

St. Ann's Hospice

St Ann's Hospice Little Hulton

Inspection report

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

Ratings

Overall rating for this location

Outstanding 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Outstanding 

Are services responsive to people's needs?

Outstanding 

Are services well-led?

Outstanding 

Summary of findings

Overall summary

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

- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers and went above and beyond what would have been expected to meet individual needs and wishes.
- Services were delivered in a way to ensure flexibility, choice and continuity of care and were tailored to meet patients' individual needs and wishes. The service planned and provided care in a way that fully met the needs of local people and the communities served. It also worked proactively with others in the wider system and local organisations to plan care and improve services.
- Leaders ran services well, led innovations and supported staff to develop their skills. Staff understood the vision and values, and how to apply them in their work. Staff were motivated to provide the best care they could for their patients. There was a common focus on improving the quality and sustainability of care and people's experiences. Staff were proud to work at the service and felt respected, supported and valued. Leaders operated effective governance processes and staff at all levels were clear about their roles and accountabilities. The service engaged well with patients, staff and the local community.

We found areas of good practice:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- There was a holistic approach to assessing, planning and delivering care and treatment to people who use the services. The safe use of innovative and pioneering approaches to care and how it is delivered were actively encouraged. All staff were actively engaged in activities to monitor and improve quality and outcomes. Teams were committed to working collaboratively and found innovative ways to deliver more joined-up care to people who use services.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	Outstanding 	Our rating of this service stayed the same. We rated it as outstanding. See the summary above for details.



Summary of findings

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Summary of this inspection

Background to St Ann's Hospice Little Hulton

St Ann's Hospice is situated in the Little Hulton area of Salford, Greater Manchester and is registered as a charity. Services include an 18 bedded inpatient unit, The Being You Centre (providing in person and online support to people living with a life limiting illness), hospice at home, an enhanced community specialist palliative care team, a rehabilitation service, homeless palliative care service, bereavement support, complementary therapies and a 24 hour advice line.

The head of clinical services was the registered manager.

The service is registered with the CQC to provide:

Treatment of disease, disorder and injury

Diagnostic and screening procedures

Transport services, triage and medical advice provided remotely.

How we carried out this inspection

We visited the inpatient unit and observed a clinical nurse specialist home visit. We spoke with staff delivering inpatient, community and bereavement services. We held interviews with service leads and executives. We spoke with 31 staff and volunteers including clinical nurse specialists, registered nurses, health care assistants, medical staff, bereavement staff, catering staff, housekeeping and facilities staff, reception and non-clinical staff. We also spoke with three patients and relatives who had experienced support from hospice staff. We observed care and treatment provided in the inpatient unit, reviewed data about the service and reviewed eight patient care records.

We undertook this inspection as part of a random selection of services rated Good and Outstanding to test the reliability of our new monitoring approach.

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

Outstanding practice

We found the following outstanding practice:

- Staff demonstrated the highest level of compassion. There were examples of where staff had gone the extra mile to support patients and those close to them at the end of life. This included supporting patients to connect with estranged family members at the end of life. Feedback from patients and those close to them was consistently positive.

Summary of this inspection

- Services were delivered in a way to ensure flexibility, choice and continuity of care and were tailored to meet patients' individual needs and wishes. The service planned and provided care in a way that fully met the needs of local people and the communities served. The hospice had worked to increase the inclusion of underrepresented patient groups as part of their strategy. They worked to increase access to services for the homeless population, people with learning disabilities, people with autism, those from a range of cultural backgrounds, older patients, and those with dementia.
- Leaders ran services well, led innovations and supported staff to develop their skills. There was a common focus on improving the quality and sustainability of care and people's experiences, including in the wider community. They worked within the community to influence improvements to palliative and end of life care. The hospice had received the investors in people gold award in 2021. They were finalists in the Nursing Times workforce of the year award and Health Service Journal awards in 2019 for their community specialist palliative care service. They had been recognised for their work on supporting the homeless population of Greater Manchester to access specialist palliative care services. Leaders supported staff in their wellbeing and had trained mental health first aiders amongst the staff team.

