condition deteriorating were used within the service. The plan we reviewed had been discussed with the patient and their relative as to what treatment they wanted in this situation. There was evidence of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) discussions with patients and their CPR status was recorded.

For patients who were in the last days and hours of life, the service used an Individualised Care Plan for the Dying person, which was based on the Five Priorities for the care of the dying person.

The service was planning to replace the DNACPR form with the ReSPECT document.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We attended the nursing staff handover on the inpatient unit and observed staff discussing the psychological and mental health needs of patients. We attended the multidisciplinary team (MDT) meeting and observed staff discussing the psychological, emotional and spiritual needs of patients and those close to them. We saw evidence of the use of Palliative Care Outcome Scales (IPOS) to identify patient concerns and symptoms.

### 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 had enough to eat and drink, particularly those with specialist nutrition and hydration needs. We saw evidence of the use of a Nutrition Communication and Assessment Tool completed by a patient, which identified needs around eating and swallowing for example, however this was not dated or signed by staff.

Medical staff reported an individualised approach to nutrition and hydration needs. This included artificial nutrition and hydration and the importance of conversations with relatives about this, and of review to monitor for adverse effects. Staff described a broad approach which considered aspects such as stimulating appetite and well presented food from the kitchen.

We saw evidence of oral care assessments. Staff used pink sponges for mouth care, however we did not see risk assessments for their safe use.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. If appropriate, the service used the Malnutrition Universal Screening Tool for nutritional risk assessment to identify patients who are malnourished or at risk of malnutrition.

Specialist support from staff such as dietitians was available for patients who needed it. The service had access to the dietetics and speech and language therapy team at the local NHS trust.

### 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 Palliative Care Outcome Scale (IPOS) symptom rating scale which included a pain rating scale. The pain requirements of a patient were addressed in a care plan for this. Nursing staff used a pain chart to monitor and score patient pain and there was a daily review of pain medication.

Staff used the Abbey pain scale for patients with cognition or communication difficulties. Staff we spoke with reported they had completed Purple Star training to help them care for patients with learning disabilities which included enhanced pain assessment training.

Medical staff we spoke with explained that when assessing a patient's pain, they would consider the underlying cause of pain in their management and would also consider use of pain relief methods other than medications.

Patients received pain relief soon after requesting it. Patients received prompt and adequate pain relief and there was a pain assessment tool in use.

Staff prescribed, administered and recorded pain relief accurately. Prescribing was clear, safe and appropriate. Staff completed medicines records accurately and kept them up to date.

### Patient outcomes

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

The service participated in relevant national clinical audits. We saw that the service was participating in the Hospice UK clinical benchmarking programme for hospice in-patient units (IPU). They collected data on IPU bed occupancy and patient throughput, and three patient harm metrics, which were pressure ulcers, patient falls and medication incidences. This meant the service could measure and compare these outcomes over time with peer organisations and use the findings to make improvements.

We saw posters that the service had produced for the 2021 Hospice UK Conference showing initiatives and improvement projects.

The service used the Outcome Assessment and Complexity Collaborative (OACC), which included a number of tools, to assess whether a palliative care service is making a positive difference to patients and families. The service audited the use of these tools every six months to check they were being completed for patients. The April 2022 audit results showed both increases and decreases in compliance for completion of the tools at particular points in a patient's treatment.

Outcomes for patients were positive, consistent and met expectations, such as national standards. The feedback we saw from patients, family, friends and carers was consistently positive, although some surveys had small numbers. We saw the results of the FAMCARE 2021 survey of bereaved relatives. The results were positive and compared favourably with national results, although numbers were small.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. We saw the audit programme schedule for 2021-2022. This showed that the majority of audits scheduled for 2021 had been completed, although for some there was a significant delay between the scheduled date and the date of publishing. For 2022 the schedule showed that a number of audits were overdue for re-audit. However, we saw examples of repeated auditing of various areas. Managers used information from the audits to improve care and treatment.

