Hospice at Home West Cumbria

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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	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

Our rating of this location went down. We rated it as requires improvement because:

- The provider did not clearly define mandated training, including levels of safeguarding training required by job role.
- The provider did not ensure all staff completed mandatory training in accordance with the provider's policy and target compliance rate.
- Not all staff received appropriate levels of safeguarding training in accordance with Intercollegiate guidance (2019).
- The provider did not ensure all staff including but not limited to trustee and volunteer reception staff had barring and disclosure (DBS) checks in place.
- The provider did not have clear, documented ceilings of care in place, and we saw limited intervention or care planning used by the registered general nurses, providing nursing care.
- The provider had a lack of appropriate systems and processes in place to evidence robust HR management of trustee and volunteer files. The provider did not always ensure staff were competent for their roles.

However:

- The provider had enough staff to care for patients and keep them safe from harm and abuse.
- They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment and gave patients pain relief when they needed it.
- Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families, and carers.
- The provider 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.
- Staff understood the providers 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. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	Requires Improvement 	Our rating of this service went down. We rated it as requires improvement because: See the summary above for details. We rated this service as requires improvement because safe and well led requires improvement. Caring, effective and responsive were rated as good.

Summary of findings

Contents

Summary of this inspection

Background to Hospice at Home West Cumbria

Hospice at Home West Cumbria provides high quality, palliative and end of life care to people living in West Cumbria.

Hospice at Home West Cumbria is a registered charity providing 24-hour nursing care with personal care interventions. The hospice provides skilled nursing care on a one-to-one basis to adults within their own home or alternative residential settings, enabling them to remain in their chosen place of care at end of life.

Hospice at Home West Cumbria provides care and support to people in the community, services offered cover home nursing, domiciliary care, family and bereavement support, complementary therapies and lymphoedema care) to people in their own homes.

The provider covers 400 square miles along the western side of Cumbria, covering a scattered rural population from Maryport, to Millom and into the Eskdale and Wasdale valleys (Copeland, South Copeland and Allerdale), serving a population of around 137,000 people.

Care is delivered to people in their own homes and communities and includes those in nursing homes and hospitals including:

• 3 Integrated care communities and Millom

• GP practices

• 3 community hospitals

• 1 district general hospital

• All care homes; nursing and residential homes

Services are delivered free of charge to those who need them. Around one fifth of the provider income comes from the NHS with the remainder raised through income generating activities, legacies, trusts and grants.

The provider offers a home nursing and support at home service.

The provider is the sole provider of specialist lymphoedema care in West Cumbria. A challenging condition that affects many people (Lymphoedema is a chronic condition where excess fluid is retained in the tissues causing painful swelling). It can be as a result of cancer or cancer treatment, but it can also be caused by other non-cancer related conditions.

The provider also delivers a range of family and bereavement support services for families, carers and those bereaved; these include one-to-one support, group support and complementary therapy. The bereavement team help with loss, grief and bereavement concerns. Qualified staff and volunteers, support service users, carers and families by providing complimentary therapies, one to one sessions and group support.

Hospice at Home West Cumbria is an independent provider registered to provide the following regulated activities:

Summary of this inspection

- Treatment of disease, disorder or injury.
- Diagnostic and screening procedures.
- Personal care.

For the period April 2022 to March 2023

- 243 new service users received home care.
- 207 lymphoedema referrals were received.
- 134 service users were supported by the family and bereavement service including complimentary therapy through a range of therapies and interventions provided by staff and volunteers.

We last inspected this service in August 2015 and rated the service as good overall.

How we carried out this inspection

The team that inspected the service comprised of a CQC lead inspector, 2 acute hospital inspectors, a specialist nurse advisor and an offsite CQC inspection manager. This inspection was overseen by Sheila Grant (Interim Deputy Director).

This inspection was a short notice announced inspection, staff knew we were coming to observe routine activity.

We spoke with the registered manager who was also the nominated individual. The service employed a team of Registered Nurses (RGN's) and healthcare assistants (HCA's). We spoke with 14 members of staff including clinical and administrative staff.

They all participated in the service delivery of the regulated activity and are referenced as staff throughout the report.

We spoke with 6 service users who had used the service and reviewed feedback they had provided on the day of inspection.

We observed the team undertaking home visits in the community. We also visited the providers lymphoedema clinic, family and bereavement support and the complementary therapy sections of the service.

We reviewed a range of policies, procedures and other documents relating to the running of the service. After our inspection visit, we reviewed performance information about the service and information provided to us by the service.

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

Areas for improvement

Action 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 MUST take to improve:

Summary of this inspection

- The provider must ensure disclosure and barring checks for trustees and volunteers are completed in accordance with the provider's policy, they must be updated regularly and a comprehensive record of when to update these checks must be held. **(Regulation 5 (1)(2) (a)(b) 3 (a) (b))**
- The provider must ensure that staff providing care and treatment have the qualifications, competence, skills, experience, to do so safely. This includes but is not limited to ensure all staff including volunteers and trustees undertake mandatory and safeguard training. **(Regulation 12 (1)(2)(c))**
- The provider must ensure staff providing care and treatment assess the risks to the health and safety of service users. This includes but is not limited to ceilings of care must be evident and in place **(Regulation 12 (1) (2) (a) (b))**
- The provider must ensure staff providing care and treatment assess the risks to the health and safety of service users. This includes but is not limited to a robust process must be in place to ensure effective care planning is completed for all patients receiving care. **(Regulation 12 (1) (2) (a) (b))**
- All staff and volunteers employed by the provider must receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. This includes but is not limited to a robust HR management process must be in place to ensure staff receive regular appraisal and staff personnel files are reviewed & updated ensuring staff and volunteers are competent to undertake individual roles. **(Regulation 17 (1) (2) (a))**

Our findings

Overview of ratings

Our ratings for this location are:

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

Requires Improvement

Hospice services for adults

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

Is the service safe?

Requires Improvement

Our rating of safe went down. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills; however, this was not comprehensive, and the provider did not make sure all staff completed it.

Staff received mandatory training, although this was not always comprehensive to meet the needs of patients and staff.

Trustees, clinical staff and volunteers are required to complete mandatory e-learning modules and face-to-face training. The IT training platform provided a suite of training modules and those identified as mandatory and non-mandatory are loaded onto individual staff profiles and reminders are automatically generated as the module becomes due. Training modules are selected for each role and progress against the training matrix was monitored at staff management and committee meetings.

The IT system generated reports, however, did not identify new starters and those on sick leave.

Managers told us that staff training records were stored electronically. Mandatory training completion evidenced compliance rates of 92% (clinical staff), 67% (volunteers) and 91% (trustees) which did not meet the provider target rate of 95%. A training log was maintained, however there was inconsistent check and challenge with regard completion rates.