Our findings

Overview of ratings

Our ratings for this location are:

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



Hospice services for adults

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

Are Hospice services for adults safe?

Good



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

Mandatory training

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

Staff received and kept up-to-date with their mandatory training. Overall e-learning mandatory training compliance was at 95% against a target of 90%. Additional training was completed through a rolling annual programme for modules such as basic life support, manual handling and medicines management. The current rolling programme commenced in October 2021 and data we reviewed showed that 20% of eligible staff had completed basic life support and manual handling training to date. Staff were scheduled to complete this training in the six months from the start date and were on schedule to complete it by the end of the year. The previous year's completion rate was 100% for basic life support and 94% for manual handling. At the time of inspection 77% of nurses had completed medicines management training in the current year, with plans in place to ensure all nursing staff had completed the training by the end of the year.

The mandatory training was comprehensive and met the needs of patients and staff. Training modules included health and safety, fire safety and infection control. Training was designed to meet the needs of all staff based on their role within the hospice. For example, nursing staff completed verification of death, tissue viability and syringe driver training. Clinical staff completed training in the identification of metastatic spinal cord compression (a serious condition where cancer can press on the spinal cord). Clinical staff had regular training in the management of reversible causes.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training.

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.



Hospice services for adults

Nursing and medical staff received training specific for their role on how to recognise and report abuse. This included level three safeguarding training. Compliance was at 84% against a target of 85%. All new staff working in the hospice completed safeguarding awareness training within their first six weeks in post. Compliance for this was at 100%.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff had received training in equality, diversity and human rights and understood their responsibilities in relation to this.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. There was a dedicated safeguarding lead role within the hospice. The postholder acted as a resource for staff on safeguarding concerns and issues. They took a lead role in the monitoring and evaluation of safeguarding service provision across the hospice. There was a safeguarding strategy in operation with clear priorities that included creating a culture of learning and improving communication and partnership working. An annual safeguarding report provided an overview of safeguarding processes and their application.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with demonstrated a good understanding of safeguarding processes and their responsibilities. Safeguarding referrals were audited and reported on and quarterly safeguarding assurance meetings were held with the local clinical commissioning group (CCG) safeguarding team.

Staff followed safe procedures for children visiting the ward. This included ensuring they were accompanied at all times by a parent or guardian.

Cleanliness, infection control and hygiene

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

Ward areas were clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. There were clear cleaning schedules which staff followed. There were enhanced cleaning measures in place during the pandemic, including regular cleaning of high touch areas.

The service generally performed well for cleanliness. An annual infection control audit was conducted, measuring compliance against cleanliness and infection control processes. Hand hygiene audits showed 100% compliance for the three months prior to the inspection.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff using and disposing of PPE appropriately. There were measures in place to ensure appropriate guidance was followed in relation to reducing the risk of infection. Risks had been assessed in relation to Covid-19 and mitigating action was in place, including appropriate screening for staff and visitors, and regular testing. Social distancing measures were in place, including restrictions on the number of people in areas within the hospice. Visitors wore PPE in line with national guidance.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

There was a system to record and report on hospice acquired infections through collated surveillance data. There had been two Covid-19 infections reported in 2020/21 in line with guidance.



Hospice services for adults

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. Patients told us that staff were quick to respond and provide support as required.

The design of the environment followed national guidance. Patients were cared for in single rooms or shared bays with en-suite facilities. Shared bays were large enough to allow for social distancing. Rooms were designed to provide comfort and safety.

Staff carried out daily safety checks of specialist equipment. Clinical equipment, including beds, hoists and assisted baths were regularly maintained. Calibration of medical devices was carried out annually. Equipment that was faulty was repaired or replaced. Equipment used for emergency situations was appropriate and accessible for staff when needed. We saw this was logged as checked daily and single use equipment was within 'use by' dates.

The service had suitable facilities to meet the needs of patients' families. There were dedicated spaces for families. This included a space for teenagers that included games facilities and a newly designed coffee shop and spiritual space.

The service had enough suitable equipment to help them to safely care for patients.