### 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.

The service allocated new staff a full induction tailored to their role before they started work. The service had an induction programme and provided additional sessions tailored to the role of staff. For example, in addition to the generic service induction, new GP trainees received an induction specific to their experience and role. However, data for induction attendance from May 2021 to May 2022 showed that overall, only 75% of new starters during this period had attended the induction.

Managers supported staff to develop through yearly, constructive appraisals of their work. The service completed annual appraisals for employees. However, 17% of clinical staff and 11% of non-clinical staff appraisals were out of date. Of those out of date, 83% were planned to take place by the end of June 2022.

The three doctors directly employed by the service had the local NHS trust as their designated body for the national medical appraisal and revalidation programme and were up to date with their appraisals. The Medical Director of the service was a trained appraiser for this programme and was an appraiser for a minimum of six doctors per year. Other doctors, such as GP trainees, completed appraisals as part of their external training programmes. We did not see data for these.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. The consultants were clinical or educational supervisors to GP trainees and the specialist registrar, and completed workplace based assessments for them.

The clinical educators supported the learning and development needs of staff. The service had an in-house education programme and there was also the East and North Hertfordshire Palliative and End of Life Care education programme.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff we spoke with reported that there were team meetings once a month. An online newsletter was available for staff who could not attend.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff reported they had monthly one to one meetings to manage objectives and identify development needs. They reported they could access training to develop further. Managers made sure staff received any specialist training for their role.

Managers recruited, trained and supported volunteers to support patients in the service. Volunteers attended the service induction and elements of the mandatory training programme.

### 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. There was a weekly multidisciplinary team meeting which was attended by doctors, a social worker, a pharmacist, and representatives from the hospice at home and community nursing staff, and inpatient nursing staff.

Good

# Hospice services for adults

Staff worked across health care disciplines and with other agencies when required to care for patients. The service participated in a range of external meetings at regional, integrated care system and East and North Hertfordshire levels, on various aspects of palliative and end of life care, for example steering groups and strategy meetings, and meetings on specific conditions and aspects such as heart failure, frailty, falls and COVID-19.

The service collaborated with another local hospice and local NHS hospital to develop integrated heart failure and palliative care services for patients with heart failure and had worked on projects across the integrated care system to improve care for patients with heart failure.

The service operated a palliative care advice line 24 hours a day, seven days a week, for the community. The advice line is accessible to patients, family, and community health care professionals.

There was an Admiral Nurse based at the service. Admiral Nurses specialise in dementia care, and in this case, dementia care with a palliative and end of life care focus. The Admiral Nurse provided support, advice, education and training to other healthcare professionals, carers, families and patients living with advanced dementia who were approaching the end of their life. For example, the service provided a training programme on caring for people with dementia which was open to health care professionals working in this area, including hospice staff, nurses, GPs, therapists, home carers and charity organisations, and family carers.

The service hosted frailty nurses who worked with care home staff and GPs to provide support to care homes. For example, the frailty nurses would provide frailty assessments, review deteriorating patients and help residents with care planning. The care planning helped to avoid inappropriate admissions and promoted onward referrals to the wider MDT. The service also provided training on frailty.

The hospice at home service was able to give case examples of multidisciplinary working with district nurses, occupational therapists and paramedics.

As part of the inpatient assessment process staff recorded patients' consent to share information with other professionals as part of their ongoing treatment and care.

## Seven-day services

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

Staff could call for support from doctors and other disciplines, including mental health services, 24 hours a day, seven days a week. There was a first on call doctor and access to a consultant out of hours. There was access to the mental health crisis team.

The service had access to the local NHS hospital pathology service for the processing of blood samples, for example. The service had a service level agreement with a charity to courier blood and other samples to the local NHS hospital. This courier service was available 24 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 in patient areas. We observed information leaflets displayed in patient areas of the service.

The service provided group work, for example relaxation classes, and complimentary therapies**.** The Ernest Gardiner Centre provided services including physical rehabilitation, gym, patient workshops, family support services, counselling, wellbeing classes, and a gardening area.

