

St Mary's Hospice Limited

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from 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?	Good	
Are services well-led?	Good	

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

St Mary's Hospice is operated by St Mary's Hospice Limited. Facilities include a 15 bedded inpatient unit, which includes single rooms with en-suite facilities and small multi-bedded bays. The 15 beds included two home from home beds which were commissioned separately by the local clinical commissioning group. In the reporting period July 2018 to June 2019 there were 1,759 individuals cared for in the inpatient and day case services at the hospice.

There is a "family centre" where patients and their families can stay together. There is access to a peace room for prayer or quiet reflection, a dementia friendly conservatory and gardens. Other facilities include a lounge offering refreshments and information for patients and visitors.

The hospice provides inpatient, outpatient and community care to people aged 18 years old and above. We inspected all services provided by the hospice.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced part of the inspection on 17 and 18 September 2019.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

The main service provided by this hospice was inpatient and community care. Where our findings on inpatient care for example, management arrangements also apply to other services, we do not repeat the information but cross-refer to the inpatient service level.

Our rating of this hospice stayed the same. We rated it as **Good** overall.

We found good practice in relation to inpatient care:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- 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.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.
- 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.

Summary of findings

- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.
- 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 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 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 monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.
- 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.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care.
- Staff gave patients practical support to help them live well until they died.
- Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was 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.
- 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.

Summary of findings

- 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.
- Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service 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.
- 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.
- 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.
- 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. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- 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.
- 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.
- 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.

However, we also found the following issues that the service provider needs to improve:

- There were points during the reporting period when the service did not always use systems and processes to safely prescribe, administer, record and store medicines.

Heidi Smout

Deputy Chief Inspector of Hospitals Midlands

Summary of findings

Our judgements about each of the main services

Service

Hospice services for adults

Rating

Good



Summary of each main service

St Mary's Hospice provided hospice care to adults through inpatient, day hospice and community services. Bereavement and counselling services were also provided.

We rated the service good overall because the service was good in safe, effective, caring responsive and well led.

Summary of findings

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Good 

St Mary's Hospice

Services we looked at

Hospice services for adults

Summary of this inspection

Background to St Mary's Hospice Limited

St Mary's Hospice is operated by St Mary's Hospice Limited. The hospice opened in 1979. It is a private hospice in Birmingham, West Midlands. The hospital primarily serves the communities of Birmingham and Sandwell. It also accepts patient referrals from outside this area.

The hospital has had a registered manager in post since April 2016.

Referrals received by the hospice include, but are not limited to, symptom management, psycho-social support, respite or terminal care.

Patients receive holistic care to support physical, psychological, social and spiritual needs. Patients have access to medical advice, social work and chaplaincy support, physiotherapy, occupational and complementary therapies.

A day hospice service is available which consists of two multi-disciplinary supported therapeutic days and a volunteer led "welcome group" and a multi-disciplinary breathlessness management programme. Therapies, including art and music, are available to patients and they also receive specialist palliative care interventions either on site or at outpatient appointments.

There is a community palliative care team consisting of clinical nurse specialists, a community palliative care consultant, occupational therapists and a family carer and support team.

The family carer and support team provide specialist counselling, spiritual and psychosocial support to

patients, carers and family members, including children whose loved ones are ill. They also assist with concerns related to benefits, housing or other social needs, referring patients to other agencies as necessary.

The chaplaincy team provides spiritual support to those who request it and bereavement support is provided by highly skilled volunteers, all of whom are trained to support people during grief and loss.

Physiotherapy, occupational therapy and pharmacy services are provided by arrangement with a local NHS foundation trust.

Activity takes place at three GP surgeries, as hospice satellite clinics, run between the hours of 9.30am and 12.30pm by clinical nurse specialists who provide holistic assessment and advisory support to primary care. Between June 2018 and July 2019, the volume of clinic activity was 90 attendances.

Two designated registered nurses work closely with 21 care homes in the local area, supporting staff with education around end of life care based upon a six steps programme.

There was a focus on community, with a community development and partnerships lead, working externally, to identify opportunities for asset-based community development.

The hospice provided a community hub for patients and their carers (which has operated at various locations in South Birmingham) through their support at home service. Since inception there have been 20 group sessions with an average attendance of seven people per group.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and a specialist advisor with expertise in adult hospice care. The inspection team was overseen by Bernadette Hanney, Head of Hospital Inspection.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection as part of our routine inspection programme.

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced part of the inspection on 17 and 18 September 2019.

Information about St Mary's Hospice Limited

The hospital has one ward and is registered to provide the following regulated activities:

- Personal Care
- Nursing Care
- Treatment of disease, disorder or injury
- Diagnostic and screening procedures
- Transport services, triage and medical advice provided remotely.

During the inspection, we visited the inpatient unit and accompanied staff on community visits. We spoke with 10 staff including registered nurses, health care assistants, reception staff, medical staff, allied health professionals, senior managers and the chief executive officer and one trustee. We spoke with six patients and two carers/relatives. During our inspection, we reviewed four sets of patient records.

There were no special reviews or investigations of the hospice ongoing by the CQC at any time during the 12 months before this inspection. The hospice has been

inspected three times, and the most recent inspection took place in July 2016, which found that the hospice was meeting all standards of quality and safety it was inspected against.

Activity (July 2018 to June 2019)

- In the reporting period July 2018 to June 2019 there were 1,759 inpatient and day case episodes of care recorded at the hospice.

Services accredited by a national body:

- Gold Standard Framework

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Pharmacy
- Physiotherapy
- Occupational Therapy
- Speech and Language Therapy
- Dietician

Detailed findings from this inspection

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

Notes

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.

- All staff received and kept up-to-date with their mandatory training. We reviewed data relating to compliance with mandatory training. All modules had compliance rates of 100% apart from fire (96%), patient handling (94%), basic life support (95%) and infection prevention and control (97%). We saw all staff, who had not completed the training, had been booked onto courses.
- The mandatory training was comprehensive and met the needs of patients and staff. The hospice had an agreed programme of statutory and mandatory training for staff and volunteers. This included basic life support, equality and diversity, fire safety, infection prevention and control, information governance, load handling and patient handling. Training was delivered face to face and as e-learning modules. Staff felt the training provided was adequate to ensure patient care was safe.
- Managers monitored mandatory training and alerted staff when they needed to update their training. Mandatory training compliance was monitored centrally by the hospice administration team who kept a database. When staff were due for completion,

emails were sent to their line manager to ensure the notifications were sent and booked on the next available course. Completion of mandatory training was linked to staff appraisal and any gaps were discussed and action was taken to ensure training was booked and completed.

Safeguarding

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

- All staff received training specific for their role on how to recognise and report abuse. We reviewed data relating to hospice staff compliance with safeguarding training and saw 100% of staff had completed the required training. This included but was not limited to nursing, medical, therapy and housekeeping staff. The safeguarding training programme included adult safeguarding levels one two and three, depending on their level of contact and engagement with adults. For example, staff who were engaged in assessing, planning, intervening and evaluating the needs of adults, where there were safeguarding concerns, were trained to level three. Staff were also trained in children's safeguarding levels one, two and three depending on their level on contact and engagement with children. Female genital mutilation and modern slavery were incorporated into safeguarding training delivered to staff on hospice induction. The training was delivered face to face and as e-learning modules. The lead for the family and carers support team and deputy lead was trained to level five safeguarding and provided advice and support to the rest of the hospice.

Hospice services for adults

All staff, including volunteers, were required to undergo disclosure and barring service (DBS) checks. We reviewed four DBS documents, two for staff and two for volunteers. All of which had come back clear.

- Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff we spoke with were able to describe the steps they would take in the event patients were being harassed or discriminated against. They were aware of the relevant policies and processes for escalation. Staff were compliant with equality, diversity and inclusion training.
- Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff of all levels and disciplines could give examples of what constituted abuse and what process they had followed when they had identified a patient at risk of or suffering significant harm. Patients had been appropriately referred when safeguarding issues had been identified. Practice was in line with hospice policy and procedures.
- Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff could describe the process they would follow if a safeguarding referral needed to be made. The hospice had a safeguarding and prevent lead who was also the child sexual exploitation lead. They could be accessed if staff required additional support or advice.

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.

They kept equipment and the premises visibly clean.

- Ward areas were visibly clean and had suitable furnishings which were clean and well-maintained. All areas we visited were visibly clean and the hospice had ensured furnishings complied with the most up to date infection prevention and control guidance. For example, the furniture in the family room was being replaced at the time of our inspection to ensure it was compliant with infection prevention and control guidance.

- Cleaning records were up-to-date and demonstrated
- Quarterly Infection prevention and control cleaning audits were completed by appropriate supervisors.
- Cleaning records were completed on daily check sheets.
- Infrequently used water outlets were flushed on a weekly basis.
- Colour coding of cleaning materials were in use.
- Deep cleaning of all barrier nursed rooms took place prior to reoccupation.
- All chemical product safety data sheets were in date and available for inspection for all products used within the catering facility.
- There were areas of improvement identified but actions were taken to ensure any issues were addressed. For example, it was identified a deep clean of the conference rooms was overdue, but steps were taken to ensure this was carried out at the earliest opportunity.
- Staff followed We observed staff following infection prevention and control policy. All clinical staff were bare below the elbow and adequate PPE was available. We saw PPE being used appropriately during each patient interaction. Hand sanitising gel was available on the inpatient unit and to staff within the community team. We observed it being used at appropriate times by staff. Signage and guidance reminding staff and visitors to wash their hands and use the hand sanitising gel, was present throughout the hospice. The cleaning standards audit from February 2019 showed deep cleaning of barrier nursed rooms were always carried out within 24 hours, which was in line with policy.
- Rate of acquired infections were low. We reviewed data relating to the type and number of infections identified within the hospice between July 2018 and June 2019 and saw there were:
 - MRSA colonisation on transfer to hospice: 4
 - MRSA Infection: 1
 - MRSA bacteraemia: 0
 - Clostridium Difficile (C.Diff) : 6

Hospice services for adults

- MSSA: 0
- Of the four patients identified as having MRSA, they were known to have MRSA colonisation on transfer to the hospice, from previous routine MRSA screens on hospital admissions. All patients received decolonisation treatment and were barrier nursed from admission.
- One patient was admitted from a local acute NHS trust with what appeared to be an infected percutaneous endoscopic gastrostomy (PEG) site. PEG is an endoscopic medical procedure in which a tube (PEG tube) is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate. The site was swabbed on admission and found to have MRSA around the site. The patient received antibiotic treatment and was barrier nursed.
- Of the six patients identified as C. Diff positive, five had developed symptoms prior to admission to hospice, either in the community or in hospital. Due to high levels of vigilance their C. Diff positive status was identified through stool samples taken in the hospice when patients developed symptoms of diarrhoea. One patient developed symptoms during their inpatient stay and a root cause analysis (RCA) showed a recent history of various broad-spectrum antibiotics. All patients were barrier nursed and received the appropriate antibiotic treatment. RCA were performed for all cases of C. Diff which were identified on the inpatient unit.
- Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw equipment being cleaned appropriately and labels were used to show they were clean.