The mandatory training was comprehensive, modules included but were not limited to fire safety, infection control, medicines management, information governance and end of life care education. Face to face courses included basic life support, syringe driver training and manual handling.

Staff completed equality and diversity training. In addition, they received training in end of life, learning disability and dementia.

The provider recognised that some improvements were required to strengthen oversight of the training staff had completed. We raised this as a concern on inspection. Senior leaders provided an immediate response regarding actions to be instigated moving forward. These included:

- Administrative anomalies had been identified and action instigated to resolve for future performance reporting.
- The training matrix was to be reviewed for 2024 for sign off at the next board meeting.
- Additional bespoke learning objectives for RGN's to be introduced.
- Externally provided modules will be separated out from on-line and the targets reviewed to reflect timing issues and availability of trainers and staff.
- Individual volunteers had been offered one to one training and support to complete the modules, however if insufficient progress is made, they will not be able to remain with the service.
- Amendments will be made to management supervision and reporting procedures.
- Line managers now had access to the IT scorecard strengthening oversight and assurance.

All staff we spoke with told us that managers supported them with mandatory training. Staff were scheduled time to complete training modules, which were predominantly received through an electronic training platform.

Safeguarding

Staff understood how to protect patients from abuse. However, staff did not always receive training on how to recognise and report abuse.

Staff did not always receive training specific for their role on how to recognise and report abuse. For example, we reviewed 9 volunteer driver personnel files which evidenced not all drivers had completed adult safeguard training Level 2 in line with Intercollegiate guidance (2019). The providers adult and children safeguarding policy mandated level 2 adult and children safeguarding training for volunteer patient drivers.

This was a risk as these staff work in an unsupervised capacity with service users and their families and therefore posed a risk to vulnerable adults and children.

We raised our concerns with the registered manager on the day of inspection. The provider took prompt action to address this. All volunteer drivers were contacted informing them of the need to complete safeguard training with immediate effect. The provider gave assurance that no patient transport would be allocated to individual drivers until they had completed the appropriate training. All volunteer drivers had been set up to complete safeguard training. We were assured by the provider that children are not transported.

In addition, we reviewed 2 trustee training records and saw they had not completed adult safeguard level 1 training since commencing the role November 2022. The providers adult and children safeguarding policy mandated level 1 adult and children safeguarding training for trustee volunteers. Post inspection the provider gave assurance that the 2 trustees had completed adult safeguard level 1 training in January 2023. This assurance was not made available on the day of inspection; however, we are now assured that training has been completed.

The provider gave assurances all trustees had been contacted informing them of the need to undertake non-compliant mandatory training modules with immediate effect.

We reviewed the provider safeguard training matrix which evidenced compliance rates for adult safeguard training which evidenced clinical staff and volunteer staff had achieved (level 1) 95%, (level 2) 92% and (level 3) 100%. Safeguard children training evidence compliance rates of (level 1) 81%, (level 2) 100% and (level 3) 100%.

Requires Improvement

Hospice services for adults

During inspection, we identified a lack of appropriate systems in place to evidence adherence to the requirements of the Fit and Proper Persons (Directors) regulation 5. For example, we did not see evidence of DBS checks in place for trustees and reception staff. No risk assessments were evident regarding potential risks of one-to-one interactions between volunteer receptionists, and trustees without DBS checks in place.

This meant we were not assured that safe, effective systems were in place to safeguard patients and staff.

We raised these concerns with the registered manager on the day of inspection. The provider took prompt action to address the concerns raised. We received assurance that DBS checks were instigated with immediate effect for all trustees. The receptionist role had been suspended, pending completion of DBS checks. In the interim clinical staff covered the receptionist role.

All staff we spoke with were able to define safeguarding protocols and understood who to contact with safeguarding alerts. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. We saw safeguarding referrals had been made at the time of inspection.

We saw staff received safeguarding supervision and worked closely with external health care professionals including district nursing colleagues and social care organisations, to share safeguarding concerns. We saw examples of this documented, as part of our inspection.

The service's adult and children safeguarding policies, referenced national guidelines, and contained links to local authority safeguarding information and PREVENT. PREVENT is a government led programme which aims to safeguard vulnerable people from being drawn into terrorism.

The registered manager of the hospice was the safeguarding lead and was trained to level 3/4. The provider had planned for the SFR lead role to be led by a senior clinician; plans were in progress to action this. The registered manager told us the safeguarding lead should hold a minimum Level 3 safeguarding qualification with the expectation of upskilling to level 4 within 6-12 months of appointment. This was reflected in the SFR policy which was in date and next due for review November 2024.

Regular supportive supervision of the safeguarding lead and the director of clinical services was established and delivered by the Integrated Care Board (ICB) Deputy Designated Professional for Safeguarding.

We saw evidence to support the provider had safeguarding supervision contract in place (May 2023). The contract was agreed with North Cumbria Clinical Commissioning Group. The contract evidenced agreement for regular peer review, reflection, best practice, training and education was provided for the safeguarding lead of the hospice.

We reviewed the North East and North Cumbria Integrated Care Board North Cumbria Safeguarding Health Outcomes Framework (SHOF) Quarter 2 (2023/2024). The report evidenced commissioner assurance had been approved following review in September 2023.

The safeguarding lead and director of clinical services are part of the North Cumbria Sub ICB Safeguarding Professionals Forum. These meetings bring together various professionals with the aim of embedding safeguarding lessons and best practice around specific themes, for example domestic abuse and the importance of routine enquiry questions.

The provider had developed a safeguard audit tool, to ensure all appropriate actions had been taken following a safeguarding alert submission. We reviewed this as part of our inspection and saw all necessary actions had been completed.

We saw on inspection the use of the safeguarding log. The log evidenced responses to concerns raised were in line with the Cumbria Safeguarding Adults board current policy and procedure.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves, and others from infection. Staff kept equipment and their work area visibly clean.

The registered manager was the infection control lead nurse. The lead had links with the local NHS trust infection control team, disseminating infection prevention information/newsletters to clinical staff.

Staff were observed following infection control principles including the use of personal protective equipment (PPE). We saw posters displaying hand hygiene techniques including the 5 moments for hand hygiene in line with the World Health Organisation 2015 (WHO).

Staff completed infection control risk assessments prior to entering a patient's home. On the day of inspection, we had planned to attend visits with the home nursing team; however, 3 patient risk assessments had highlighted COVID 19 infections. We did not complete home nursing visits; however, we did attend 1 support at home visit. We observed effective hand hygiene practice before and after patient contact and the use of PPE.

The provider had an infection prevention and control standard precautions policy which was in date (Review July 2026), had a named author and was version controlled.

Environment and equipment

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

Hospice at home operated from 2 sites. The head office was operated from Finkle Street where patients could attend specialist lymphoedema clinics and bereavement and complimentary services. Finance and marketing teams were based at this address.