### 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.**

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff we spoke with also reported they would perform a capacity assessment for each decision.

The DNACPR forms used by the hospice included a prompt about patient capacity to make and communicate decisions about CPR and for documentation of communication with the patient and their relatives or friends about the resuscitation discussion. DNACPR forms were reviewed at the consultant ward round each week.

The service audited the completion of DNACPR forms to check that DNACPR forms were completed in full and that decisions were documented in the Advanced Care Plan on the patient's electronic record. The most recent audit was completed in April 2022 and looked at the DNACPR forms completed by the service for 33 inpatients admitted during July to December 2021. Five parameters were audited, with three showing 100% compliance, one 97% and one 94%.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff we spoke with were able to explain how to gain consent.

The service audited consent to record sharing for patients and carers. Patients and carers had the option of consenting to their information being shared with the service from their electronic record, and for their records created at the service being shared with their GP. This audit looked at evidence of discussion and provision of written information about record sharing on the consent template of patient electronic records and whether consent was given or refused. The most recent audit was completed in March 2022 and looked at the consent records of 53 patients and 32 carers.

Ninety-one percent of patients had evidence of a discussion and / or written information provided about record sharing. In 94% of patient records, sharing of information with the service preference had been recorded and in 87% sharing of service records with GPs preference had been recorded. In 97% of carer records, sharing of information with the service preference and sharing out of the service preferences were recorded.

Staff recorded consent in the patients' records. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. We saw that patient wishes had been documented in their record. Staff reported they would also speak to a patient's family about the patient's wishes and to understand what was in their best interests.

Clinical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. This was part of the mandatory training programme and was required to be completed annually.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Good

# Hospice services for adults

Staff could describe, and knew how to access policy and get accurate advice on, the Mental Capacity Act and Deprivation of Liberty Safeguards. The service had a designated Mental Capacity Act and Deprivation of Liberty Lead and Champion. Staff we spoke with knew how to assess capacity.

## Are Hospice services for adults caring?

Good

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

### Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. The relative we spoke with at the inspection felt staff were attentive to the patient's needs and was appreciative of the staff interactions and support they had experienced. Patients we spoke with in day services reported the staff were 'brilliant'.

Patients said staff treated them well and with kindness. We saw the positive feedback given to the service from patients and relatives, which included comments about the kindness shown by staff. We spoke with a relative on the inpatient unit who described the kindness experienced by them during their admission.

Staff followed policy to keep patient care and treatment confidential. It was procedure to record patient preferences on record sharing. The inpatient feedback collected for October 2021 to March 2022 showed that patients felt their privacy, dignity and confidentiality were always respected. The day services feedback for January to March 2022 showed that 95% of patients felt their privacy, dignity and confidentiality were always respected, with 5% answering these aspects were respected most of the time. Numbers of responses received were small for these surveys.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. We observed staff discussing the management of all aspects of the patient's care at the multidisciplinary team meeting and at the nursing staff handover on the inpatient unit. The education programme offered training on psychological skills, spiritual care and cultural awareness.

### Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. We saw feedback given to the service by patients and relatives, which showed they felt well supported and had opportunities to discuss everything that was important to them. There was psychological support and counselling available.

Good

# Hospice services for adults

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. We observed staff discussing and addressing these aspects for patients and their relatives at the weekly multidisciplinary meeting and staff were able to give examples. In addition to services supporting adults, the service also offered support for children living with adults with serious illnesses and who had been bereaved.

### 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. We saw the inpatient unit (IPU) survey results for October 2021 to March 2022. Although numbers were very small the vast majority of patients participating felt the nurses involved in their care were always approachable and explained what they were doing, with a small minority of patients answering that this happened most of the time or some of the time. The service sent questionnaires to patients seen for the first time in outpatients, on admission to the IPU or at a home assessment for feedback on doctors. We saw the results of the questionnaires for 2021 to 2022. Although numbers were very small these showed that patients felt doctors spoke to them in a way that was easy to understand and made sure they understood.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The service collected feedback on comment cards. We saw comment cards feedback for October 2021 to March 2022. These asked patients and carers about what went well and how the service could improve, although for three of these months there had been no feedback received. We saw that the service also received feedback in letters, cards and emails, and collected feedback on doctors, the inpatient unit, day services and complementary therapy.