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. We saw call bells within reach of patients and they told us they were answered quickly.
- The design of the environment followed national guidance. All clinical environments and clinical areas

were safe and suitable for patient care. Corridors were wide and had hand rails along them to assist patients with mobility difficulties. Bed spaces were spacious and were free from trip hazards.

- Staff carried out daily safety checks of specialist equipment. The sample of equipment we checked had been recently serviced and appropriately tested. We saw staff had carried out safety checks on equipment. For example, resuscitation trolleys were checked in line with best practice on all wards we visited.
- The service had suitable facilities to meet the needs of patients' families. The inpatient unit had 13 inpatient beds and two additional home from home beds. There were also counselling rooms, a physiotherapy treatment room and two treatment rooms.
- The service had enough suitable equipment to help them to safely care for patients.
- Staff disposed of clinical waste safely. Clinical waste was segregated and disposed of in separate clinical waste bins or sharp-instrument containers. We saw staff following waste management practices during our inspection and none of the waste bins or containers on the wards were unacceptably full.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks.

- Staff completed risk assessments for each patient on admission / arrival and updated them when necessary and used recognised tools. When patients were admitted to the inpatient unit staff carried out risk assessments in relation to Waterlow, moving and handling, falls, nutrition and hydration, venous thromboembolism (VTE) and bed rails. Within the four patient records we reviewed, all appropriate risk assessments were completed. We also reviewed a records audit from February 2019 which showed compliance with most of the assessments on admission and on a weekly basis was above 92% (14/15 patients). However, the audit showed compliance with VTE assessments was only at 67% (10/15 patients). The audit identified recommendations and learning which was shared with the appropriate teams.

Hospice services for adults

- Staff knew about and dealt with any specific risk issues. Staff we spoke with knew how to reduce risks to patients and keep them safe. For example, patients at higher risks of falls were admitted to patient bays closer to the nursing station. This was so the staff were closer to them if they required assistance, be more responsive and increased patient visibility.
- The hospice made a clinical decision not to have a deteriorating patient policy or implement national early warning score (NEWS) charts on the inpatient unit. The rationale for this was most patients, in their care, express a wish not to have their care escalated to the acute setting when their health expectedly deteriorates. Medical and nursing staff were very proactive in establishing an advance care plan with patients and families on admission, which ensured patients' wishes for their care were clearly documented and known to the clinical team. Observations are not routinely taken but after specific episodes in care; for example; on admission as a baseline, post fall, suspected infection for patients who were for escalations of care. Increased monitoring did take place for those patients suspected of having opioid toxicity. An observations chart and guidance had been devised and implemented on the inpatient unit.
- An advance care plan audit was carried out and has been shared as part of the inspection process.
- The service had access to mental health liaison and specialist mental health support. There were counsellors within the family and carers support team who offered support to patients across all service lines when required.
- Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. A ligature point risk assessment was carried out for the inpatient unit in October 2018. We reviewed the risk assessment and saw risks had been scored, control measures had been identified and it was clear who was responsible for taking specific actions. For example, one control measure was to risk assess patients upon admission and keep them under review. If patients scored as high risk, one action taken, was to admit them to a patient bays instead of an individual room.
- Staff shared key information to keep patients safe when handing over their care to others. The hospice's emergency transfer standards were outlined in their guidelines for patient transfer to hospital from the in-patient unit and day hospice. Basic clinical information was printed from a summary view in our electronic record and included, but was not limited to:
 - Next of kin;
 - Preferred place of care and death;
 - Advance care plan (ACP)/Do Not Attempt cardiopulmonary resuscitation status if known;
 - ACP document or equivalent such as My Life Booklet;
 - Advance decision if in place; and
 - Specific communication and or language needs
- For inpatients a copy of drug prescription and administration charts would also be forwarded. It was also standard practice for a referral letter to the accepting clinician or accident and emergency to be included. Some acute trusts could view patient records directly as they had access to the hospice's electronic patient records system.
- Shift changes and handovers included all necessary key information to keep patients safe. We observed a clinical nurse specialist huddle and saw staff discussing individual patients to share information to ensure safe care and treatment was delivered appropriately. For example; staff discussed care plans and what the last contact with the patient was.

Nurse staffing

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

- The service had enough nursing staff of relevant grades to keep patients safe. The inpatient unit had a nursing establishment based on 16 beds plus two

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home from home beds. At the time of our inspection, there were 13 beds, plus two home from home beds open, so the nursing establishment was enough for the number of patients admitted.

- On the inpatient unit there were three shifts; early, late and night. The nursing staffing arrangements on an early shift were five registered nurses and three nursing assistants. On a late shift, there were four registered nurses and two/three nursing assistants. On a night shift there were three registered nurses and two nursing assistants. We were told there had been occasional gaps on night shifts so twilight shifts were implemented, 7.30pm to 12am, when this happened.
- The staffing provision on the day hospice consisted a band six physiotherapist lead, two band five registered nurses, one band four nurse, a band three nursing assistant and an administrator. This was enough to provide nursing cover for approximately 22 patients during the day.
- Within the community palliative care team there were 12 clinical nurse specialist and two band six registered nurses who were training to become clinical nurse specialists. The two band six registered nurses were part way through their six-month competency programme.
- The hospice at home service team consisted of three band six registered nurses, five band five registered nurses, five band three nursing assistants and two band two nursing assistants.
- The family and carers support team consisted of three social workers, two adult counsellors, one children's counsellor, two children's workers, volunteer coordinators, volunteers and administration support.
- 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 inpatient unit used a staffing model, which was a ratio of four patients to one registered nurse for specialist palliative care environments. A similar ratio was applied to determine appropriate numbers of health care assistants. A daily meeting was held to determine dependency of existing patients and levels of staffing and to make decisions about further admissions based on needs and safety. The community palliative care team staffing levels were determined and agreed through the nursing director, based on national recommendations of approximately one clinical nurse specialist per 50,000 population.
- Caseloads for clinical nurse specialists were manageable. We were told clinical nurse specialists had caseloads of 33 if they worked full time, and less if part time. We reviewed data from quarter two (2018/19) to quarter one (2019/20) and saw average case loads were between 27 and 31 patients.
- Caseloads for each professional working within the families and carers support team were dependent on the level of input required for clients at any moment in time. The workload for each individual and each branch of the service was monitored through line management and clinical supervision. If there were unanticipated absences or vacancy, referrals into the service were appropriately triaged. A rapid response service and waiting list for less urgent bereavement care helped to ensure those with more pressing needs were identified and caseloads did not build to unacceptable levels.
- The ward manager could adjust staffing levels daily according to the needs of patients. Roster gaps were covered by internal bank or external agency staff. The annual requirement for agency cover was monitored closely and kept to a minimum.
- The number of nurses and healthcare assistants on all shifts on each ward matched the planned numbers. We reviewed staffing rota data and saw gaps in shifts were minimal.
- The service had low vacancy rates. We reviewed data provided by the hospice which showed there was vacancies for multiple roles across all the service lines within the hospice. However, upon reviewing updated data relating to the number of vacancies within the clinical service lines and there was only one clinical nurse specialist vacancy within the community palliative care team. All other clinical positions were filled.
- The hospice had low turnover rates. We reviewed data relating to turnover rates from quarter two (2018/19) to quarter one (2019/20) and saw the rate was lower than the hospice target of 5%.

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- The hospice had variable sickness rates. We reviewed data which showed the rates of sickness across service lines which were higher than expected. For example, sickness rates for registered nurses had reached as high as 12% within some months over the previous 12 months. In the same period, healthcare assistants had reached as high as 15%. Action was taken when sickness levels rose higher than expected to ensure the safety of patients. For example, when sickness occurred within the community team, staff were not replaced but work was postponed or reallocated dependent upon the needs of the patient. Sickness in the day hospice or hospice at home was covered by reallocation of duties to staff from other areas or using internal bank.
- Managers limited their use of bank and agency staff and requested staff familiar with the service. Most bank staff used across all services lines were existing staff and had been through corporate and local induction previously. They had full awareness of policy and procedure and up to date statutory and mandatory training. We reviewed data which showed agency staff use was low. For example, agency registered nurses were only used for 43 hours over the previous 12 months, but agency healthcare assistants had been used to cover 730 hours over the same period.
- Managers made sure all bank and agency staff had a full induction and understood the service. Any new members of bank staff completed a full induction programme which included shadowing an existing member of staff, in the area they were working, during a shift. They were also expected to complete statutory and mandatory training relevant to their role. The inpatient unit developed a booklet specifically for new agency nurses. We reviewed the booklet and saw it contained all appropriate information. For example, it contained an assessment, which was used to ensure agency nurses could carry out safe medicine administration.

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. All areas of the service had access to medical advice 24 hours a day, seven days a week. There were doctors available for face to face contact across inpatient and community settings, during working hours Monday-Friday and out of hours (5pm-9am Mon-Fri and over weekends). Ward rounds were carried out by junior doctors on weekends and they provided updates to consultants by telephone.
- The medical staff matched the planned number. The medical staff were deployed across all service lines using an integrated approach. We were told work was carried out daily to ensure each service line had medical cover. There was not much flex in the medical provision, but gaps were always covered through reprioritisation.
- The service had a good skill mix of medical staff on each shift and reviewed this regularly. There were one/two new registrar(s) who rotated into the hospice every six months. There were two GP trainees who worked on the inpatient unit. There were two speciality doctors who both worked part time (both three days a week), who primarily worked on the inpatient and day hospice but also provided cover within the community. There was three whole time equivalent (WTE) consultant cover. One of which was dedicated to the community team.
- The service always had a consultant on call during evenings and weekends. A first and second on call rota provided access to face to face reviews for inpatients (1st on call) and specialist telephone advice from consultant staff (2nd on call) for inpatients, community and acute local trust.