Staff disposed of clinical waste safely. Waste was appropriately segregated and stored securely. Sharps bins were correctly labelled and disposed of within the appropriate timeline, in line with national guidance.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Patients had treatment escalation plans that detailed the agreed threshold for treatment, defining the circumstances where access to hospital treatment may be appropriate. Staff monitored patients for deterioration and changes were discussed when needed and at daily handover meetings where appropriate escalation was agreed.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. Risk assessments were integrated into the electronic record system. They included the risk of falls, malnutrition and pressure ulcers.

Staff knew about and dealt with any specific risk issues. For example, they had protocols for the recognition and treatment of neutropenic sepsis and venous thromboembolism.

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

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.



Hospice services for adults

Shift changes and handovers included all necessary key information to keep patients safe. These included the involvement of members of the multidisciplinary team and clear records were maintained.

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 staff a full induction.

The hospice had enough nursing and support staff to keep patients safe. Rotas showed there was a minimum of three registered nurses on each shift with four on a morning shift on the inpatient unit. There were three healthcare assistants on duty during the day and one overnight. This was in line with the hospice's established safer staffing levels based on a bed occupancy of 18 patients or less.

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. There were clear safer staffing guidelines to support decision making. This included staffing plans for each shift based on bed occupancy. At the time of the inspection there were 18 beds available on the inpatient unit, with nine of them occupied.

The managers could adjust staffing levels daily according to the needs of patients. Patient dependency was reviewed daily and when changes were apparent. They used an acuity tool and concerns were escalated in line with hospice guidance, including reporting mechanisms for when staffing was at minimum levels. The number of nurses and healthcare assistants matched the planned numbers.

The service had low vacancy rates. Managers told us that 1.8 whole time equivalent posts on the inpatient unit had been recruited to, with new starters going through their induction at the time of the inspection. one healthcare assistant post had been recruited to, with the postholder due to start at the end of November 2021. The specialist palliative care nursing and rehabilitation teams was at full staffing establishment. Vacant posts for therapy and family support staff were being actively recruited to. There was a process to escalate inadequate staffing which included reporting it as an incident, redeploying clinical staff where possible and informing trustees and commissioners. There had been no incidents requiring escalation in the records we reviewed.

Managers limited their use of bank and agency staff and had bank staff familiar with the service, to ensure continuity of care. The hospice had regular bank staff working with them and did not use agency staff.

Managers made sure all bank staff had a full induction and understood the service.

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.

The service had enough medical staff to keep patients safe. There were 2.1 whole time equivalent consultants covering both St Ann's and a local community service.

The service had a good skill mix of medical staff. Three speciality doctors worked at the hospice, providing cover across the seven day week. This included virtual ward rounds at weekends and attendance as required for routine admissions and full patient reviews, There was a team of rotational trainee doctors including registrar, foundation year two and GP trainees. Registrar cover was provided for both the inpatient and community services.



Hospice services for adults

The service always had a consultant on call during evenings and weekends. There were reciprocal medical cover arrangements with the local NHS trust. Consultants were second on call across two hospices and advice lines as part of a team of 13. Junior doctors provided the first on call cover.

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. Electronic records were available with appropriate access and security arrangements for both inpatient and community services.

Records were stored securely and appropriately password protected. Records were regularly audited, including monthly checks of electronic information to ensure this was appropriately accessible in line with data security arrangements.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. There were links to the local acute trust that provided a pharmacist and medicines under a service level agreement. Medicines were prescribed using paper records and, there was a plan to introduce an electronic prescribing system. Advice and guidance was available for prescribers and a quiet area had been introduced to allow staff to focus at busy times.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Staff used local and national guidance when prescribing medicines for both inpatients and patients in the community. Patients received checks on their medicines when they were admitted, and staff ensured patients were confident with medicines when they were discharged.

Staff completed medicines records accurately and kept them up to date. Records demonstrated that medicines were prescribed, following national palliative care guidance. Patient's allergies were recorded and there were no administration gaps for regular medicines. Times and reasons for prescribing were recorded for 'when required' medicines to ensure a safe gap between doses was observed.

Staff stored and managed all medicines and prescribing documents safely. The dedicated medicines room was secure, and access was restricted to appropriate staff. The environment was monitored, and controlled drugs were checked daily in line with the providers policy.