Staff supported patients to make advanced decisions about their care. We saw that care plans and DNACPR decisions had been discussed with patients and relatives.

Staff supported patients to make informed decisions about their care. The questionnaires giving feedback about doctors showed that patients felt doctors were effective at involving them in deciding how to handle problems, explaining risks to treatment, giving them enough time, allowing them to make up their own mind and checking they were happy with the planned treatment. As mentioned above, numbers participating were very small. We spoke with a patient in day services who reported they were fully informed and had been given all the information and guidance they needed.

Patients gave positive feedback about the service. We spoke with two patients in day services and one relative on the inpatient unit, and all gave positive feedback about their experience of the service. We read numerous positive comments from patients and relatives in the feedback received.

## Are Hospice services for adults responsive?

Good

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

Good

# Hospice services for adults

## 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. The service had previously carried out a population needs analysis together with another local hospice and the Clinical Commissioning Group.

The service was able to provide examples of collaborations with other local and regional palliative care and end of life organisations to deliver and improve care for the local population.

The service had made the decision to reduce the number of beds from 12 to six, but reported they were assured this had not affected patient waiting lists or care, due to a general move towards community care and a centralising of the waiting list.

The service was involved in working with charity hostels for homeless people in the surrounding areas to deliver palliative support in the community to homeless people with life limiting illnesses, and to improve the palliative care knowledge of those working with homeless people. The service had also made links with the street homelessness team to extend the reach of their support.

Facilities and premises were appropriate for the services being delivered.

The service was able to provide accommodation overnight for relatives of inpatients.

The service offered family support services for the relatives of patients. These included professional counselling sessions, and services for children and young people, for example art therapy and working with the schools liaison. The service also had a social worker who provided practical and emotional support to patients, their families and carers.

Staff could access emergency mental health support 24 hours a day seven days a week for patients living with mental health problems, learning disabilities and dementia. The service had access to the Mental Health Crisis Team.

The service had systems to help care for patients in need of additional support or specialist intervention. The service had an Admiral Nurse who provided support for patients living with dementia. The service had access to the Health Liaison Team for patients living with learning disabilities.

Managers ensured that patients who did not attend appointments were contacted. For missed doctors' appointments, it was procedure to rebook these as required. For day services appointments, it was procedure to make phone or letter contact to offer a new date for new patient appointments. It was procedure to offer three appointments before discharging patients from the service, and if patients missed all three appointments, the service would write to the patient and referrer to inform them of their discharge. The service would advise discharged patients that it would reopen the referral at any time if requested by the patient or referrer.

## Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff could discuss complex cases with a Consultant Clinical Psychologist. There was an Admiral nurse who provided support and advice on dementia care, and the service had a Learning Disability Purple Star Award, as well as access to the Health Liaison Team for learning disabilities.

Staff understood and applied their training to meeting the information and communication needs of patients with a disability or sensory loss. The service had measures in place to adhere to the accessible information standard. The service used a core assessment for patients which included prompts about communication difficulties, hearing and language, which were documented on their electronic record within this assessment. The service performed an accessible information standards audit which looked at the recording of communication and hearing needs of patients on patient core assessments. The December 2021 audit found that compliance had remained the same as the previous audit at 76%, indicating no improvement had been made to the recording of communication and hearing status for patients.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters when needed. The service had arrangements in place for accessing translation services.

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

Staff had access to communication aids to help patients become partners in their care and treatment. There was access to hearing loops at reception, outpatients and the inpatient unit. Staff had access to communication boards and would use pen and paper if required to communicate.