Allied Health Professional Staffing

- The service had enough allied health professionals to keep patients safe. A band six physiotherapist provided cover five days a week. They worked across the inpatient unit and day hospice. Therapy staff were contracted via service level agreement with a local acute NHS trust.

Hospice services for adults

- The medical directorate held responsibility for monitoring activity levels and supervising staff, to ensure workloads were appropriate and patient safety optimised.
- Physiotherapists attending patients at their homes were contracted by the local community NHS trust.
- There was no physiotherapy cover on weekends.

Records

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

- Patient notes were comprehensive and all staff could access them easily. The hospice had an electronic patient record (EPR) system. We reviewed four sets of patient records and each contained all the appropriate information. Records could be accessed by those who had authority to do so.
- Referrals from healthcare professionals were received using a referral form for specialist palliative care services. Patient details were entered onto the EPR according to the information received. For some patients, where their GPs were utilising the same system, notes were automatically aligned with the GP record and care information was shared directly between primary care and specialist palliative care services. For those patients from different EPR practices, basic demographic information and some medicine was logged in primary care and could be seen and manually cross checked. The hospice also had access to the clinical portal at the local NHS trust which allowed staff to view outpatient letters and imaging/pathology results when patients received their secondary care in that setting.
- When patients transferred to a new team, there were no delays in staff accessing their records. All clinical service lines used the electronic patient record system so when patients transferred from one service line to another, their records were easily accessible.

On discharge from the hospice, all patients were provided with a clinical letter for their GP, with copies

sent key clinicians. There were departmental standards set for the information shared and templates to guide content, across the different arms of the service.

When community referrals were received from a source other than a patient's GP, the hospice wrote out to primary care and informed them they had been asked to offer services. For patients who were transferred from a hospital setting to an inpatient setting, their GPs were informed via hospital discharge documentation.

- Records were stored securely. As patient records were electronic, they were password protected and so access was restricted to those who were authorised to use the system.

Medicines

Practice, systems and processes, observed during our inspection, to safely prescribe, administer, record and store medicines, was in line with safe practice. However, practice throughout the reporting period had not always been compliant.

- We did not identify any issues with storing, administering, recording or prescribing medicines during our inspection. However, there had been instances, throughout the reporting period, when staff did not always follow systems and processes when safely prescribing, recording and storing medicines. Processes in relation to administering drugs were always followed. During our inspection, we reviewed six medicine management audits. They related to anticipatory syringe driver prescriptions, electronic verbal orders, medication storage, updating medication list, controlled drugs and drug fridge temperatures. The dates of the audits ranged from November 2018 to April 2019. The audits highlighted areas for improvement across all areas and actions taken to improve practice were detailed in the audits. Areas of non-compliance included but were not limited to:
 - Documentation omissions (across most audits);
 - Resetting fridges after documenting out of range readings (November 2018);

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- Medication left unattended in medication room (December 2018);
 - Medication room temperature not recorded daily (December 2018);
 - Notes recording medications at each visit did not have two sources of medicines reconciliations (November 2018); and
 - Controlled drug prescriptions did not always state the form of the drug and the frequency of the dose was not specified on regular prescriptions (January 2019).
 - The hospice was reporting medication incidents. We reviewed data from quarter two (2018/19) and quarter one (2019/2020) which showed there had been more medication incidents per quarter, when benchmarked against the average number for medium sized hospices. The benchmarking data was provided by a national hospice charity.
 - All areas of improvement and recommendations were fed back to the appropriate teams, but we did not have any updated audits to confirm practice had improved. However, the audit reports did show high levels of compliance with policy and national/local guidance. For example, practice in relation to syringe drivers was compliant with the palliative care formulary and local guidance from the palliative care network, medication was stored in a secure area, medications were within their date of expiry.
 - Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. We reviewed four patient records and could see their medicines had been reviewed regularly. We observed advice being given to patients about their medicines and allergies had been recorded. Two nurses had signed and prescribed medicines appropriately.
 - There were seven non-medical prescribers within the hospice. A qualified non-medical prescriber worked on the inpatient unit. The community palliative care team (CPCT) had four staff who were qualified non-medical prescribers and two other members of staff from CPCT were due to undertake training in September 2019.
 - Staff stored and managed medicines and prescribing documents in line with the provider's policy.
- Documents in relation to management and prescribing were stored securely and managed appropriately. We did not identify any issues with this during our inspection.
- Staff followed current national practice to check patients had the correct medicines. Pharmacy support was provided each morning who carried out stock monitoring. This included a pharmacist and a technician. They also attended the medicines management committee. This was arranged through a local acute NHS trust. The hospice and the local acute NHS trust had a service level agreement since April 2017. As set out above, the hospice carried out audits to review their practice in relation to medicines management. We did not identify any issues with staff following national practice at the time of inspection but there were issues identified in audits carried out earlier in the year.
 - The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Any alerts relating to medicine incidents, themes and trends were circulated across all service lines to ensure safe practice. The chair of the medicine management committee was the service lead for safe and secure handling of medicines.
 - The hospice was in the process of implementing electronic prescribing. At the time of our inspection, the hospice was using paper documents for prescribing. Progress was in the initial stages, but the hospice planned to fully implement electronic prescribing within 12 months. It was felt the new system would reduce medicines errors and help with consistency.
 - Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Patient group directions (PGDs) were used within the services provided. The hospice used 21 PGDs, all of which were agreed locally at the medicine's management committee.

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

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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 were aware of what incidents needed to be reported and when. They were aware of the processes they needed to follow. Incidents were reported using paper forms and given to service leads to investigate. The hospice was in the process of developing plans to implement an electronic incident reporting system. A working group had been set up to progress the initiative.
- Staff reported all incidents that they should report. We were not aware of any incidents which were not reported when they should have been.
- Staff reported serious incidents clearly and in line with policy. There had been 16 serious incidents from July 2018 and June 2019. Eight related to safeguarding issues. Six related to pressure tissue damage. One related to a medication issue which was reported to the police. One related to an assault. We reviewed three serious incidents during our inspection and each one had been reported appropriately and in line with policy.
- During the same period, there had been 15 deaths reported and were followed up by the involvement of a coroner. One of those deaths was of a person subject to an authorisation to deprive them of their liberty from a supervisory or court protection. Two of the deaths resulted in an inquest. Five of the deaths related to people who were at the point of death, subject to an authorisation under the deprivation of liberty safeguards, such procedures were usual in these circumstances.
- There had not been any never events from July 2018 to June 2019. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Staff understood the duty of candour. They were open and transparent and gave patients and families a full

explanation when things went wrong. The duty of candour had been applied seven times from July 2018 and June 2019. There was an up to date duty of candour policy and staff were aware of their responsibility in being open and transparent in explaining, guiding and advising when a duty of candour either verbal or written (or both) was required. Hospice staff received duty of candour training and were aware that duty of candour also applied in situations where a patient may yet suffer harm or distress because of something going wrong with their care. The hospice's incident reports required the reporter to indicate if a patient and/or family have been informed of an incident prior to submission. This ensured all incidents, whether beyond our control or avoidable, were declared to individuals.

- Managers debriefed and supported staff after any serious incident. Staff attended learning from death review meetings and managers provided support to staff when difficult situations and serious incidents arose. Staff told us they were debriefed and received support from managers. We were given an example of feedback and support being given in respect of the removal of non-invasive ventilation at end of life.
- Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We reviewed three serious incident root cause analysis reports. Each was thoroughly investigated by an appropriate manager and the appropriate learning, actions and recommendations were identified. We saw patients/families/carers were involved in the process.
- Staff received feedback from investigation of incidents, both internal and external to the service. Staff told us they received feedback following the reporting of an incident. This included the actions that had been taken and those which had yet to be implemented.
- Staff met to discuss the feedback and look at improvements to patient care. For example, falls reviews took place regularly to discuss how care could be improved for individual patients. Physiotherapists were involved to offer advice and were always asked to carry out a review if patients have fallen three times or more.

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- There was evidence that changes had been made as a result of feedback. We were given an example where there had been an incident involving a prescription error by a GP. Following investigation of the incident new processes were implemented to ensure GPs could access the duty clinical nurse specialist for advice on palliative medication.

Safety Thermometer (or equivalent)

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

The hospice monitored the number of new pressure ulcers, falls with harm and new urinary tract infections in patients with a catheter monthly.

- Patient safety performance was variable. We reviewed patient safety data from quarter two (2018/19) to quarter one (2019/20). The data showed patient falls had been above and below the national average, for medium sized hospices, for two quarters respectfully. It also showed medication errors had been above the national average in each of the four quarters.
- Safety performance data was displayed on the inpatient unit for staff and patients to see. Safety performance data was displayed on the inpatient unit.
- Staff used the safety performance data to further improve services. Safety performance data was collected on a quarterly basis and discussed at clinical governance meetings. The data was also used in quarterly quality dashboards. If issues with performance were identified action was taken. For example, refresher training was provided.

Are hospice services for adults effective?

(for example, treatment is 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 hospice delivered care in line with the six steps to success programme. The programme aims to enhance end of life care through facilitating organisational change and supporting and educating staff to develop their roles around end of life care and was supported by the National End of Life Care Programme.
- Research and sharing of best practice was encouraged to ensure the service was providing evidenced based services. The hospice participated in the National Institute for Health Research portfolio studies and other academic research was conducted on site. This was subject to approval and governance via the research steering group. The group included membership from a local university and patient representatives.
- Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff knew when and how to explain to patients their rights under the Mental Health Act.
- The hospice provided a range of services that met people's needs by recognising the patient was approaching the end of their life and conducting appropriate holistic assessments in partnership with them and their close family and friends. Care was tailored to their individual needs and wishes and was focused on helping people to live well until they die.
- The hospice was repeating an organisational assessment of how outcome assessment complexity

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collaboration (OACC) measures were already being used and where they should initiate or improve their utilisation, to enhance their understanding of the impact they had on service users.