The pharmacist provided induction training for doctors and nurses who were new to the hospice. A clinical education team provided nursing staff with medicines training and annual competency checks which were completed on a rolling programme. Medicine administration record audits were undertaken to ensure patients received their medicines safely.

Staff learned from safety alerts and incidents to improve practice. Information about medicines and safety alerts were shared with staff via notices, weekly prescribing huddles, email bulletins and monthly cross site incident meetings. Senior staff attended local intelligence network meetings in the region regarding controlled drugs management.

There was evidence of learning and improvements following incidents and errors. Staff reflections were completed, and changes implemented where possible.



Hospice services for adults

Incidents

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

Staff knew what incidents to report and how to report them. Staff were clear what constituted an incident and the process to report them.

Staff raised concerns and reported incidents and near misses in line with provider policy. There had been 112 incidents reported across the hospice in the year prior to inspection. Reporting categories included near misses, patient and non-patient incidents, equipment failure, safeguarding and building/facilities issues. Falls, medicines incidents and pressure ulcers were reported to Hospice UK for benchmarking. Data showed that most incidents resulted in low or no harm to patients. The hospice compared data with previous years' results as well as through comparisons with national reporting, and we saw that there were limited variances in the number of incidents reported.

Staff reported serious incidents clearly and in line with provider policy. One serious incident had been reported to external bodies as required and we saw that the investigation included a full review of the patient's admission. Action involved liaising with NHS colleagues about a potential missed fracture so that this could also be investigated externally.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Staff apologised to patients and their families and took time to address immediate and longer term actions to minimise risks.

Staff met to discuss the feedback and look at improvements to patient care. Regular prescribing huddles were led by medical staff. This included reviewing medicines incidents and safety alerts and involved discussing all aspects of prescribing operationally with a view to improving practice. Other operational forums for discussing incidents included infection prevention and control meetings, safety assurance group meetings, and the clinical quality performance committee meeting.

There was evidence that changes had been made as a result of feedback. Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Safety thermometer

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

The service continually monitored safety performance. A quality safety board was displayed on the inpatient unit, providing patients and visitors with an overview of performance. At the time of inspection, the display for the previous month showed that hand hygiene compliance was rated at 100% and patient experience was 100% positive. There had been five falls on the unit and zero pressure ulcers.

Are Hospice services for adults effective?



Hospice services for adults



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. Managers monitored national guidance and adopted this into policies and frameworks within the service.

The Five Priorities of care at the end of life were incorporated into the care planning process within the hospice. We saw that patients were assessed to ensure they were recognised when in the last days of life and that individual care plans were in place with involvement of the patient and those close to them.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. There was a holistic approach to assessing patients' needs that included psychological and emotional needs. Handover records showed that the needs of both patients and their relatives and carers were considered. Staff worked together to support those needs. Referrals for psychological support were made and psychological and family support services were available within the hospice.

Nutrition and hydration

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

Staff made sure patients had enough to eat and drink, particularly those with specialist nutrition and hydration needs. Patients' needs were assessed on admission and on an ongoing basis. Care was appropriately planned, and patients were supported to meet their needs. Catering staff provided tailored nutrition based on patients wishes and preferences and ensured that food was available throughout the day. In addition, patients could access snacks whenever they wanted.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. They assessed the need for oral care and supported patients to maintain oral hygiene and comfort. Staff received training in meeting patients' nutritional needs and assessing swallowing difficulties. Patients were supported to make choices about their nutrition and hydration and information was given to support this. For example, in relation to choosing to eat despite swallowing difficulties and the risk of choking and ways to minimise this.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition.

Specialist support from a dietitian was available for patients who needed it. Case studies showed that patients struggling to eat due to symptoms were supported and that the dietitian liaised with catering staff to ensure that small, highly nutritious and frequent meals were provided with positive results.



Hospice services for adults

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. Tools included those for use with patients who were non-verbal and those with dementia. Patients had clear plans for the management of pain and other symptoms. Staff administered pain relief and monitored its effectiveness. Patients received daily medical reviews and prescribing ranges were adjusted as required to ensure that patients had access to the pain relief they required.