The clinical base was situated at Workington Community Hospital in office space. The nursing at home service and the support at home servicer were based at this address.

The provider had a service level agreement (SLA) with an external agency for servicing and inspection renewal of a passenger hydraulic lift, powered patient hoist and 2 electrical patient treatment couches. The yearly quality assurance check had been completed in June 2023.

We saw evidence to support the provider had a maintenance planner. This included for example but was not limited to; fire extinguisher servicing, nurse call, portable appliance testing (PAT) and boiler servicing.

Electrical equipment was PAT tested; we saw evidence to support a service engineer report evidencing completion undertaken October 2023.

The provider was not responsible for patient equipment in the community. Equipment was provided by general practitioners, NHS trust and district nursing teams.

The provider ensured appropriate fire risk assessments had been completed for the Finkle street building. We reviewed the risk assessment dated January 2023 and saw the risk score overall was rated low with all areas assessed.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks; however, ceilings of care were not evident. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.

Upon receipt of patient referral, information was screened, and initial assessment undertaken. The provider used a traffic light referral indicator system which evidenced red as urgent, amber as non-urgent and green as routine. Each referral indicator had phase of illness, criteria, staffing, response time and care provision and review & monitoring.

The service used a North Cumbria and North East Caring for the Dying Patient document (CDP). We saw evidence of this in use in care records. This document consisted of 4 components:

- Relatives/carers contact information and healthcare professional signatory information.
- Medical assessment.
- Initial holistic nursing assessment.
- Daily ongoing assessment.

A triage referral process was used by staff. We saw evidence of the flowchart in use which clearly evidenced the process for triaging referrals into the home nursing and support at home service. There was a referral criteria process in place for the lymphoedema service.

Staff completed risk assessments for each patient at point of initial assessment using a recognised tool, and reviewed this regularly, including after any incident. A further review of risk was carried out during the patients first visit. We reviewed the initial referral form and saw risk was considered across several areas such as capacity, behaviour and past and present medical history.

Environmental risk assessments were completed for all patients, pre and upon initial visits to the patient's home. A dynamic risk assessment was undertaken on each visit and any changes / additional risks reported to senior members of staff. The Karnofsky Performance Scale Index (KPSI) was used to assess patients at end of life. This allows patients to be classified as to their functional impairment. This can be used to compare effectiveness of different therapies and to assess the prognosis in individual patients.

However, we did not see evidence of individual ceilings of care in place. This is a phrase heard particularly in intensive and palliative care. It refers to the maximum level of care which the patient is set to receive, and this is often a complex and sensitive decision reached between the patient, their family and the healthcare team responsible for the patient.

This posed a risk that patients would not receive care and treatment in line with national guidance and best practice, which may result in potential harm or failure to provide necessary safe care and treatment.

We raised our concerns with the registered manager on the day of inspection.

We received assurance that a ceilings of care procedure for registered nurses (RGN) had been drafted and instigated. We reviewed the document which referred to areas of practice which fall outside of competency/skill base. The document stipulated if areas of additional training/education were required to enable the RGN to provide safe care, this must be addressed before the RGN delivered care and support to the patient.

Post inspection the provider gave assurance whilst a written procedure was not in place at the time of inspection there was a system in place for individual patient referral and ongoing care which is uploaded into the electronic patient record.

Nurse staffing

The service had enough nursing and support staff to keep patients safe. Managers regularly reviewed and adjusted staffing levels and skill mix.

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

The managers used an acuity tool to calculate requirements and adjusted staffing levels daily according to the needs of patients.

The service had no clinical vacancies and low turnover rates. Senior leaders told us due to recruitment challenges of the "assessment and coordination nurse" post; a review of on call working arrangements had been undertaken in the home nursing team. The review led to a decision to fully integrate the role into the home nursing team with a rolling rota (covering 7 days).

The home nursing team leader was established within the team currently working to increase referrals and build relationships with other organisations to promote what services the provider has to offer.

The support at home team had been live since the beginning of June 2023, seeing an increase in referrals into the home nursing service allowing the team to provide wrap around care in some cases.

Records

Staff did not always keep detailed care planning records of patients' care and treatment. Although initial assessment records were comprehensive. Records were available to all staff providing care and were stored and transported securely.

The service was moving towards a paper lite model with the introduction of electronic recording aligned to agile working. However, at the time of inspection some paper-based records were still in use such as initial assessment documents, first home visit reviews and initial referrals.

The provider had adopted a live daily review of records to ensure patient records were reflective of handovers and daily reviews.

Team leaders told us that they also had full access to community colleague's electronic records, to enable teams to work together effectively to benefit their patients.

We reviewed the electronic records of five patients and saw that staff accurately completed detailed initial assessments, including home visits and thereafter completed daily handovers in accordance with the activities of daily living. The electronic system provided a template for completion to ensure all areas of care and support were completed. Staff

were able to add free text updates for each shift covering some aspects of the care and treatment that had been given and this box then prompted nursing staff to complete care plans for the key words identified such as catheter care, mobility and wound care. In records we reviewed we did not see detailed care plans evidencing patients care and treatment. We discussed this at the time of inspection. Staff were unable to articulate how care outcomes and interventions were documented and evidenced.

This posed a risk that patients would not receive care and treatment in line with national guidance and best practice, which may result in potential harm or failure to provide necessary safe care and treatment. This also meant that nursing intervention could not be accurately measured to ensure the care provided was appropriate and beneficial for the patients. This is not in line with the royal college of nursing guidance in relation to patient records and care planning.

Following inspection, the provider took immediate steps to introduce effective care planning systems and recognised the importance of effective care planning and intervention monitoring. We reviewed the core care plan document which included but was not limited to symptom management, oral intake and oral hygiene, skin integrity, personal care, continence and mobility. The provider gave assurance that interventions were clear and evidenced in the assessment /care planning framework. The personalised assessment framework used, accurately measures the care and the outcomes of the care interventions provided. These care records are shared between providers which give a clear overview of the patients care requirements and outcomes. This mitigates the risk between health professionals.

The provider completed 5 audits of nursing and end of life records for patients. Audits were completed quarterly, and results reported to the clinical assurance meeting with the medical advisor. We saw evidence of the quality assurance audit blank document which was in line with the National Audit of Care at the End of Life (NACEL) audit criteria, Palliative and End of Life Care Statutory Guidance for Integrated Care Boards (ICBs) and National Institute for Health and Care Excellence (NICE) end of life care agenda.

Medicines

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

The service did not prescribe, record or store medicines. All patient medication was prescribed by the local NHS hospital Trust who had overall care of the patient, and this was kept at the patient's home.

The service's nursing staff were able to administer some medicines in accordance with their training and nursing qualification. Staff told us some healthcare assistants administered prescribed opiate medications following training and competency assessment by the specialist palliative care team.