- A further event was going to be held with other regional hospices and commissioners to share achievements and learning. A final commissioning for quality and innovation report was to highlight the next steps in continuing to improve their impact measurements and better demonstrate effectiveness of services.
- To ensure care was personalised and bespoke, the hospice planned to make better use of the integrated palliative care outcome scale (IPOS) cohort data to inform future service design and strategy. This work was to help ensure services were continuing to care in the most effective way for the whole population. The hospice was planning to scope software and IT support requirements and submit a proposal for funding to allow them to progress with this project.

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, including those with specialist nutrition and hydration needs. The hospice on-site kitchen provided three meals a day, with snacks and drinks offered at regular intervals and on request. Patients received menu choices before each meal. Patients told us their dietary needs were met and ample choice was provided to them.
- Water jugs were at bedsides and within patient reach. We saw they were refreshed regularly. Hot and cold drinks were offered at regular rounds and were provided on request in between times. A choice of cups, mugs, glasses, straws and beakers were available to suit individual needs and preferences. The hospice occupational therapist advised on equipment needed, as required.
- Patients' experience of nutrition was subject to audit. A nutrition and hydration steering group was convened in 2018 to implement patient safety alert recommendations relating to modified texture diets. The steering group continues to meet to support safety and quality in nutritional care.
- Staff fully and accurately completed patients' fluid and nutrition charts where needed. When clinically indicated, artificial hydration was provided intravenously or subcutaneously. Fluid balance and/or renal function was monitored when required. The hydration status of patients nearing end of life was assessed daily. Impeccable oral care and good communication with family was understood as essential elements of getting hydration care right. The hospice had participated in clinically assisted hydration at end of life feasibility research trial and were praised for being one of the highest recruiting units. The hospice was awaiting the decision as to whether they would be accepted as a recruiting site for the full study.
- Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Patients' nutritional needs and preferences were assessed by a named nurse on admission and an individualised nutrition care plan was completed. Details of medical dietary requirements were passed to the catering staff. This included whether patients had a special diet (diabetic, low salt etc), allergies and whether patients had international dysphagia diet standardisation initiative (IDDSI) modified texture requirements. Catering and clinical staff had received training on IDSSI standards. Catering staff also discussed directly with inpatients their dietary preferences both on admission and regularly thereafter.
- Nursing staff assisted patients with feeding when needed. Patients with these needs received their meals on red coloured trays to aid communication between catering and nursing staff
- The multidisciplinary team were strongly encouraged to respect and prioritise nutrition over other aspects of care at mealtimes.
- Patients were weighed when it was relevant to their individualised nutritional care plan but not routinely.
- Specialist support from staff such as dieticians and speech and language therapists was available for

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patients who needed it. Speech and language therapy (SALT) and dietitian advice and assessment were accessed via local acute trust and community services as required.

- Nutritional supplements and feeds were sourced from pharmacy. Nursing staff were skilled to support patients requiring enteral feeding via percutaneous endoscopic gastrostomy (PEG).
- The multidisciplinary team supported inpatients to consider the most comfortable seating, positioning and equipment (adaptive cutlery and crockery etc) for mealtimes. Nursing staff assisted with hygiene needs before and after meals.

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. We saw the pain assessment tool which was used within the inpatient unit. It recorded the description of the pain, the site and level of pain experienced based on a score of one to 10.
- Patients received pain relief soon after requesting it. We saw, and patients told us pain relief was provided to them when they required it. Patients told us staff regularly asked them if they were in pain and would try to make them as comfortable as possible.
- Staff prescribed, administered and recorded pain relief accurately. During our inspection, we did not identify any issues with the prescribing, administering or recording of pain relief. However, as mentioned in the medicines section, the hospice had identified areas of improvement in their practice regarding controlled drugs through audit.

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 had been accredited under relevant clinical accreditation schemes.

- The service participated in all relevant national clinical audits. The service performed well in national clinical outcome audits and managers use the results to improve services further. As part of the Commissioning for Quality and Innovation framework (CQUIN) for 2019-20 the hospice implemented the outcome assessment complexity collaboration (OACC). The OACC measures were used to improve effectiveness and team working, drive quality improvement, deliver evidence on the impact of services, inform commissioning and achieve better results for patients and families.
- As part of this the hospice had implemented the integrated palliative care outcome scale (IPOS) across all clinical departments as an evidence based holistic assessment tool. This prioritised what mattered most to the patient which was then incorporated into their care plan. This was recorded and used at multidisciplinary team meetings to assess progress and outcomes. This ensured there was a systematic holistic assessment framework which enabled best assessment and a means to ensure outcomes were measured; both for the individual and the service. We saw these documents being completed on admission and then reviewed during admission. However, the hospice did not have the IT capability to measure cohort data at scale and so monitoring performance was not yet possible.
- The family and carer support team (FaCST) had implemented the carers support needs assessment tool. It was being used for all carers seen by the FaCST to ensure holistic assessment of need and a plan of care was then shared and agreed with the carer, recorded and reviewed. This data was being collected and audited to explore cohort data on primary needs of carers to be used to inform future service design.
- Managers carried out a comprehensive audit programme. The hospice had a clinical audit programme that was agreed and developed collaboratively across the hospice. Audits were based on hospice priorities and audited against standards set in local or national guidelines, recommendations from independent reviews or patient safety alerts.
- Managers used information from the audits to improve care and treatment. For example, an audit was carried out to review completeness,

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accuracy and relevance of “do not attempt resuscitation” (DNACPR) forms and advance care plans. We reviewed the most recent audit, carried out in October 2018. The audit highlighted areas of high compliance but also identified areas which required improvement. The audit showed, documenting the rationale for DNACPR decision making, involvement of families when a patient lacked capacity and written information about resuscitation not being documented as being given needed to be improved. As a result, the audit report was presented at the medical team meetings, where staff were reminded about the processes which must be followed, the DNACPR leaflet was put into every admission pack which was given to patients/relatives/carers.

- The hospice had a set key performance indicator (KPI) for discussing advance care plans with patients. The KPI the hospice had to meet was 75%. We reviewed data from quarter two (2018/19) to quarter one (2019/20) which showed the hospice had achieved compliance with this KPI in every quarter with percentages of 82, 89, 89 and 90% in each quarter respectfully.
- Managers shared and made sure staff understood information from the audits. Audits were shared with staff at team meetings and copies were available within the hospice. We saw evidence of this within meeting minutes and staff told us they were updated on audit results.
- Improvement was checked and monitored. The audits were monitored for completion each quarter and reported up through to the audit steering group and clinical governance committee.
- The service was accredited by the Gold Standard Framework. The GSF launched in 2000 to improve standards of end of life care in all settings. The hospice provided a clinical nurse specialist home education programme in the locality.

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. All new starters were subject to a six-month probationary period, which included three specific assessment points. Only on successful completion would their permanent position be confirmed. The hospice gained ongoing assurance as to the effectiveness of registered nurses as they maintained their effectiveness through their registration with the Nursing Midwifery Council (NMC) and the revalidation process. The hospice was also assured staff could perform their roles safely as they completed competency assessments. Healthcare assistants and nurses had a competency workbook they had to complete which had to be signed off by their line manager. The competencies required theoretical and practical assessments, which were also used to identify learning needs. We reviewed completed competency workbooks for healthcare assistants and registered nurses. We saw competencies had been signed by staff and an appropriate supervisor. Competencies for nurses included but were not limited to:
 - Preparing to administer and administering blood/blood products for patients;
 - Obtaining a venous/arterial sample for blood transfusion; and
 - Intermediate/advanced clinical palliative care skills.
- Managers gave all new staff a full induction tailored to their role before they started work. Staff underwent a formal induction before they began their role which encompassed health and safety, mandatory training and use of equipment. As part of the process a checklist had to be completed and signed off by staff and their manager. We reviewed four completed checklists for two nurses and two healthcare assistants and found they had undergone the necessary induction process.
- Managers supported staff to develop through yearly, constructive appraisals of their work. Annual appraisal was mandated which supported incremental progression. The appraisal encouraged reflection of hospice values and objectives that aligned with

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strategic priorities. Staff told us they received annual appraisals and said the process helped them to reflect on their performance and identify areas for improvement.

- Appraisal compliance figures varied depending on role. We reviewed data which showed compliance with appraisals was at 100% for some roles, which included medical staff, facilities, executive directors, human resources and IT. Compliance across the rest of the roles, which included but was not limited to registered nurses, healthcare assistants and clinical nurse specialists, ranged between 40 and 91%. Delivery of staff appraisals was still ongoing and we were told every member of eligible staff would receive an appraisal by years end.
- Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. The hospice had a clinical supervision policy and managers were encouraged to have regular one-to-one meetings with their staff. All staff received one-to-one line management and clinical staff had additional clinical supervision. Clinical supervision was used to support staff to reflect on their practice and maintain high quality care and took place on a six-weekly basis. Team debriefing sessions were also undertaken when required to examine learning from particularly complex cases. Within the hospice, 112 staff had a named person who provided them with regular clinical supervision. This included but was not limited to 56 inpatient nurses, 10 medical staff and 15 integrated community team staff. Staff across all clinical service lines told us they received effective clinical supervision.
- There were enough clinical educators to support staff learning and development. The hospice employed a practice development nurse and a quality assurance nurse whose roles was to work with the teams to ensure high quality practice was being delivered. Staff were supported with their revalidation, encouraged to be reflective practitioners and show commitment to continuous professional development.
- Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us training needs were identified by their line manager through appraisals, one to ones, incidents and complaints. They said managers were supportive in developing them in terms of clinical practice, knowledge and leadership skills.
- Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Team and departmental meetings included an education component where staff shared learning from courses or conferences, present results of audits relevant to their area or share other learning from work experiences.
- Managers made sure staff received any specialist training for their role. The hospice had an annual learning and development budget for individuals to access role specific learning and development. This was based on organisational, professional and individual requirements and learning needs were agreed through discussions with staff at appraisals and one to ones. Across the community palliative care team, one registered nurse was undertaking a MSc in palliative care, one was undertaking a BSc in palliative care, three completed independent prescribing courses, one has completed health assessment training modules and two will be undertaking individual prescribing in September 2019.
- Managers identified poor staff performance promptly and supported staff to improve. The hospice had a performance management policy and processes were used when any underperformance was identified. Support was then given to the staff member, to meet the required standards, using an employee improvement plan.
- Managers recruited, trained and supported volunteers to support patients in the service. Each volunteer was required to apply, after which they were interviewed and two references were required. As with clinical staff, each volunteer underwent a formal induction which consisted of a welcome from the chief executive officer, an overview of the hospice's vision and values, an explanation of the services provided and a session with human resources and the clinical education lead. During induction volunteers also received training on health and safety, fire safety, information governance, equality and diversity and safeguarding adults and children.