### 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. We saw data for waiting times to access the different services offered by the service, which was dated May 2022. This showed that for the inpatient unit, 75.2% of patients were admitted the same or next day after referral, and 15.9% within two to five days. For hospice at home, 85.7% of patients referred were seen the same or next day, and 9.2% were seen within two to five days. For Continuing Health Care (CHC), 82.7% of patients were seen the same or next day, and 10.2% within two to five days. For day services, the service aimed to see patients, or at least offer a new patient appointment, within 14 days. Data showed that 54.6% of patients were seen within 14 days for day services. The data provided did not indicate the period of time the data was based on. We asked the service for their audit of waiting times to access the service, and they supplied figures on the percentage of patients seen within different time frames for the different services provided.

The service received requests for inpatient admissions through the North Palliative Care Referrals Centre (NPCRC) which was available Monday to Friday from 9 am to 5pm. The NPCRC would triage the urgency of the admission. Urgent admission requests made out of hours were discussed with the on call doctor and nurse in charge of the inpatient unit. If urgent admission was not immediately possible, alternative arrangements, for example admission elsewhere, domiciliary visits or Hospice at Home team care would be discussed.

For the Hospice at Home service, urgent referrals could be made Monday to Friday from 9am to 5pm by telephone to the Referrals Coordinator /Community Liaison Clinical Nurse Specialist. Out of hours referrals were made by telephoning the service switchboard, which would direct calls accordingly.

Good

# Hospice services for adults

The service operated an advice line for professionals, patients and families 24 hours a day, seven days a week.

Managers and staff worked to make sure patients did not stay longer than they needed to. The service operated a Fast Track Continuing Health Care (CHC) Service, which aimed to enable patients to remain at home by preventing avoidable hospital admissions and facilitating early discharge from hospital or hospice in-patient care.

Managers worked to keep the number of cancelled appointments to a minimum. It was procedure to only cancel new patient appointments in the case of staff sickness where the service was unable to reallocate the appointment to another staff member, or in the case of a COVID-19 outbreak when it was not safe for vulnerable patients to attend in person, and the patient did not have access to attend virtually or by telephone.

When patients had their appointments cancelled managers made sure they were rearranged as soon as possible and within national targets and guidance. If the service needed to cancel an outpatient appointment, it was procedure to give as much notice as possible and to arrange an alternative date with the patient directly by telephone, then send written confirmation of the new appointment.

The service moved patients only when there was a clear medical reason or in their best interest. The service had a policy for transfer of a patient for treatment elsewhere. The decision process for this was multidisciplinary and involved consideration of the pros and cons with medical and nursing staff and discussion with the patient and their family.

Managers and staff started planning each patient's discharge as early as possible. Discharge planning and the suitability of the home environment where applicable was discussed at the weekly multidisciplinary team meeting. 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 mostly knew how to complain or raise concerns. Survey results showed that most of the patients and relatives asked knew how to complain, but a few did not. The numbers in the survey were small.

The service clearly displayed information about how to raise a concern in patient areas. Guide to complaints leaflets were available in patient and relative areas.

Staff understood the policy on complaints and knew how to handle them. Staff we spoke with reported that if negative feedback was received, they would encourage people to make a complaint, and were keen to learn from complaints.

Managers investigated complaints and identified themes. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff we spoke with reported that all complaints were addressed and discussed as a team, and action was taken.

## Are Hospice services for adults well-led?

Good

# Hospice services for adults

Good

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

## Leadership

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

We spoke with the Chief Executive Officer (CEO), acting Director of Patient Services and the Medical Director during our inspection. The hospice was led by the CEO. There was an application in progress for the CEO to become the Registered Manager at the time of our inspection. The CEO was clinical by background and had many years of experience as a CEO at two different hospices. In addition to participation in other external groups, the CEO was Chair of the Integrated Care System (ICS) End of Life Care (EoLC) Strategy Group and Joint Chair of East & North Herts EoLC Strategy Group.

Leaders reported that they wanted to be visible and accessible to staff and visited every department daily. The acting Director of Patient Services wore their clinical uniform on most days.

There were full staff meetings three to four times a year, internet staff briefings and staff surveys. Staff we spoke with reported that the leadership team were visible and approachable. Staff surveys showed that staff felt communication from the CEO and senior leadership team (SLT) was effective.