Medicines administered were documented on an electronic medicine management system. Medicine management training was mandated to be completed by all clinical staff on a yearly basis. Staff told us they followed the providers medicine policy, management of controlled drugs policy and injectables medicine policy.

We saw evidence in the patient records we checked that staff had completed medicines records accurately and kept them up to date when they had administered medicines.

Senior leaders told us that staff were training in medicine administration. Training and support were ongoing in relation to medication and symptom control, provided by clinical nurse specialists on a quarterly basis. Syringe driver training was delivered to RGN's face to face by trained specialist palliative care team nurses based at the local NHS Trust.

Requires Improvement

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. Managers ensured that actions from patient safety alerts were implemented and monitored.

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. The provider had a clinical procedure in place to ensure incidents and potential incidents were reported swiftly. All staff we spoke with were able to articulate the incident reporting process.

Staff were encouraged to report all near miss incidents and had received training on the process in place.

Staff reported serious incidents clearly and in line with the service's policy.

Staff understood the duty of candour. They were open, transparent, and gave patients and families a full explanation if and when things went wrong. The provider had a duty of candour policy which was in date (Review May 2024), had a named author and was version controlled.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made as a result of feedback.

Managers investigated incidents thoroughly. Managers we spoke with discussed a recent incident and described how they conducted a thorough review. Although they established there was no patient harm, changes were implemented to strengthen procedures and reduce risk of repeated incidents.

We saw evidence that managers investigated incidents and shared learning across staff groups including learning to and from external organisations. External safety alerts were monitored, recorded and cascaded to clinical staff and external organisations. We saw examples of the learning shared, as part of the clinical governance meetings.

The provider instigated audit review, we reviewed the clinical incident audit for July 2023 to September 2023. The audit evidenced review of internal and external incidents. The audit showed robust actions taken including duty of candour and outcome and lessons learned. There had been an 83% increase in the total number of reported incidents. Communication was the main theme; investigation highlighted procedures had not been followed. As a result, lessons learned and actions taken demonstrated for example, reflective staff accounts instigated, feedback shared with all staff at staff meetings and collaborative working with local commissioners.

The provider had a lone working policy, lone working procedures had been enacted and the “buddy system/safe system of working” had been stress tested. The provider had reported 2 incidents in last 6 months in relation to failure to follow lone working procedures. Staff had undertaken reflective discussion sessions and re read the lone working procedures policy.

Requires Improvement

Hospice services for adults

Is the service 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. Staff protected the rights of patients in their care.

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

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

During and after the inspection we checked differing policies were up to date and incorporated best practice. The policies covered, clinical treatment and guidance, privacy, dignity and human rights, protection of liberty protected standards and the Mental Capacity Act.

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

Nutrition and hydration

Staff regularly checked if patients were eating and drinking enough. They worked with other agencies to support patients who could not cook or feed themselves.

There was evidence in the patient records we checked that staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs.

Staff fully and accurately completed patient fluid and nutrition records where needed.

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.

Patients received pain relief soon after requesting it. Patients we spoke with told us staff regularly reviewed pain medications.

Healthcare assistants within the home nursing team are trained to administer doses of prescribed pain killers.

Staff followed 'just in case' medication authorisation sheets, administered and recorded pain relief accurately.

Requires Improvement

Hospice services for adults

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 clinical audits. We reviewed the annual schedule of clinical audits.

The audit schedule evidenced audits undertaken, frequency and staff responsible for collation.

The provider used a traffic light referral indicator system which evidenced red as urgent, amber as non-urgent and green as routine. We reviewed the provider trend analysis for period July to September 2023. This showed the total numbers of care hours provided in that period as 2317.25.

Outcomes for patients were positive.

Managers and staff used the results to improve patients' outcomes.

The lymphoedema team had introduced an evaluation form for patients attending treatment clinics to capture the efficiency of the treatments provided as well as gaining valuable feedback from the patients. We reviewed audit data that reflected this, feedback was extremely positive.

The team also introduced the lymphedema quality of life questionnaire (LYMQO) tool providing the team with a before and after intervention picture in order to assess the impact on a patient's quality of life.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time.

Due to the increased levels of cancelled and "Did Not Attend" (DNA) appointments within the lymphoedema and family and bereavement support services, the provider had trialled a digital system to improve attendance levels at appointments/clinics. The pilot commenced September 2023, feedback was positive, and the system was fully integrated.

The connect system was completely interoperable with the providers clinical IT platform. Appointment reminders were delivered automatically allowing cancellation to increase efficiencies across the teams.

Patient questionnaires were coded directly back to the clinical system allowing the provider to collect important information fast and efficiently whilst also improving the patient experience. Missed appointments had reduced allowing a more streamlined service.

Managers used information from the audits to improve care and treatment.

Managers shared and made sure staff understood information from the audits.

Competent staff

The provider did not always ensure all staff were competent for their roles. Managers did not always appraise all staff's work performance. Staff appraisal meetings were not consistently undertaken and evidenced for trustee and volunteer drivers.

During inspection, we found lack of appropriate systems and processes in place to evidence robust HR management of trustee and volunteer files.

This meant we were not assured that all staff were competent to complete individual roles.

We raised these concerns with the registered manager on the day of inspection.

Review of trustee personnel files evidenced that trustee references were verified and there was no evidence of appraisal. There was no photographic identification and no recorded induction for trustees.

The provider took prompt action to address this. We received assurance that all trustee references had been checked and verified by the registered manager on the 20 November 2023. The recruitment procedure has been updated to include a check on references. We reviewed the process which covered formal interview process, induction and post induction check lists. The last two recruitment trustee files had been spot checked and verified by the registered manager. Photographic identification had been verified with copies uploaded into trustee files, trustee name badges have been issued.

A new trustee appointment checklist had been produced and uploaded into trustee files. The provider told us an induction process was in place but not signed off at board. We reviewed the trustee induction checklist which included key checks to action and sign off.

Plans were in place for future trustee appraisals to be included individually. Appraisals are undertaken annually; the most recent appraisals were completed in April 2023. A summary of the key points was presented to the HR and Governance Committee, but individual appraisals had been mislaid. Next annual appraisals were scheduled for early 2024. We were assured that trustee appraisal compliance was 100%.

The provider had a formal induction programme for new clinical staff. New staff were supported by a named colleague at point of induction. Probationary review was instigated at start of employment and signed off at 6 months. We saw evidence of the template used by the provider which evidenced review of objectives, training and support required.

Clinical staff appraisal compliance was 97%. Outstanding clinical staff appraisal was scheduled on the mid December 2023.

Managers gave all new staff an induction tailored to their role before they started work. Staff we spoke with told is they were fully supported with a robust induction and shadowed colleagues, to ensure they understood all aspects of their role. The provider issued an induction pack to ensure consistency of completion.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Clinical staff received regular appraisals, objectives were discussed, and staff told us they felt supported by team leads and senior management.