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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. All clinicians were involved in regular multi-disciplinary meetings, including volunteers. This provided an opportunity to ensure patients had effective and individualised care plans and for peer review of clinical practice. The hospice had a process and system which catered to patient needs through individualised care plans for each patient. Their choices and preferences were documented and communicated across the multidisciplinary team. Teams included staff who had a broad range of skills, experience and qualifications and strong partnerships with other health and social care providers were created to maintain continuity of care through effective communication.
- Staff worked across health care disciplines and with other agencies when required to care for patients. The hospice often received direct telephone communication from patients and relatives who felt they would benefit from hospice care. They were normally encouraged to approach their GP or responsible clinician for a formal referral so the appropriate clinical information to triage safely was available and the right kind of initial contact for the individual was offered.

In some circumstances, when it was clear the help required was of a very urgent nature, the hospice contacted third party health care practitioners, with patient consent or in best interests, and informed them their input has been requested. Requests were then made for initial referral details to be sent at the earliest convenience.

The care home education and training team had trained more than 300 care home staff since January 2019. It ran alongside the normal clinical nursing specialists visiting advisory service to care homes.

Staff within the hospice and home and clinical nurse specialist teams had close working relationships with the district nursing teams, care homes and acute palliative care teams. This ensured they worked

together to provide integrated care to patients. We saw this when referrals to the inpatient unit were received but a bed was not readily available. Action was taken to ensure all appropriate healthcare providers were informed and care was delivered to the patients while they waited for a bed to become available. In some cases, a local hospice was contacted to see if there was bed availability there.

Seven-day services

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

- The inpatient unit was open 24 hours a day, seven days a week. Patients could access consultant and doctor advice seven days a week.
- The clinical nursing specialist CNS team were available seven days a week, 24 hours a day. However, between the hours of 5pm and 9am, was a telephone advice line. The CNS team did carry out visits on the weekend but not at night.
- The day hospice was open from Tuesday to Thursday and was open 10am to 3pm. On a Monday the day hospice was used to facilitate the specialist clinics. Wednesdays were dedicated to initiating new patients to the service. The day hospice was available to patients as a 12-week therapeutic programme. Therefore, available to patients during the day hospice opening hours during that period.

Health promotion

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

- Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. The hospices' range of services were focused on different goals and outcomes to reflect diverse groups. For example, the day hospice service had a therapeutic programme which had a focus on living well and enablement. This had a greater representation of people with conditions other than cancer who attended as they were living longer with multi-morbidities and required care which focused on enablement.

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Consent and Mental Capacity Act (Deprivation of Liberty Safeguards only apply to patients receiving care in a hospital or a care home)

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act 1983, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. The hospice had a policy and procedures relating to the Mental Capacity Act 2005. The hospice provided training on Mental Capacity Act and Deprivation of Liberty Safeguards that was mandatory. Staff we spoke with knew what their responsibilities were and could accurately describe what processes they would follow if a patient did not have the capacity to consent to care and treatment. There were 32 patients, from July 2018 and June 2019, who lacked capacity and had made a valid advance decision to refuse treatment which could or did affect the care provided to them by the hospice.
- Staff gained consent from patients for their care and treatment in line with legislation and guidance. We reviewed the most recent review of the hospice's clinical guide in relation to decision making and mental capacity from December 2018. It incorporated the National Institute of Health and Care Excellence (NICE) decision making and mental capacity [NG108]. The clinical guide was assessed against the guidance to ensure it complied with NICE guidance, which it did. During the inspection, we observed staff adhering to the clinical guide. Staff gained patient consent before carry out care and treatment and documented it in records.
- Staff clearly recorded consent in the patients' records. We reviewed four patient records and saw consent had been documented in all applicable circumstances.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff were able to provide examples of how and

when to assess whether a patient had capacity. They had appropriate levels of knowledge on how to gain consent and how to assess it. The hospice had appropriate assessment tools for doing so. Between July 2018 and June 2019 there were 19 patients who had given another person valid and active lasting power of attorneys with authority to take decisions about the services provided.

- When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. We reviewed four patient records, within which, we saw examples of best interest decisions documented appropriately.
- Staff made sure patients consented to treatment based on all the information available. We observed staff obtaining consent during our inspection and explaining the proposed care and treatment to patients to ensure they understood what they were consenting to.
- Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. There was a Mental Capacity and Deprivation of Liberty lead who could provide advice and support to staff if required. Staff knew who this was and said they would contact them when required.
- Staff implemented DoLS safeguards in line with approved documentation. We reviewed the DoLS safeguarding documentation which was appropriate.

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. Patients told us staff were responsive to their

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needs and provided high quality care. We observed staff interacting with patients and engaging in pleasant conversation. All clinical staff were due to participate in a mandatory training workshop looking at compassion. The purpose of the workshop was to provide the opportunity for staff to identify personal and organisational/cultural changes that should be implemented to sustain the highest level of compassionate care.

- Patients said staff treated them well and with kindness. Each patient we spoke with told us staff treated them well. This was also reflected in the comments the hospice received following treatment. For example, from January and March 2019 the hospice received comments from patients and their families which included:
 - “The care from the hospice is first class on a medical and emotional level”
 - “As a registered nurse myself, I thought I would find it difficult to allow anyone else to care for my Mum, as I thought no one else could possibly provide care better than me. I can honestly say I was so wrong... I will be forever grateful”
 - “Don’t change what you’re doing...”
- Staff followed policy to keep patient care and treatment confidential. The hospice had an information governance policy and staff were compliant with it. Conversations between staff and patients were kept private and sensitive information was never shared in the presence of those not authorised to hear it.
- 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 were empathetic to patients with mental health needs and we saw this during our inspection.
- Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. The hospice respected the diverse nature of each individual and were responsive to the needs of the multi-cultural nature of their patient population. For example, the hospice had a

designated spiritual care coordinator, spiritual care volunteers and multi-faith chaplaincy support. There was a multi-faith room available for all to use located within the inpatient unit.

- Certain communities preferred support from a volunteer of the same sex. Requests were also made to be supported by a volunteer of a similar age group. Where possible the hospice facilitated this.
- The hospice supported individuals in learning a new language, transporting to and from religious venues and with volunteers who were able to read from religious text to comfort their patients.
- We observed patients being offered spiritual support during our inspection. For example, arrangements had been made for a Jewish care support worker to visit the hospice to visit a patient.
- The hospice was careful to ensure dignity and privacy in the way they delivered physical care. Privacy and dignity were respected during physical and intimate care. At every opportunity, curtains around bed spaces were drawn by staff when intimate care was being provided to the patient.

Emotional support

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

- Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed the approach staff took when interacting with patients, which was supportive and put patients at ease. For example, a patient told us when they were admitted, they were anxious and scared. They said staff were supportive and were able to calm her down. She said the advice provided has helped them through their admission. The family and carer support team offered a range of services for patients and families with complex psychosocial needs.
- Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Most patients were admitted to single rooms, so staff could support them privately

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although some bed bay areas were used. However, the inpatient unit also had rooms and areas which could be used for difficult conversations and for people to take time to reflect.

- Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff and volunteers were experts in using empathy and opening up conversations about an individual's emotional and social needs.
- 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. Family and visitors were able to share mealtimes with inpatients by ordering meals from the kitchen or bringing in their own food and using the microwave. This helped to make patients, families and carers more comfortable.

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 observed staff discussing care with patients clearly. Patients told us they understood what was happening and what treatment/care they required. They said staff used language they understood and were able to ask questions. We observed staff and patients agreeing when and how treatment/care would be delivered.
- Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. The hospice had a learning and development programme which provided advanced communication skills training. This training included the use of SAGE & THYME which is a mnemonic that acts as an aid memoire for a structured conversation with a person in distress or with concerns.
- Patients and their families could give feedback on the service and their treatment and staff supported them to do this. A survey was in use within the hospice which enabled patients, families and carers to provide feedback on the care received. A carer support needs assessment tool was also being used by the family and

carers support team, but phased implementation was planned across all clinical services to ensure the hospice fully addresses all carers needs and offers support or sign posting to other services.

- Staff supported patients to make advanced decisions about their care. Staff were proactive with advance care planning, documenting in the electronic patient record an individual's future wishes around treatment escalation and place of care. This helped staff to know they were always acting in line with what the patient wants even when they lost the capacity to make decisions about their own care.
- Staff supported patients to make informed decisions about their care. Staff encouraged patients to identify their physical symptoms and they were addressed using the skills of the whole multidisciplinary team. Meals were served in the hospice dining conservatory, at chair beside beds or in bed according to patient choice.
- A high proportion of patients gave positive feedback about the service in the patient, families and carers survey. We reviewed the data between quarter two (2018/19) and quarter one (2019/20). The hospice had achieved scores above the national average (95%) in all but one quarter. The quarter below the national average was 93%.

Are hospice services for adults responsive to people's needs? (for example, to feedback?)

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.

- Managers planned and organised services so they met the changing needs of the local population. The hospice provided a community hub for patients and

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their carers (which has operated at various locations in South Birmingham) through their support at home service. Since inception there have been 20 group sessions with an average attendance of seven people per group.