The SLT felt confident approaching the CEO who was their line manager and reported that they could discuss anything and had regular check ins with them.

The leadership team were able to explain the priorities and challenges for the service. This included sustainability, for example in relation to funding and workforce recruitment and retention. They were able to explain how these priorities and challenges were being approached and remedied. They also demonstrated an understanding of the wider palliative care and end of life sector in their region and of their local community. Leaders understood the importance of their workforce to the success of the service and had invested in staff education and development programmes.

## 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 2022 to 2025. Within this the service had a vision to support 'all people in our community living with life-limiting conditions and their families and carers, to live as well as possible and according to their own wishes'. It was their mission to provide 'compassionate and holistic specialist palliative care to those in our community' and to 'share our knowledge and expertise to enable wider access to the best end of life care'.

The views of staff, patients and carers were input into the vision and strategy, and the service had worked with the board of Trustees to develop these. The service had embedded the values by linking job descriptions, interviews and appraisals to the values.

The strategy acknowledged the importance of sustainability in the form of staff and culture, and sustainable funding. The service was funded in equal parts by the Clinical Commissioning Group (CCG), fundraising and trading (charity shops). In addition, the service worked towards other sources of financial assistance such as grants. Leaders were able to describe the service approach to a sustainable workforce. For example, measures such as an international recruitment drive and leadership training and development, including succession planning.

It was clear that serving and involving the local community and responding to their needs was an integral part of the service's rationale. Leaders explained the change in emphasis from inpatient to community-based care that was taking place in palliative care settings within the region to allow people to stay at home, and how they were working to facilitate this new model. This strategy represented a more virtual ward approach, with the CCG driving towards more virtual beds.

The service was engaging in a joint partnership project and working with the CCG to create a single point of access and contact referral hub, or joint co-ordination centre, for the region, operating from 9am to 5pm. Patients would be triaged through a single pathway and the palliative care waiting list would be held centrally by the hub. The service currently covered two days a week and there was a 9am meeting with the specialist hub to discuss bed availability and expected referrals. There was currently no date planned for going live, and the progress had been held up by General Data Protection Regulation (GDPR) concerns of other parties.

The service was also driving towards greater accessibility to, and awareness of, the service for different patient groups within the palliative care setting (different types of life-limiting conditions and different backgrounds), such as the homeless community.

### 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.**

Staff feedback about the service as a place to work was positive, based on the staff we spoke with and the results of staff surveys. They felt well supported and enjoyed working as part of the hospice team.

The service had a set of values as follows:

- Place the patient at the heart
- Take inspiration from our community
- Deliver a high-quality service
- Continually learn and improve
- Respect everyone
- One team with a shared vision

It was evident from our findings during the inspection process that the service was focused on fulfilling these values from the attitudes and enthusiasm that we observed.

The service recognised the importance of staff, and their career development, as an asset in achieving the care that they wanted to provide. This was apparent from the education programmes and other opportunities such as leadership training and development.

The service was keen to maintain continuous improvement and sought ways to find even better and more individualised care for patients, and care which strived to meet the needs of the local community and population.

The leadership set an example and fostered a positive culture which filtered through from the top down. There was an open and honest culture where staff felt comfortable to raise concerns at all levels, and which valued the opportunity to improve. Staff we spoke with reported that they were encouraged to feedback concerns and ideas in order for learning and improvement to take place. The service had a Freedom to Speak up Guardian. Staff felt leadership were visible, approachable and supportive. We saw 'You Say, We Did' posters which demonstrated that leadership were receptive to staff feedback.

### 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 Trustees shared clinical governance with the CCG. The board of Trustees normally consisted of 12 trustees; at the time of the inspection there were nine Trustees. Trustees had a range of backgrounds, which included risk, retail and education, as well as clinical backgrounds such as GP, consultant and research. Leadership reported that the Trustees provided helpful critiques and challenges that prompted useful analysis and reflection. Trustee meetings were held every six weeks, at which time matters including risk registers, reports from the clinical governance committee, finance and general purposes committee, trading company, health and safety, policy review and ratification were reviewed. Trustees attended 'meet and greets', and there was always a Trustee on the panel for recruitment to senior posts.