Patients received pain relief soon after requesting it. Staff were observed responding promptly to requests for pain relief. Patient feedback demonstrated that staff were prompt to respond when patients were in pain. Staff evaluated the effectiveness of pain control, both following administration of pain relief and over time, throughout care experiences through the use of patient outcome measures.

Staff prescribed, administered and recorded pain relief accurately. Prescriptions were clearly recorded and included ranges so that staff could titrate doses according to patient need. Pain and other symptoms were monitored on a daily and continuous basis and staff had access to clear guidance about effective treatment for the range of symptoms at the end of life.

Patient outcomes

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

The service participated in relevant national clinical audits and improvement activities. Examples of these included delirium, dry mouth and venous thromboembolism (VTE) prevention.

The clinical nurse specialist team participated in a local community mortality audit of patients under the care of their GP, to monitor quality measures in relation to the diagnosis of and care of patients who were dying. This showed that 100% of patients had a care plan in place and 96% of patients had their wishes incorporated into their care plan.

Results in 2021 were compared with results from 2019. These showed some deterioration in quality measures, for example, there was a reduction in the recognition of dying by the GP, from 95% in 2019 to 75% in 2021. There was a significant reduction in end of life care plans being completed by GPs, from 90% in 2019 to 38% in 2021. However, the audit also showed an improvement in patients being reviewed every three days. An action plan included staff reflection on the results and the potential impact of the pandemic on the quality of care and record keeping. Discussions included the role of the clinical nurse specialist to improve patient outcomes and there was ongoing action and support to GP practices to drive and review improvements.

Managers and staff used tools to improve patients' outcomes. The hospice used the palliative care outcome score (IPOS) to understand the overall experience and status of patients at a specific point in time. Patients self-scored based on their experience of symptoms. Where patients were unable to self-score, staff completed a score based on their assessment of the patient. The scores were recorded at different stages of a patient's treatment. For example, patients admitted with severe or overwhelming pain were at 29% whereas at the second IPOS scoring this was 15%, indicating that patients were supported to manage their pain.



Hospice services for adults

Managers used information from the audits to improve care and treatment. Hospice leads recognised that the second IPOS score was not always recorded, this had been identified as a national issue. The hospice had set up a data work group to look at gaining greater clarity of the measure, focusing on the initial score to understand the complexity of patients and the most prevalent symptoms on admission. This project group worked collaboratively with the Greater Manchester Strategic Clinical Network to embed the measures into practice in the most efficient way.

The hospice had a planned audit programme which was monitored by the quality improvement group. Examples of internal audits included an audit of the rehabilitation palliative care approach, discharge medication, frailty and data quality. Managers told us that some projects had been delayed due to there not being a clinical governance lead in post for a period of time, however, now that this role had been filled, progress was being made. An audit of discharge medication identification of good practice such as recording of allergies, as well as areas for improvement such as the use of Latin abbreviation which may lead to confusion for patients and family members. The audit showed clear recommendations for improvement such as educational initiatives and a six monthly re-audit.

Improvement was checked and monitored, and managers shared and made sure staff understood information from the audits. The quality improvement group monitored audit progress and results. Improvement activities were regularly reviewed, and initiatives were implemented. For example, action to reduce the risk of falls had included the identification of times when falls were more likely and an increase in frequency of intentional rounding (where staff routinely check on patients) at these times.

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. Both clinical and non-clinical staff had access to additional training through the practice development centre and organisational development and training manager. Staff had opportunities to develop their skills in line with the objectives of the service and the provision of care to patients.

Managers gave all new staff a full induction tailored to their role before they started work. The induction programme had been adapted to a virtual format during the pandemic. Induction included core training for all new starters and was tailored to individual needs in relation to shadowing and one to one support.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff we spoke with confirmed they received regular appraisals and support for their development. Data provided by the hospice showed that 99% of hospice staff had received an up to date appraisal.

Managers supported staff to develop through regular, constructive clinical supervision of their work. They had access to group and individual supervision. Heads of department had completed external coaching training to support their teams.

The practice education facilitators supported the learning and development needs of staff. Staff had opportunities to complete non-mandatory training to support their development. Some of this training had been impacted by the pandemic, including delays to start dates and some modules moving to a virtual delivery.