- The hospice had secured trusts and grants funding to extend their children's bereavement support groups to include bereaved children not previously linked to the hospice. For example, those who may have experienced loss through acute death or suicide. The extended groups were due to start in autumn 2019.
- The hospice provided holistic care and its services reflected the needs of the diverse population it served. They have achieved this through community engagement, patient experience feedback and individualised care planning. Induction and mandatory training taught staff how to engage patients in conversations about characteristics and to liaise closely with other key professional teams e.g. equipment services, social services and community health care to ensure patients accessed the right help and support at the right time.
- Three clinical nurse specialists had completed an independent prescribing course and were prescribing in the community and clinic settings. The hospice was also successful in negotiating with the clinical commissioning group to allow the hospice medical team prescribing rights in the community. This provided some patients better access to the medications they needed, when they needed them and reduced the burden on primary care.
- The 'Space to Breathe' service was a six-week programme designed for people living with breathlessness. The programme was designed based on best evidence and the steering group for the design of the programme included staff from the Birmingham case managers team and a local acute hospital respiratory team. By joint working it allowed shared understanding, improved relationships and a clear path for referral and access.
- The hospices community development and partnerships lead were working to identify exciting opportunities to adapt the services offered and worked alongside the people of Birmingham to improve care of the dying.
- In July 2019, the hospice had reduced their beds from 16 to 13. This decision was made to ensure the sustainability of the service. The hospice had made the decision in partnership with the clinical commissioning group. At the time of our inspection, there had not been any significant impact in terms of patient admissions or care. However, the hospice was continuing to monitor this through the inpatient admission waiting list.
- The hospice had two home from home beds which were commissioned by the local clinical commissioning group. The beds were used for patients who could be cared for at home but required the support of an inpatient service to facilitate their preferred place of death.
- Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Patient bed bays on the inpatient unit were split into male and female. Staff ensured patients were admitted onto the appropriate bays and took steps to ensure no mixed sex breaches occurred.
- Facilities and premises were appropriate for the services being delivered. The hospice had facilities designed around patient and family needs. Within the inpatient unit (IPU) there was a family centre with included a patient room and one visitor bedroom. There was a separate shower room which enabled a family member to stay in a self-contained facility that also had full kitchen facilities. This allowed families to be together in privacy. The IPU had three mobile beds that could be used in any room allowing flexibility for relatives/carers/families to sleep by the bed side if required. Each bed space also had a recliner chair for patient or family use.
- Meals and snacks for visitors were available from catering upon request. We saw the menu available to visitors which offered choice. There was a small kitchenette on the inpatient unit where simple snacks were prepared for inpatients at any time of day or night. There was a lounge area with a sofa and television for visitors to use which was away from the IPU. Vending machines were also available which ensured visitors had 24/7 availability of cold refreshments and snacks. There was free on-site parking.

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- There was a children's room located within the day hospice to support children and young people pre/post bereavement.
- Patients and their families had access to a large secure sensory garden area with seating and patio furniture. Large conservatory area that has been fully refurbished to be dementia friendly.
- There were multiple quiet rooms which were used for sensitive and confidential conversations/meetings.
- There was a multi-faith peace room with a separate prayer room.
- Staff could access emergency mental health support for patients with mental health problems, learning disabilities and dementia. Within the hospice, there were trained counsellors and staff who could provide mental health support to patients.
- The service had systems to help care for patients in need of additional support or specialist intervention. Services were tailored to individuals. The support at home service was the newest addition to their services. It offered volunteer led emotional and practical support, companionship and social support, respite for carers and community-based peer support hubs for patient and carers.

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. The hospice had plans to launch a mental health first aiders scheme in September 2019. This was to promote broader understanding around mental health issues. The hospice supported the last two mental health awareness weeks through events and information workshops.
- The ward was designed to meet the needs of patients living with dementia. The inpatient unit consisted of patient bays and individual rooms. If patients were living with dementia they were admitted to beds

which posed the least amount of risk to their safety. The unit had a dementia friendly conservatory which had been designed to ensure the needs of patient living with dementia were met. The conservatory had furniture with built in pressure relief cushions in neutral patterns look like conventional home furniture, the flooring was non-reflective and had acoustic noise reducing properties, signage was upgraded to be clear and easy to read with good contrast between text and background. The layout of the room was set to provide clearly defined spaces for sitting and dining and to encourage social interaction between all users and created uninterrupted access to the garden and seasonal awareness. A music player with radio was in situ with a selection of music styles to encourage patients to reminisce. The colour scheme provided bold colours but avoided any colours or patterns that caused perceptual issues and ensured clear definition between the walls and the floor. The conservatory was chosen for the natural lighting levels to help with orientation of the time of day, adjustable lighting was also installed to allow for longer usage without detriment to patients with dementia.

- Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The hospice ran an awareness session for staff on visual impairment in conjunction with a national deaf/blind charity.
- The service had information leaflets available in languages spoken by the patients and local community. The hospice had information leaflets in the seven most common languages in their catchment area.
- Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed. The hospice recruited volunteers from many different ethnic, social and professional backgrounds to try and accommodate patient preferences, when possible. Within the hospice there were 26 volunteers who collectively spoke 14 different languages including: Mandarin, Urdu, Spanish, and British Sign Language. The volunteers practiced six faiths collectively. This was to ensure that language, as well as cultural and religious sensitivities, were not a barrier to accessing the service.

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- Patients were given a choice of food and drink to meet their cultural and religious preferences. On patient and visitor menus there was a notice to notify the cook for medical or cultural requirements. We were told special meals were ordered in if the cooking staff could not facilitate a request on site.
- Staff had access to communication aids to help patients become partners in their care and treatment. There were 44 staff across the hospice who had been trained in advanced communications. Clinical staff working in complex areas had advanced communication skills training which was delivered by the cancer network. Clinical staff also had clinical supervision with a Psychologist, during which they developed their advanced skills through critical reflective practice. Enhanced communication skills training was currently being developed the hospice's education team.
- There was a system of triaging referrals to ensure the hospice were using their resources appropriately and offering individuals the right choices at the right time for them. The hospice relied on the referrers' judgement about urgency (from two to 10 days). The hospice set themselves a target of contacting all individuals no later than 72 hours of their referral being received and were invited to attend a community clinic, hospice clinic or be assessed at home. Those people referred as two-day urgent referral were contacted within 24-48 hours of referral. We reviewed data relating to the response times to urgent and non-urgent referrals from quarter two (2018/19) to quarter one (2019/20). The hospice had achieved 100% compliance with their targets in each quarter.
- Day Hospice (DH) patients were contacted within a week of their referral being received. There may be a wait if transport was required to attend the DH, but patients were kept informed about projected date for first attendance. Patients could be re-referred for the DH programme again after six months, if required. Attendance levels were monitored, and numbers booked predicted non-attendance rates, to ensure capacity was sustained and maximum numbers of patients were being offered places.

Access and flow

Patients could access the specialist palliative care service when they needed it. Waiting times from referral to achievement of preferred place of care and death were in line with good practice.

- Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. There was a waiting list for inpatient admissions which was managed by the multi-disciplinary team, including a triage nurse. The patients on the list were discussed daily and beds allocated according to clinical priority. Waiting times were audited regularly and reported to the clinical governance committee and clinical commissioning group. The hospice worked closely with partners across the region, including; other hospices, community providers and acute trusts, to coordinate admissions. When a hospice bed could not be immediately offered to an individual, they were often provided additional support in the community. For example, hospice at home service or given the option of access to bedded care in another environment, when appropriate. We reviewed data relating to the waiting list for inpatient admissions from quarter two (2018/19) to quarter one (2019/20). The waiting times for admission ranged between three and four days.
- The integrated community team developed an urgent response system. A nurse based in the hospice at home team was allocated each day as available to react to requests for assistance quickly, by either visiting the patient at home the same day or co-ordinating other community services the patient requires. This meant even when an individual's named clinical nurse specialist was not available, there was always access to face to face palliative care support. An out of hours clinical nurse specialist on call service was available from 5pm to 9am. This could be used for telephone advice. This meant there was always access to support for those caring at home. Any complex medical queries were escalated to the out of hours consultant on call service.
- The family and carers support team service was delivered by a small team of paid staff and a large cohort of volunteers. There have been occasions in the last year, where unanticipated staff absence or lack of volunteer availability has impacted the hospice's

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ability to offer immediate assessment for bereavement care. In this situation, the hospice held and managed a waiting list. The hospice was working on service improvements to optimise volunteer recruitment and retention and minimise single person dependency across the specialisms.

- Patients referred to “Space to Breathe” were contacted as referrals were received and given appointments to attend the next available cohort. Time limited programmes allowed more equitable access to the service.
- Patients who have been known to the service before and discharged, could trigger a re-referral by telephoning in. In this circumstance, the patient’s GP was contacted and asked to send any up to date clinical information.
- Managers and staff worked to make sure patients did not stay longer than they needed to. Staff engaged with patients about advance care planning at the earliest but most appropriate opportunity, to establish what their preferred place of care was. This meant care plans could be implemented and action was taken to ensure patients were cared for where they wanted. If it was a patient’s wish to be cared for at home, and it was safe to do so, discharges would be planned, and provision made to facilitate this. However, if it was the patient’s wish to be cared for within the hospice, this was facilitated.
- Staff planned patients’ discharge carefully, particularly for those with complex mental health and social care needs. Discharges were coordinated with third party health and social care providers to ensure patients, wanting to be cared for at home, were safe. Staff appropriately liaised with local authorities and community healthcare providers to secure appropriate care packages and then worked alongside them to deliver the care which reflected patient wishes.
- All community palliative care team referrals were triaged and allocated to a caseload using the first contact system. The hospice has seen a year on year rise in demand for services and have adapted ways of working to meet the demand. There was currently no waiting list system for community input. Patients on clinical nurse specialist caseloads were followed up by

a registered nurse in hospice at home service to maintain timely review. This was done by using the tasks and ledger process on the electronic patient record. Patients were discharged from a caseload when their condition and symptoms were stable.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

- Patients, relatives and carers knew how to complain or raise concerns. Patients were issued with a patient information booklet once they started to receive care from the hospice. The booklet outlined the methods they could use to raise a concern. There was a shorter compliments, complaints and suggestion leaflet for patients, visitors and supporters which was available within the hospice.
- The service clearly displayed information about how to raise a concern in patient areas. The hospice had a complaints and concerns section on their website, featuring a telephone option and an option to write. They also received reviews on social media where people could publicly share their feedback. A copy of the complaint procedure could be obtained from reception on request.
- Staff understood the policy on complaints and knew how to handle them. Staff knew what the complaint procedure was and could explain what they would do if a patient wanted to raise a formal concern about their care.
- The hospice received 16 complaints from 1 July 2018 to 30 June 2019. Eleven were handled through the hospice’s formal complaints procedure. Eight were upheld. The target date for responding to complaints was 30 days. Nine complaints were resolved by the target date and the others were near to the timeframe.
- Managers investigated complaints and identified themes. We reviewed three complaints files during our inspection. We saw each was appropriately investigated and learning was identified.