Other meetings held at the service included Clinical Governance Committee, Health and Safety, Senior Leadership Team, Clinical Team Leaders, Medical, Day Services, Hospice at Home, Incidents, Multidisciplinary Team, Drug and Therapeutics and all staff meetings. The minutes we saw had a clear structure and staff had access to minutes of meetings when they were unable to attend. Across the various meetings, a broad range of governance and operational matters were covered.

The service had a quality and compliance manager. Part of their role was to oversee the incident reporting system, manage the incident reporting process and lead the incidents meeting.

The Medical Director was the Caldicott Guardian for the service and led on medical audit and quality improvement.

The service had policies and procedures which were easily accessible to all staff. Certain policies were reviewed and signed off by the CEO and the Board of Trustees, and others were signed by the CEO and reviewed by the Medical Director or by the Director of Patient Services. The service also provided certain policies and guidelines within the medical induction pack for new doctors and required that they sign to confirm they understood where to find policy documents.

### Management of risk, issues and performance

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

The service had systems in place to record, mitigate and monitor risks. There was a risk register that showed identified risks, the causes and consequences, a likelihood assessment and controls.

There were induction and mandatory training programmes, and up to date policies and procedures which were easily accessible to staff, which helped to minimise risks to people.

There was an audit and re-audit programme and national benchmarking to identify areas for improvement and learning. The service had a fit for purpose incident reporting and investigation system and weekly incident meetings, together with an open culture which encouraged staff to raise concerns about any risks they identified. There were established routes by which to share learning from audits and incidents.

Staff performed risk assessments for individual patients, recorded these and the required actions in the patient's record and reviewed them.

### 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.**

Staff received training on information governance as part of the mandatory training programme. The Medical Director was the Caldicott Guardian for the service and dealt with patient confidentiality issues. A breach of GDPR was recorded on the risk register, and GDPR related incidents could be reported through the incident reporting system.

Patient records were a combination of electronic and paper records, with the majority of the information being stored electronically. Access to electronic records was restricted and password protected, and paper records were stored in a locked trolley to avoid confidential patient information being accessed by inappropriate persons. Patient information was easily accessible to authorised staff and with patients' permission medical information from before their admission to the service could be viewed by staff. The mixture of electronic and paper records sometimes meant that some information was disjointed.

There were arrangements in place to submit notifications and data to the relevant external bodies, including the Care Quality Commission and the CCG.

We saw a 2022 schedule for IT updates and upgrades and that the service was in the process of implementing a digital transformation, which included planning to move to a cloud based system.

### 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 collected the views and feedback of patients, relatives and carers through surveys and verbal feedback, and there was a complaints process in place for patients and relatives. The service collected feedback from staff through staff surveys and meetings and encouraged staff to raise ideas. The service used this information to help make changes and improvements to the service and care provided.

The service was able to provide a number of examples of external collaborations with other organisations within the region where they worked together to improve care for patients. This included the development of an integrated heart failure and palliative care service, the frailty nurse service and the provision of palliative care for people experiencing homelessness.

The service was represented in palliative and end of life care networks and groups at regional, integrated care system and East and North Herts levels, and nationally with Hospice UK. This meant that the service could be involved in improvement processes and share best practices with others in the same sector to improve care at the service and within the sector generally.

### 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.**

It was evident from our conversations with staff and attendance at meetings that continuous learning and improvement was very much a part of the ethos of the service. Learning and improvement was achieved through both the services own internal processes and externally through collaborations with other relevant organisations.

The service had an education department which produced training sessions and was responsive to staff suggestions and needs arising. The service also took part in the East and North Herts Palliative Care education programme.

The Medical Director was the research lead for the service with a remit to ensure the service remained research active. The service was able to give a number of examples of research projects and presentations of research at Hospice UK.