Team lead appraisals were completed by the registered manager. Team leaders completed front line staff appraisals. Following inspection, the registered manager clarified there needed to be a check and challenge process in place alongside a spot check audit process surrounding staff appraisal. Appraisal records are recorded on files by the business support manager and for volunteers by the volunteer coordinator. Appraisal compliance was reported to HR & Governance committee quarterly.

Clinical staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The provider offered opportunities for staff to connect with peers and healthcare colleagues working across the region. We saw a number of workshops were recently attended by the hospice staff as part of a healthcare collaborative across North Cumbria. We also saw home nursing re-assessment workshop attendance. All staff we spoke with told us they were fully supported to with requests to further develop their skills and knowledge. We also saw the provider offered both student nurse and medical staff placements.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. During inspection staff attended a conference organised by the provider surrounding reconnecting, rebuilding and respecting patients at end of life.

Managers made sure staff received any specialist training for their role. Nursing care and support was provided by Registered General Nurses (RGN's) and Health Care Assistants (HCA's) with a minimum National Vocational Qualification (NVQ) Level 2, most had NVQ 3. HCA staff were also required to complete clinical competencies.

The Support at Home Service provided a domiciliary care and support package to individuals in their own home. Support was provided by HCAs with a minimum NVQ Level 2.

Lymphoedema care was provided by RGNs, of which one holds a specialist qualification (Graduate Diploma in lymphoedema management). The service was supported by an HCA at NVQ Level 2, undertaking in house competency-based outcomes. Lymph Assist clinics are managed by an HCA.

Family and bereavement services are provided by clinical staff with appropriate qualifications in Psychology, Adult Social Care, Safeguarding and role specific bereavement training. The team are supported by family and bereavement support volunteers who also undertaken role specific bereavement training.

Complementary Therapies are provided by therapists with role specific qualifications (Reiki levels 1, 2, and Reiki Master, Reiki Master Teacher Certificate, Reflexology Diploma, Indian Head Massage Diploma, Diploma in Adapting Complementary Therapies for Cancer and Supportive Care. The Senior complementary therapist had recently become a level 2, Practitioner in Emotional Freedom Techniques (EFT).

In June 2022 the complementary Therapist qualified to deliver Therapeutic use of Aromastick therapies. (The Christie School of Oncology). The service was supported by complementary therapy volunteers with role specific training (massage, reflexology, Reiki, mindfulness).

Multidisciplinary working

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 (MDT) meetings to discuss patients and improve their care. For example, we observed a daily handover meeting where needs of patients and their families were discussed, and ongoing care was planned. This was attended by clinical staff and administrative.

Requires Improvement

Hospice services for adults

We saw that MDT discussions included symptom control, safeguarding, escalation plans, falls risk, nutritional risk, skin risk, and do not attempt cardiopulmonary resuscitation (DNACPR) choices. Discussion also covered approaches to family inclusion and patient involvement. We observed that symptom control discussions included patient feedback.

Seven-day services

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

The home nursing service offered care 7 days a week, including wrap around care overnight if required.

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

Clinical teams were able to flex the support that they offered to ensure every patient received the level of support that they needed. We saw additional visits were able to be offered, even on the same of day, when needed.

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

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.

Staff completed consent training. Staff we spoke with understood how and when to assess whether a patient had the capacity to make decisions about their care and knew who to contact for advice. Staff made sure patients consented to treatment based on all the information available and clearly recorded their decision. When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions.

Is the service caring?

Good

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients we spoke with said staff treated them well and with kindness. We observed care and support provided within a patient's own home and saw staff took time to explain each aspect of the care being provided in a calm and empathetic manner. This patient and family members were not rushed, and staff demonstrated an understanding of the needs of those receiving support.

Staff followed policy to keep patient care and treatment confidential. We saw sensitive information discussed respectfully.

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.

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. For example, the provider offered a family and bereavement support (FABS) service providing emotional support to patients, carers and their families with a range of support options tailored to meet each individual's needs following an initial assessment. The team is made up of experienced staff and volunteers who help people with coping, loss, grief and bereavement. The FABS service offers inclusivity by continuing to develop additional easy read information both online on the provider website and in hard copy format. The FABS volunteers, offer one-to-one emotional support to patients, their loved ones and those who are bereaved. Volunteers offer support in people's homes, at the therapy and information centre and in community settings. The patient and carer groups meet face-to-face, and which is delivered fortnightly. These groups are co-facilitated by FABS volunteers, and the provider sought feedback from the group which was evaluated to assess the impact of the support. We reviewed comments received back from patients and saw it was extremely positive. Feedback included 'I felt more at peace with myself' and 'I was able to function, return to work, and look after my family'.

Senior staff told us they remained committed to support carers and were developing additional carer wellbeing sessions. The aim of the sessions was to bring carers together, offering time out of their caring role whilst providing support, guidance and coping strategies.

Carers 'Coffee & Chat' and patient groups commenced September 2023, in line with the FABS plan. There was also a bereavement group called 'Grieve Well Together', developing and delivering specialist in-house training sessions, and continuing to work in collaboration with other local hospice teams. The new FABS workers assumed lead facilitation roles in the grieve well together group and are now embedded in the facilitation role.

Staff demonstrated empathy when having difficult conversations.

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.

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.

Requires Improvement

Hospice services for adults

Staff made sure patients and those close to them understood their care and treatment. Patients and those close to them were active partners in their care. Staff were fully committed to working in partnership with people and making this a reality for each person. Staff empowered patients to have a voice about their care and treatment and to realise their potential by encouraging small daily achievements.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The provider had instigated a simple format feedback form for patients and families. Staff told us that the feedback form had been reviewed following feedback from patients. Feedback highlighted the need for a simpler format to be instigated. The leaflet consisted of 5 key questions with yes, no, prefer not to answer tick boxes.

To collate patient feedback the provider had instigated a feedback working group. The objective was to gain a shared understanding of the need for and the use of "feedback and evaluation" forms. The aims of the group:

- Were to understand the difference between feedback and evaluation. For example, the patient experience (patients' evaluation of the care provided relative to their expectations).
- Identify what the provider was doing with the data. For example, performance assessment and benchmarking in line with regulatory body requirements / comparisons with other healthcare providers and assessment of progress over time.
- Identify any areas for change.
- Identify analysis responsibility.

The working group had an action plan in place showing who was responsible, progress update and completion.

Staff supported patients to make advanced decisions about their care.

Patients gave positive feedback about the service. For example, we saw compliment cards from patients and families identifying their positive experience of care provided to patients and significant others.

Is the service responsive?