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- Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Within the complaints files we reviewed, we saw complaints were appropriately acknowledged and patients received feedback on their complaints. Their questions were addressed, and they were notified of what changes had been implemented or learning identified. In addition, anyone who had an issue and wanted to bring it to the hospice's attention had the option to discuss it with the head of human resources. The head of human resources held organisational responsibility for coordinating responses to all complaints. People could also write to the hospice regarding their concerns, via the chief executive officer.
- Managers shared feedback from complaints with staff and learning was used to improve the service. Feedback, compliments and complaints were shared. Identified learning was shared and actions taken to improve care. Services were adapted to ensure the hospice was fulfilling changing patient and family's needs and expectations. We saw evidence of this within clinical governance meeting minutes and staff told us they received regular updates on complaint outcomes.
- The hospice received 132 compliments from 1 July 2018 to 30 June 2019.

Are hospice services for adults well-led?

Good 

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

Leadership

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

- Leaders within the hospice had the required skills, knowledge and experience to run the service. The chief executive officer (CEO), medical director and

director of nursing had been in their role for many years and had extensive knowledge of the hospice and end of life/palliative care. The CEO had a strong background in business administration with specific qualifications in marketing, health and social care and teaching. Both the medical director and director of nursing held qualifications in palliative care and had extensive experience in a variety of health care settings. The director of nursing also had a master's in leadership for health service improvement.

- The challenges to quality and sustainability were understood by the leaders and they had identified actions needed to address them. Leaders told us the challenges were centred around funding and recruitment and retention of staff. Actions had been identified to address the challenges. For example, it was recognised the hospice inpatient unit could not continue to keep 16 beds open without financial, quality and safety implications, so the decision was taken to close beds to ensure the sustainability of the service and quality and safety of the care delivered.
- Leaders were visible and approachable. Staff told us all levels of leadership were visible and approachable. Staff felt they could raise concerns, issues and ideas with their line manager or escalate to senior leadership without hesitation.
- The relationship between senior leaders, including trustees, and operational staff was effective. We spoke with senior leaders, operational staff and a trustee. All described their relationship as being effective. We were told there was an environment within the hospice and governance structures where challenge was welcomed and encouraged.
- Trustees ensured they met their governance responsibilities and had a good understanding of quality and safety of care. The chair of the clinical governance committee was a trustee and two other trustees sat on the committee. Many of the other trustees had a background or expertise in health care and held roles within acute or community NHS trusts. During the inspection, we spoke to a trustee who was able to explain their role within the governance structure and demonstrated their understanding of quality and safety.

Vision and strategy

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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.

- There was a clear vision and a set of values, with quality and sustainability as the top priorities. The vision of the hospice was “A future where the best experience of living is available to everyone leading up to and at the end of the life.” The trust had a strategy for delivering on their vision which was outlined in their hospice strategy 2016-2020. The strategy was based on five priorities:
 - Providing a better experience at the end of life.
 - Expanding our specialist centre of research and learning.
 - Locating our facilities so we can reach more people.
 - Being an employer and volunteering centre of choice.
 - Achieving growth, influence and financial stability.
- A study was conducted into the future demands for hospice care over 2017 and 2018. This was to redesign services, so they were fit for the future. This involved looking at various sources of data related to future demand and consultation with a range of stakeholders. Staff and volunteers were engaged through workshops.
- There was a robust, realistic strategy for achieving the priorities and delivering good quality sustainable care. The hospice was delivering on their vision and strategy. Since the launch of the hospice’s strategic plan, the number of patients seen by the hospice had increased year on year from 1200 in 2015/16 to 1,699 in 2018/19. The hospice had also successfully introduced several new service initiatives to ensure responsiveness to the growing demand for hospice care. This included satellite clinics, new day services/therapies, a triage nurse to facilitate and coordinate referrals and extending family and carer support through the support at home service.
- The vision, values and strategy were developed using a structured planning process in collaboration with staff, people who use services, and external partners. As mentioned above, the trust had a formal strategy and were delivering it. They were in the process of updating their strategy using input from staff, referrers, volunteers and patients. For example, the hospice had formed a partnership with another local hospice to assist and support each other for the benefit of patients. This was a formal partnership agreement and it was thought by working more closely together it would ensure more people received better care at the end of life. A business case was being developed for a jointly coordinated 24/7 hospice at home and urgent response service.
- A resilience plan was developed to ensure services were sustainable and recurrent. The resilience plan was presented to the board of trustees in July 2019. One aspect was a reduction of inpatient beds within affordable levels. This was done in communication with the clinical commissioning group who were informed about patients requiring admission. Other units were being used where occupancy rates were lower, so referrals could be diverted according to need and capacity. There was close monitoring of quality assurance during the changes.
- Staff knew and understood what the vision, values and strategy were, and their role in achieving them. The values of the hospice were; delivering quality care, improving access for all, sharing expertise, working collaboratively and changing attitudes. The values were displayed within the hospice and staff were aware of what they were. We observed staff living the values during our inspection. Staff were aware of how they were helping the hospice achieve its vision. Staff and volunteers were encouraged to inform the hospice strategy, through open forum sessions.
- The strategy aligned to local plans in the wider health and social care economy, and services had been planned to meet the needs of the relevant population. The updated strategy being developed by the trust was focussed on developing a whole system approach to ensure they fit in with but were also influential in the sustainability and transformation plans (STP). The chief executive officer (CEO) was chair of the end of life and strategic planning group within the STP and so had direct influence in how end of life systems were being designed. This allowed the hospice to work with

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other end of life care providers within the region and share resources to enable better care and treatment for patients. The group had a work programme which aimed to integrate end of life care across all STP work-streams. The STP work programme incorporated the recommendations from the hospice's study into the future model of hospice care.

- Progress against delivery of the strategy and local plans were monitored and reviewed. We spoke with the CEO and reviewed the most recent strategy and associated action plans. A strategic subgroup of the board of trustees was set up to enable trustees to conduct their responsibilities to lead and develop the new strategic plan with the executive team and ensure deadlines were met so it could be launched ahead of the next financial year.

Culture

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

- All staff we spoke with felt supported respected and valued. Staff told us how supportive their immediate line manager was but also commented on the support from senior leaders. The hospice submitted award nominations to recognise the contributions of individual staff members and volunteers and to showcase the achievements of specific services and the hospice in general. Staff felt this award scheme provided recognition for the work they did. The hospice recognised long service, by giving internal awards to staff and volunteers. This year they recognised some individuals who had provided care for all throughout their 40-year history.
- The culture of the hospice centred on the needs and experience of the people who used the services. Staff at every level and within each service were passionate about delivering care and treatment which addressed their patients' needs. Leaders were focussed on ensuring patients received care and treatment which was safe and of the highest quality. This was demonstrated in the care being delivered, the focus on ensuring lessons were learned when issues arose and the attitude of staff we spoke with.
- Staff felt positive and proud to work in the hospice, whether on service they worked within. Every member of staff we spoke with was proud to work for the hospice and told us they looked forward to coming in to work every day.
- The culture encouraged openness and honesty at all levels within the organisation, including with people who use services and leaders and staff understood the importance of staff being able to raise concerns without fear of retribution. The duty of candour was understood by all staff we spoke with. Staff felt able to raise concerns and told us there were no barriers when escalating incidents or complaints. Staff said they were open with patients when things went wrong and were encouraged to do so by leadership.
- The hospice had a named freedom to speak up guardian and four champions. There was a grievance policy and whistleblowing/freedom to speak up procedures for staff to use when they had concerns/issues.
- Appropriate learning and actions were taken when concerns were raised. We saw from minutes of governance meetings there were agenda items focussed on learning from incidents, complaints and feedback. We also saw recommendations and learning being highlighted in incident reports which was fed back to staff.
- There were mechanisms for providing all staff at every level with the development they need, including high-quality appraisal and career development conversations. As discussed in the competent staff section above, all staff received an annual appraisal where career development would be discussed. Following which, actions would be agreed, and steps taken as an when appropriate.
- There was a strong emphasis on the safety and well-being of staff. As mentioned above, in the background section above, the hospice provided a clinical nursing specialist (CNS) service to patients. The CNS would often work on their own when treating patients in the community. The hospice had a lone

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worker policy which was used to ensure there were processes to keep CNS staff safe. For example, each CNS had an electronic ledger which duty nurses had access to, so they knew where staff were. Staff were required to call the duty nurse following their final visit to confirm their safety. The hospice also had a staff well-being strategy. Over the last two years, a range of well-being initiatives had been implemented which included resilience workshops, wellbeing days and mental health awareness events.

- Equality and diversity were promoted within and beyond the organisation. The hospice was awarded the “Investors in Diversity” level 2 award by the National Centre for Diversity and were the first UK hospice to receive this award. The hospice had a dignity at work and equal opportunities policy which outlined how the hospice supported their workforce. The human resources department completed equality data verification which supported awareness of how the hospice workforce complements the communities it served and identified any shortfalls in characteristics represented. All staff received mandatory equality and diversity training every two years.
- The hospice was committed to the disability confident scheme. The disability confident scheme is a government scheme that supports employers to make the most of the talents disabled people can bring to the workplace. The hospice applied to continue being part of the scheme for the next two years and were awaiting confirmation of the outcome.
- The hospice had links to a specialist recruiting website which attracts candidates from Black, Asian and Minority Ethnic communities.
- The hospice attended PRIDE and EID events within Birmingham to promote their services and highlight that support they provide for everyone.
- A representative from the hospice attended an event at a refugee centre to forge links and increase awareness of volunteering and employment opportunities across the community.
- The Board of Trustees reflected the diverse community the hospice served. It was inclusive of male and female members from different cultural backgrounds, bringing with them a diverse set of skills and expertise.

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.