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



Hospice services for adults

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. There were a range of courses available to staff. These included leadership development, advance care planning, learning disabilities, anxiety management, fatigue, motor neurone disease, bereavement and nutrition. Many courses were available to internal and external staff and aimed to address identified patient needs.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. There was a range of support mechanisms in place. For example, staff who were redeployed at the start of the pandemic, for example, day service staff who worked on the inpatient unit, were supported through a buddy system.

Managers made sure staff received any specialist training for their role. The hospice consultant team supported undergraduate and postgraduate training including attendance at regional teaching sessions. Medical trainees attended monthly training within the hospice.

Managers recruited, trained and supported volunteers to support patients in the service. This included training and support for those volunteers returning following a pause in volunteer activity due to the pandemic.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. There were weekly inpatient and community multidisciplinary team meetings. Within the inpatient unit there were a range of multidisciplinary approaches alongside the formal weekly meeting. This included extended weekly handovers on two days during the week including on a Friday to ensure patient management plans were in place for the weekend.

Staff worked across health care disciplines and with other agencies when required to care for patients. The hospice had a multidisciplinary approach to care delivery. This included a rehabilitation service, occupational therapy, physiotherapy, dietetics, lymphoedema and complementary therapies. Community and clinical nurse specialist (CNS) staff worked closely with other agencies to deliver care in the community. This included joint CNS MDT meetings with acute NHS CNS' and regular meetings with GPs and community nursing teams. The community MDT had involvement from chaplaincy, occupational therapy and social work staff as well as medical and nursing teams.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression.

Seven-day services

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

Consultants led daily ward rounds, Monday to Friday. At weekends consultants attended handovers and saw patients face to face when required. Clinical nurse specialists (CNS') provided a seven-day service across the hospice and acute NHS setting. This included sharing weekend duties with hospital-based CNS' who also provided cover for the hospice at weekends on a rotational basis.

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



Hospice services for adults

Health promotion

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

The service had relevant information promoting health and wellbeing. This included advice and support on nutrition, pain control, social, emotional and spiritual needs. Staff cared for patients using a holistic approach and regularly monitored patients' wellbeing.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Assessment tools were incorporated into the patient record system.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. This included written consent for certain procedures, such as blood transfusions.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff used a comprehensive assessment process that included options for decision making against a particular issue and involved the multidisciplinary team and where appropriate, those close to the patient where mental capacity was compromised.

Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records.

All clinical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. These were recorded as part of quarterly safeguarding reports.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

Are Hospice services for adults caring?



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



Hospice services for adults

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff interacting with patients in a way that allowed them time to ask questions, gain clarity and an understanding of treatment and care. Staff built good rapport with patients and family members, including within short interactions, quickly establishing supportive and compassionate relationships at times of distress and anxiety. Patients consistently said staff treated them well and with kindness.

Feedback from patients and those close to them was consistently positive about how staff treated them. For example, one patient told us that staff were 'absolutely caring, compassionate and extremely supportive of me and my family'. Written feedback from another patient included that they had 'never come across such dedicated staff as I have in here, I have full confidence which makes me feel comfortable.' Patients and families consistently told us that nothing was too much trouble for staff.

Staff followed policy to keep patient care and treatment confidential. This included ensuring that conversations and interactions occurred in private and that conversations were not overheard.

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 focused on the needs of patients irrespective of their background or circumstances. They demonstrated compassion when supporting patients including those with long standing mental health or substance misuse issues. Staff had received training in dealing with patients exhibiting challenging behaviour due to their circumstances or poor mental health. Staff shared with us examples of when they had supported patients and family members experiencing a range of emotions including anger and anxiety. Staff consistently demonstrated compassion when dealing with these interactions.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff consistently worked together to provide compassionate care tailored to individual needs. They went above and beyond to find ways to meet patient's wishes in the last days of life. Examples included a patient who had previously suddenly wanted to go home to die despite having complex symptom control issues. Although the patient had changed their mind and decided to stay at the hospice, their family were anxious that they would again change their mind. They lived in a complex situation where access to their home was limited due to them being unable to get out of bed. Staff visited the patient's home to assess access and contacted the fire service and a private ambulance to work out a plan in case of a sudden decision for discharge. The plan was not needed but the family were comforted that an option was in place.