Good

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

Hospice at Home West Cumbria provides care and support to people in the community, services offered cover home nursing, domiciliary care, family and bereavement support, complementary therapies and lymphoedema care) to people in their own homes.

Managers planned and organised services, so they met the needs of the local population.

Requires Improvement

Hospice services for adults

Facilities and premises were appropriate for the services being delivered.

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

The service had systems to help care for patients in need of additional support or specialist intervention.

Hospice at Home provided differing service delivery methods including, home nursing, family and bereavement support, complimentary therapy and a specialist lymphoedema service. Social and emotional support was provided by patient support volunteers as members of the home nursing team with role specific training.

The home nursing service provides palliative and end of life care and support to patients and their families, predominantly in patients' own homes, but also in care homes and community hospitals. Care is provided by a dedicated team of Registered General Nurses (RGN's) and Health Care Assistants (HCA's), supported by a senior nursing team, team leader and administrative support.

When patients are referred to the home nursing service an initial assessment is undertaken to identify appropriate support options. The home nursing team worked alongside other health and social care professionals to ensure a fully integrated approach. We reviewed the providers referral process and saw clear referral guidelines which incorporated a traffic light coding system for each patient. Red patients were deemed to be most urgent and therefore priority, although each patient was assessed according to their individual circumstances. Staff are then deployed according to the need and priority of the patient.

The support at home service commenced in June 2023 offering up to three visits every day from qualified staff to provide specialist palliative care in the patient's home. An hour each visit is offered to ensure quality time is spent focussing on the patients' needs and daily activities. Regular re-assessments are completed by Senior Registered Nurses (RGN's). Referrals into other support services including home nursing, lymphoedema and family and bereavement support can be catered for.

The support at home service is available to people who have a palliative diagnosis and are eligible for 'fast track' discharge supported by Continuing Health Care Funding. A clinician involved in the person's care completes an assessment to ensure patients are eligible, making the referral to Hospice at Home West Cumbria. Senior registered nurses then visit the patient to carry out an initial assessment and complete a personalised care and support plan. The plan includes comprehensive details of the patient's needs, focusing on who they are, what matters to them and how they want to be supported by the service.

Referrals into the support at home service can be made by health care professionals involved in the patient's care, for example a GP, District Nurse, Clinical Nurse Specialist, or hospital discharge team.

The provider offered a family and bereavement support (FABS) service providing emotional support to patients, carers and their families with a range of support options tailored to meet each individual's needs following an initial assessment.

Complementary therapists offer a variety of complementary therapies tailored and adapted for the needs of the individual. Therapies included Reiki, therapeutic massage and reflexology, as well as breath-work approaches to de-escalate anxiety and invite relaxation. Staff were able to access complimentary therapy services. To access services staff had to be referred by managers and treatment approved to receive ongoing support.

Training in emotional freedom technique (EFT) was offered to service users in the community at the providers therapy and information centre. The provider recently introduced an aromatherapy service through the use of aroma sticks in Autumn 2022. Staff and volunteers completed the qualification via The Christie NHS trust. The new service was offered to patients, their loved ones and those bereaved as an additional form of support.

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.

We saw evidence in the patient records we checked that care plans were designed around the patients' individual needs.

The nursing visits to patients were not time limited. Staff we spoke with could give examples of when they had stayed for extended periods of time with patients and families to deal with issues that had arisen.

The service had information available in languages spoken by the patients and local community. For example, we saw the provider website was accessible and was available in large print, audio format, and in the service user's own language or any other format, upon request.

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

The provider is part of the Palliative End of Life Care (PEoLC) partnership group working on the North Cumbria Palliative End of Life Framework.

The End of Life (EoL) framework was being developed in conjunction with health and third sector providers to address the needs of the North Cumbria population. The aim is to deliver a comprehensive approach to care for individuals living with a life-limiting illness.

The provider participates in the Listening in Action (LiA) group "One chance to get it right".

Senior leaders told us of the good response to the LiA survey; relating to understanding where and how the care of the dying patient (CDP) document is used and how this affects patient experiences of care. The director of clinical services commenced training in the practical completion of the agreed CDP document. Roll out of the CDP was at both the acute hospital sites WCH /CIC which commenced in September 2023.

The mission being to improve care for patients and their families at end of life, by having one standard care framework (care of the dying patient document) guiding clinical staff through the steps of assessment that matter to individual patients. The care of the dying patient (CDP) document is an evidence based standard outlining care needs and preferences for patients approaching end of life.

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.

Referrals were received online by secure email and by telephone from health care professionals including GP's, Clinical Nurse Specialists in Palliative Care, community nurses, families and patients (self-referral).

Requires Improvement

Hospice services for adults

Patients could access the support at home service if the service's eligibility criteria were met. The support at home service is available to people who have a palliative diagnosis and are eligible for 'fast track' discharge which is supported by Continuing Health Care Funding. A clinician involved in the person's care will assess and identify if they are eligible and make the referral to Hospice at Home West Cumbria.

The service recorded the patient's preferred place of death and accommodated this as far as possible. The provider collated this information, we saw data from August 2023 to September 2023 which evidenced 60 patients had died at their preferred place of death.

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 provide feedback, complain, or raise concerns and the service clearly displayed information about how to raise a concern. We saw evidence of a complaints leaflet which clearly explained how to make a complaint.

The provider had a complaints policy which was in date (Review July 2025), had a named author and was version controlled.

They could submit complaints and feedback in different ways. For example, via the hospice website, by post, via cards and in person.

Friends and family test data we reviewed for the period April to September 2023, showed high satisfaction scores, although numbers of questionnaires returned were low compared with service user numbers.

Staff understood the policy on complaints and knew how to handle them.

The provider collated feedback from a variety of sources, including questionnaires, evaluation forms, thank you cards and emails. Senior leaders told us further work was required to improve collation of service user feedback. A piece of work was currently ongoing to identify the different reporting systems in place and how the information was being used to shape service delivery across clinical teams.

Is the service well-led?

Requires Improvement

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. However, they did not always manage 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.

Requires Improvement

Hospice services for adults

The provider did not meet the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors/volunteers are fit and proper to carry out this important role. Trustees and reception volunteers did not have DBS checks in place. We raised this at the time of inspection. The provider took prompt action to address this.

The hospice was overseen by a board of trustees led by a chairperson. Trustees were encouraged and expected to provide appropriate challenge when it was needed. We saw trustees brought a diverse range of skills due to their different cultural and professional backgrounds. Trustees met four times a year with principal responsibilities to ensure the financial sustainability of the charity, set the strategic objectives, and monitor performance and risk as set out in the governance handbook.

The board had set out under terms of reference, delegated responsibilities and decision making to three committees. These included clinical governance, human resource and governance and finance and income generation.

The senior management team reported to the board of trustees through regular board meetings.