- There were effective governance systems within the hospice. There were bi-monthly clinical governance meetings. The attendees included the trustees, medical directors, director of nursing, lead inpatient nurse, consultants, integrated community team lead, professional development nurse, lead clinical nurse specialist and community development lead. Minutes of the meeting were taken and circulated afterwards. The chair of the clinical governance committee was a trustee.
- We reviewed clinical governance meeting minutes for February, April and June 2019. Each meeting had standing agenda items which included but were not limited to activity monitoring, clinical policy updates, clinical audit updates, risk register, equality, quality dashboard, incidents, patient and carer feedback and infection prevention and control. Minutes were not always detailed for each agenda item but there was enough detail when issues arose. An action log was taken and discussed at each meeting.
- There was also a fortnightly executive board meeting. This was a formal meeting and minutes were taken and circulated. At the meetings, performance and safety were discussed, including each service line provision.
- Meetings took place for each service line. We spoke with the leads, who told us they were able to arrange meetings regularly, at which they would discuss clinical governance information. They discussed incidents, complaints and performance.
- The hospice had separate committees and groups which met quarterly and fed into the clinical governance and leadership structure. For example, there was a medicines management, infection prevention and control, research and steering, audit

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steering and service performance review groups. The membership of the groups included operational and leadership staff. Meetings were summarised and presented at the clinical governance meetings.

- The hospice was in the process of recruiting a governance manager as the post became vacant in August 2019. At the time of our inspection, the clinical administration lead was supporting the deputy director of nursing, to monitor quality and patient safety data.
- We were assured each service lead, both clinical executives and the chair of the clinical governance committee understood their individual responsibility for ensuring effective governance.

Managing risks, 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. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

- Performance was monitored and reviewed. The hospice produced a quarterly quality dashboard which looked at safety performance across all service lines. The quality dashboard covered falls, pressure ulcers, medication incidents, incidents, infections, safeguarding and Deprivation of Liberty Safeguards applications, patient/carer experience and staffing. Performance was also benchmarked against other hospices. We reviewed the dashboard which covered quarter two (2018/19) to quarter one (2019/20).
- This was discussed at executive board and clinical governance meetings. The hospice leadership team also reviewed clinical audit reports, National Institute of Health and Care Excellence (NICE) guidance compliance, complaints and mandatory training compliance. As described above, we reviewed three sets of minutes from February, April and June 2019 and saw the above items were discussed and in detail. When issues with performance were identified, actions were taken. For example, improvements were required in referral processes and this was taken back to the relevant team.

- Service performance was monitored and reviewed. The hospice reviewed performance in relation to inpatient bed days, day hospice activity, average length of stay, hospice at home service activity, specialist palliative care team activity, number and type of discharge and therapist activity. Planned activity was reviewed against actual service delivery for each service line. The hospice also reviewed their performance in respect of the percentage of patients who had discussed an advance care plan and the patient/carer/family satisfaction survey.
- Risks were identified, understood and recorded appropriately. The executive team were aware of the top risks for the hospice and able to explain how they were mitigating them. The hospice had an overall risk register which had 21 risks on it. The level of those 21 risks ranged between eight and 25. The highest risks associated with the hospice related to the hospice's financial stability, reserves policy and statutory compliance failure. Each risk had the date the risk was put on, the date it was last reviewed, who owned the risk and the mitigating actions, which enabled trustees and executives to focus their attention accordingly. The entire risk register was presented to the board of trustees on an annual basis identifying the procedures and systems to manage those risks with high risk ratings.
- Risks were regularly reviewed. The executive and business development team maintained a 'live' risk register that assessed governance, operational and strategic risks.
- On a quarterly basis the finance and audit, governance, compliance committee, health and safety, environment, risk, information governance, clinical governance committee and HR committees reviewed and challenged the risks relevant to their committee. This ensured the level of risk remained appropriate and mitigating actions had been taken to manage the risk.
- The executive team was responsible for the management of risk through the governance committees and ensured actions were taken to minimise and remedy identified risks. There were

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systems to share good practice and continually improve the quality of care, clinical effectiveness and leadership across the hospice. Each committee met at least once a quarter.

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.

- Performance measures and data were being collected, monitored and reviewed. Each service line had separate performance measures based on activity. As described above, in the management of issues, risks, performance, data relating to safety and performance were collected monthly and discuss at relevant meetings. The appropriate people were made aware of performance whether good or bad. Information was reviewed monthly/bi-monthly/quarterly by the various committees and leadership teams.
- The data collected was easy to understand and was clear on whether performance was within or outside an expected/planned range. The information was shared at relevant meetings and staff were aware of how their service line was performing.
- Information relating to outcome measures was being implemented but not yet embedded. As described in the patient outcomes section above, the hospice had implemented the integrated palliative care outcome scale (IPOS). However, this was a new initiative and the hospice could not yet pull data to assess whether they were performing as expected. This was being worked on, but it was not known when they would have the capability to do this.

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 hospice held open forums for staff. The forums included communication briefings, staff engagement sessions and away days. Staff told us of specific sessions they had with the chief executive officer regarding the recent bed closures.
- An online suggestion box system was in operation and staff/volunteers were encouraged to provide feedback. Staff told us they were aware of the suggestion box and would use it when they wanted to provide any feedback.
- A staff survey was undertaken, facilitated and analysed by an external agency. The results were benchmarked against previous years and with other organisations in the sector.
- The hospice had different methods of collecting feedback from their patients and their families/carers. One method was a patient/carer experience questionnaire. The responses from the questionnaire were compiled into a summary document. All comments, both complimentary and suggestions for improvements and concerns, were also included in the summary. The summary provided information on percentages for the number of patients who:
 - Felt comfortable and free from distress;
 - Experienced positive impact on quality of life;
 - Felt their main concerns/problems were addressed;
 - Believed contact with the hospice was making a difference to their experience,
 - Were able to have timely and honest conversations; and
 - Were likely to recommend the hospice.
- All service leads read the collated comments and drew out learning and developed actions specific to their departments based on patient feedback. An example of a response to carer feedback was the provision of a microwave in the visitors' lounge to heat up food.
- The responses by service leads were monitored by the quality assurance support nurse and the nursing director, to ensure actions were appropriate, timely and responded adequately to the feedback given.

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- The hospice sent out a quarterly newsletter to staff. Items in the letter included but were not limited to service developments, support sessions, learning from deaths, employee forum details, research initiatives and dementia friends' workshops.
- Patient/carer feedback and actions were discussed at clinical governance committee, where trends were identified and if needed, learning shared across the organisation
- The hospice received letters and cards from patients, their families and carers. Any letters or cards received, containing feedback, were handed to the governance department. They were collated, and the number received was included in quarterly reports. Trustees and senior managers had sight of the number received and were provided with a sample. Data was included in the quality account document together with feedback received through social media and the patient experience feedback forms.
- The public relations and marketing team interviewed a sample of patients, carers and family members who expressed wishes to give additional feedback on hospice services for marketing purposes. From the interviews, personal stories were developed and published as blogs on the hospice website and shared on social media and as part of fundraising campaigns. Full consent was obtained on consent forms and individuals were sent the final version to approve before it was used in hospice marketing. The stories provided insight into people's experiences and shed personal light on the impact of the care provided.
- The support at home service recorded audio clips of patients and carers expressing the benefits of the service. This enabled the hospice to show funders the benefits the service was providing.
- The hospice was relaunching an employee forum with representatives from across hospice departments being encouraged to engage in regular meaningful consultation and information sharing.
- As part of the engagement programme, trustee walkarounds of services took place four times a year. Action plans were produced following the visits.
- The hospice was awarded an "Employee Engagement Award" by a third-party company assisted

not-for-profit organisations develop and sustain the highest levels of employee and volunteer engagement. The award was for the hospice's employee engagement scores in their recent staff survey.

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.

- Work was being carried out to continuously improve the care and treatment provided by the hospice. A new education initiative was being launched to train staff, working on an innovative 'early intervention' project for Birmingham and Solihull, in key end of life care skills
- New initiatives were being developed to expand the work the hospice carried out. For example, the hospice was seeking funding for a hospice-based heart failure programme and were jointly bidding for resources to implement a programme of support for end of life care in the homeless population.
- As mentioned above, in the vision and strategy section, the hospice had a focus on research. The hospice had recently won an award for being one of the UK's 'most research active hospices' at the National Institute for Health Research awards.
- The hospice had participated in clinically assisted hydration at end of life feasibility research trial and were praised for being one of the highest recruiting units. The hospice was awaiting the decision as to whether they would be accepted as a recruiting site for the full study.
- Within the hospice there were two designated registered nurses who worked closely with 21 care homes in the local area. Their role was to support staff with education around end of life care based upon a six steps programme. The six steps to success programme was developed in the North West of England and is supported by the National End of Life Care Programme for End of Life Care.

Outstanding practice and areas for improvement

Outstanding practice

- The service had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.
- Managers planned and organised services so they met the changing needs of the local population. The hospice provided a community hub for patients and their carers (which has operated at various locations in South Birmingham) through their support at home service. Since inception there have been 20 group sessions with an average attendance of seven people per group.
- The hospice had secured trusts and grants funding to extend their children's bereavement support groups to include bereaved children not previously linked to the hospice. For example, those who may have experienced loss through acute death or suicide. The extended groups were due to start in autumn 2019.
- The 'Space to Breathe' service was a six-week programme designed for people living with breathlessness. The programme was designed based on best evidence and the steering group for the design of the programme included staff from the Birmingham case managers team and a local acute hospital respiratory team. By joint working it allowed shared understanding, improved relationships and a clear path for referral and access.
- The unit had a dementia friendly conservatory which had been designed to ensure the needs of patient living with dementia were met.
- The strategy aligned to local plans in the wider health and social care economy, and services had been planned to meet the needs of the relevant population. The updated strategy being developed by the trust was focussed on developing a whole system approach to ensure they fit in with but were also influential in the sustainability and transformation plans (STP). The chief executive officer (CEO) was chair of the end of life and strategic planning group within the STP and so had direct influence in how end of life systems were being designed. This allowed the hospice to work with other end of life care providers within the region and share resources to enable better care and treatment for patients. The group had a work programme which aimed to integrate end of life care across all STP work-streams. The STP work programme incorporated the recommendations from the hospice's study into the future model of hospice care.
- Equality and diversity were promoted within and beyond the organisation. The hospice was awarded the "Investors in Diversity" level 2 award by the National Centre for Diversity and were the first UK hospice to receive this award. The hospice had a dignity at work and equal opportunities policy which outlined how the hospice supported their workforce. The human resources department completed equality data verification which supported awareness of how the hospice workforce complements the communities it served and identified any shortfalls in characteristics represented.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure all staff follow medicines management policy.