The provider had a leadership group delivery plan (2022/2024). The delivery plan was in place to realise the ambitions of year 2 of the strategy. The leadership group was formed to monitor the progress of the delivery plan.

Trustees are directors of the charity and had duties under company law as well as charity law. They are expected to maintain the highest standards of integrity and stewardship; to ensure that the organisation is effective, open and accountable; and to ensure a good working relationship with the Chief Executive and Senior Management Team.

The hospice was led by a senior leadership team consisting of a chief executive officer (CEO), a Director of Clinical Services who was also the registered manager and a Director of Funding and Communications. The registered manager was the named Caldicott guardian. A Caldicott guardian is a senior person responsible for protecting the confidentiality of people's health and care information and making sure it is used properly.

We reviewed the financial report, accounts and the directors report 2021/2022. The report incorporated the provider vision, mission statement, charter and strategy, financial account overview and the trustees report.

Chief Executive Officers (CEO) of the 4 hospices at home organisations across the north, namely West Cumbria, Carlisle and North Lakeland, Tynedale and North Northumberland met regularly and had good working relationships.

Hospice at Home West Cumbria had a dedicated marketing & income generation team which facilitates and oversees all fundraising activities to raise awareness of the vital work undertaken. The team engaged with charity supporters building relationships with businesses and members of the community. The provider had a fundraising promise, available on the providers website, setting out how they ensure fundraising activities are carried out openly and honestly. The fundraising promise includes the commitment to respect supporter's rights and privacy and never put undue pressure on people to make a gift. The provider is registered with the fundraising regulator.

Vision and Strategy

The provider 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.

Requires Improvement

Hospice services for adults

The provider vision was for all people in West Cumbria to have timely access to personalised high-quality palliative and end of life care. The mission statement was to be at the heart of the community providing home nursing, emotional support, complementary therapies and lymphoedema care when and where needed.

The provider had organisational values and cultural corner stones. Organisational values were compassion, respect, integrity, accountability, excellence, inclusivity and teamwork. We saw staff display these values during our inspection.

We reviewed the provider charter which promised differing objectives surrounding high quality care supporting service users with emotional support, physical, spiritual, social and cultural needs and wishes. The provider welcomed feedback through service user questionnaires.

The provider had a strategy for 2022-2025 which outlined the plans over the next three years.

The provider strategy had 4 themes which were: service delivery and excellence, sustainability and growth, presence reputation and inclusion and governance and leadership. Each theme had planned goals and strategic objectives.

The provider acknowledged key external factors, both local and national, that influence the organisations growth and direction, both now and in the future and these had been considered during the development of the strategy. These included changes to commissioning structure and/or NHS changes and partnership working with other hospices in North Cumbria and the regions.

Senior leaders told us they had annual budget setting process in place ensuring sustainability within the organisation.

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.

Managers carried out periodic staff surveys, which staff completed anonymously via an online platform. In the most recent survey (2023), 26 responses were received, feedback was mostly positive.

All staff we spoke with said they enjoyed coming to work and felt they had good relationships and worked well as a team.

Staff we spoke with described an open culture and told us they felt their opinions mattered to managers. They said they were confident to raise any concern with their managers.

The Freedom to Speak Up Guardian (FSUG) is an independent HR consultant. They reported themes and trends to the HR & governance committee and the board of trustees.

Staff were aware of the freedom to speak up advisor and felt supported to raise concerns if and when required.

Patients we spoke with told us they felt confident and comfortable to raise any concerns with staff.

Staff we spoke with told us managers recognised their work and commitment to the business.

Requires Improvement

Hospice services for adults

Governance

Leaders did not always operate effective governance processes. Staff at all levels were not always clear about their roles and accountabilities.

During inspection, we identified a number of concerns surrounding oversight and management of staff personnel files. For example, we found a lack of risk assessments regarding potential risks of one-to-one interactions between volunteers without DBS evidence. Review of volunteer driver personnel files highlighted this staff group had not completed safeguard training in line with best practice and no appraisals had been completed. Review of trustee personnel files evidenced that trustee references were not all checked and verified and there was no evidence of appraisal. There was no photographic identification and no recorded induction for trustees.

We raised these concerns with the registered manager on the day of inspection. The provider took prompt action to address this. We received assurance of immediate action taken to rectify concerns raised which we have previously highlighted in this report.

During inspection we saw no evidence of up-to-date driver motor insurance to evidence business use or driving licenses in some volunteer driver files.

This was a risk as the provider had no assurance that volunteer drivers were competent to undertake their role safely. The governance surrounding management of personnel files was inconsistent. There was a lack of clear check and challenge surrounding the performance of staff, this was acknowledged by the senior team at the time of inspection.

We raised these concerns with the registered manager on the day of inspection. The provider took prompt action to address this.

We received assurance that volunteer driver services remained suspended for 6 out of 8 volunteer drivers pending motor insurance and driving licence document checks were validated. Two drivers had been reinstated following verification of up-to-date documentation by the registered manager.

Senior managers told us that patient drivers had not had individual annual reviews. Management of the patient drivers changed from the volunteer coordinator to the family and bereavement team leader in June 2023, and the team leader was aware that these were overdue. We received assurance that appraisals for this staff group would be completed in December 2023.

However, there were effective governance structures, processes and systems of accountability and a clear governance framework to support the delivery of the hospice at home strategy. The hospice at home leadership team were accountable to the board of trustees. Service leads reported to the board of trustees through board papers submitted, including a regular care services report. Quarterly board agenda items included progress reports against the strategy, minutes of committee meetings, risk management, policy ratification and the quality of services.

Governance arrangements were evident in the governance handbook which included guidance on the roles and duties of trustees, role profiles, terms of reference for committees, schedule of matters reserved for the board and a scheme of delegation.

Requires Improvement

Hospice services for adults

The hospice ensured good governance through an effective committee structure. Each committee meets in between board meetings supporting the board with its work. The current structure allowed the board to focus on strategic and big picture issues by delegating responsibility and empowering each committee to examine the detail and provide the precise level of scrutiny necessary.

We reviewed the governance committee meeting minutes last completed November 2023. The minutes showed review of strategic risks, staffing, performance score card, medicine administration, lymphoedema business case, safeguarding update, service exception and highlight report and director/medical advisor quality and highlight report.

We saw all clinical incidents were discussed, reviewed and evaluated as part of a regular meeting between the registered manager and the medical advisor. We observed this meeting as part of our inspection and saw detailed action plan review and robust processes for the learning and sharing of all incidents.

The provider had in place a commissioner approved grant agreement 2023/2024. We saw evidence to support this. The provider had an approved service specification in place with the local commissioner (North Cumbria). This was agreed annually and was last reviewed April 2023.

A number of task and finish groups had been set up to facilitate reviews/support strategic planning. Each working group was led by a senior staff member and supported by a trustee.

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively. They identified and escalated some risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

There was a corporate strategic risk register in place.

The provider had a strategic risk management framework and process in place which described roles and responsibilities.

The Board had an approved policy on risk management identifying the major strategic, business and operational risks for the organisation. There was a clear flow for reporting information. Each strategic risk assessment detailed a list of control measures. As part of the risk reporting and gathering assurance that control measures were working the provider completed a rolling programme of quarterly audits on each strategic risk.

Risk assessments were reviewed quarterly, and action plans updated which ensure necessary steps can be taken to manage risks. Some strategic risks listed in the risk register included:

- Inability to raise sufficient income.
- Reliance on volunteers.
- Medical malpractice.
- Recruitment and retention of key staff.
- Inadequate IT systems and data security.
- Health and safety non-compliance.
- CQC inspection downgrade.
- NHS grant changes.
- Charity Commission governance and Fundraising Regulator non-compliance.

However, during our inspection, we identified areas of significant risk that were not on the risk register. For example, lack of risk assessments regarding potential risks of one-to-one interactions between reception volunteers and trustees without DBS evidence in place, lack of clear ceilings of care and ongoing care planning assessment of patients.

This meant we were not assured all identified risks affecting the service, were always escalated to the risk register.

We reviewed the minutes from the risk group meeting (August 2023). The minutes showed evidence to support review of strategic risks, with clear actions and named person responsible. Post inspection the provider clarified the risk register set out strategic risks and not operational risks.

Each committee advised the board on specific strategic risks delegated to them to oversee. The risk group, which consists of the chairs of each committee and senior management team, oversees the risk register and advises board on the effectiveness of control measures.

We reviewed the provider business continuity plan which was in date and had actions for managers to refer to.

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.

Over the course of the pandemic the provider had to make significant changes to Information technology (IT) systems in order to operate effectively. The provider used a cloud-based storage system allowing staff access from any location. All staff members had laptop computers and had access to office space at both sites to hot desk when required. The provider invested in a cloud-based telephony system allowing all staff to have direct dial numbers, straight to their mobile phone or laptop computer.

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.

Hospice at Home West Cumbria welcomed hearing from service users, their loved ones and people who were bereaved. Service user information helped the provider to learn what they do well and any improvements they can make to care and support for people with a life limiting illness and their loved ones.

In order to really understand people's experiences and ensure the provider meets the people of West Cumbria's end of life and bereavement needs, the provider have developed a set of promises.

These promises made up the new charter and were developed by a group of passionate people including patients, their loved ones and those bereaved who have experience of the services offered at the hospice, as well as volunteers and staff members.

The charter was readily available on the provider website.

Requires Improvement

Hospice services for adults

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.

Student placements

The provider worked with the university of University of Central Lancashire (UCLan) offering placement opportunities for student nurses and medics.

The provider welcomed medical students into clinical areas/teams as part of their training programme.

The pilot model planned to:

- Accommodated a 1st year student in June 2023. This was a non-clinical placement, to support learning outcomes in understanding the organisation's systems / services.
- Accommodated 3rd and 4th year students; from September 2023 onwards, to support learning outcomes in communication and examination skills.
- Give consideration to the development of a programme suitable for 5th Year students in 2024.

The provider was part of a pilot for the delivery of an end of life (EoL) care bespoke learner placement programme. The programme covered aspects of services and care that a patient and family may have contact with and how they interface with each other to ensure seamless quality care is achieved.

The provider had supported student nurses from UCLan in this programme, response from staff and students had been positive with themes showing increased knowledge and confidence in EoL understanding. An additional 5 placements had been planned from August to December 2023.

Support at home service (home care through fast track, continuing care)

The service was launched in June 2023 seeking to address a number of challenges, not only for the organisation but across West Cumbria. The lack of palliative care services presents a predicament of families having to provide care for loved ones. The new service provides wider opportunities for bringing new people into the organisation who may not have considered working in the palliative care sector.

Collaboration and relationships

The provider had forged strong professional collaborations with a broad range of health professional and organisations. These included for example but was not limited to; the local integrated care board (ICB), GP's, district nurses, specialist palliative teams, bereavement nurses, Adult Social Care and third sector voluntary organisations.

Knowledge and expertise

With decades of hands-on experience, staff are recognised across the West Cumbrian health sector as experts in what they do, providing specialist palliative, end of life care and lymphoedema treatments to bespoke wellbeing, emotional and bereavement support.

Requires Improvement

Hospice services for adults

North Cumbria Palliative End of Life Care (PEoLC) framework

The provider is part of the (PEoLC) partnership group working on the North Cumbria Palliative End of Life Framework. The end-of-life framework has been developed in conjunction with health and third sector providers to address the needs of the North Cumbria population. The aim being to deliver a comprehensive approach to care for individuals living with life limiting illness. It is focussed on providing support needed to manage diagnosis and development of a palliative illness, including physical, emotional, spiritual, and psychosocial support for the individual, their family and care givers.

Charity of the year award 2023

The provider won the BECBC charity of the year award in 2023. The provider is an essential specialist health care provider across Werst Cumbria. They are the sole charitable provider of bespoke palliative care in the region.

Voluntary Assisted Dying

With the intention to legalise assisted dying as a choice for terminally ill, mentally competent adults in their final months of life, the provider attended a briefing session delivered by “Dignity in Dying” March 2023. Leaders told us the session was thought provoking explaining the state of play of the assisted dying campaign in the UK, a palliative care perspective on the value of assisted dying and an insight into how hospices around the world are adapting to legislation.

With a number of jurisdictions across the British Isles currently developing assisted dying proposals or examining the issue, the provider felt it was an important time for the hospice to consider what role they may or may not play in supporting people who want to access assisted dying should the law change.

The senior leadership team planned to review the position statement on Voluntary Assisted Death in the near future as the bill moves through its democratic process.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Nursing care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider must ensure that staff providing care and treatment have the qualifications, competence, skills, experience, to do so safely. This includes but is not limited to ensure all staff including volunteers and trustees undertake mandatory and safeguard training. The provider must ensure staff providing care and treatment assess the risks to the health and safety of service users. This includes but is not limited to ceilings of care must be evident and in place. The provider must ensure staff providing care and treatment assess the risks to the health and safety of service users. This includes but is not limited to a robust process must be in place to ensure effective care planning is completed for all patients receiving care.

Regulated activity	Regulation
Nursing care	Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors The provider must ensure disclosure and barring checks for trustees and volunteers are completed in accordance with the provider's policy, they must be updated regularly and a comprehensive record of when to update these checks must be held.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Nursing care

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The provider must implement effective systems and processes to ensure nursing, trustee and volunteer staff are compliant with mandatory training, including but not limited to, safeguarding vulnerable adults and children, to a level appropriate for their role. There must also be a robust process in place to monitor training, appraisal, DBS checks and personnel files.