Patients supported by the homeless service palliative care coordinator were supported in all aspects of their lives. This included social and emotional needs. There were many examples of where staff had supported them to reconnect with family members at the end of life. Staff prioritised support for both the patients and their family members. One patient was supported to buy gifts for their grandchildren they didn't know they had. They were supported to have their photograph taken by the palliative care coordinator as they wanted to have evidence that they had existed. Their photograph was then used with agreement as part of training and activity materials for the service.



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Staff continued to support a family after the death of a patient where they had helped them to get back in touch. This included support with funeral arrangements and attending the service with them, as well as providing access to counselling support following death. Feedback from a patient about the service included that staff helped them feel calm about their uncertain future and 'I feel in control and I've not had that before'.

Other patients were supported to re-connect with their family towards the end of their life, this included staff making contact with family members overseas. 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. They recognised the totality of the needs of patient's and those close to them.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. The service provided support services to help minimise distress. This included music and complementary therapies. One example was of a patient who was distressed on the inpatient unit. Staff organised music therapy and Reiki to help manage their distress. This involved the music therapist playing acoustic guitar at their bedside and was successful at bringing peace to the patient and helping them to sleep.

Staff undertook training on breaking bad news and demonstrated empathy when holding difficult conversations. Staff had received advanced communication training to support this process.

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. This included the impact emotional distress and anxiety can have on the management of physical symptoms. They provided patients with a range of support services to help manage this. These included counselling, spiritual support, complementary and music therapies and practical help to manage the origins of the distress. Staff went out of their way to provide support for patients and their family. For example, support for one young family included creating a homely environment within the hospice so that the patient and their children could watch films together in bed. This involved staff putting additional beds in the patient's room to facilitate this.

There were examples of where staff had gone over and above what was expected of them to support patients and family members, including staying with patients and families beyond the end of their shift. One of the hospice at home nurses stayed with the patient and provided comfort when their relative was too distressed to do so. The nurse stayed for several hours to support the relative, including providing practical help to begin the after death care and funeral arrangements. A patient at home deteriorated rapidly and died suddenly during a visit from the hospice at home nurse. They stayed for several hours to support the family and encouraged them to think about mementoes such as collecting a lock of hair and taking a photograph of them holding the patient's hand.

We saw examples of where patients had accessed support from the hospice for specific issues, for example, help with heating problems in their home, where hospice staff identified additional emotional support needs and took action to meet these. This included a patient who staff identified as being lonely, so they visited them at home and took action to provide more ongoing support, including access to a befriending service.

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.



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Staff made sure patients and those close to them understood their care and treatment. Family members we spoke with told us that staff kept them informed. Patients said that staff explained care and treatment to them and supported them to make decisions.

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

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Friends and Family Test survey results were positive. For example, 2020/21 results showed that 100% of patients described their experience of the inpatient unit, Being You Centre and community services as good or very good. July to September 2021 data showed consistency with these results. Patients could also complete comment cards and service level surveys which were in the process of being redesigned at the time of inspection. Feedback from family members supported by the community specialist palliative care team showed 100% were satisfied with the service received, individual feedback included that staff were caring and supportive, gave them enough time and treated them with dignity and respect.

Staff supported family members to be involved in care as much as they wished to. This included being supported to provide care after death. We observed staff supporting family members after the death of a patient and saw that they were given the option to support after death care as they chose. Staff interacted in a way that demonstrated care and compassion and were sensitive to the needs of the family, giving them the time and support needed.

Staff supported patients to make advance decisions about their care. We saw that 100% of patients on the inpatient unit had been offered support in developing an advance care plan. Where this was in place, information about the advance plan was communicated with other services when transferring care. Staff used a 'my advance care planning' document to record patient's wishes and preferences. Data showed that all patients supported by the homeless service had the opportunity to be supported to develop their own advance care plan.

Are Hospice services for adults responsive?

Outstanding



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

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the needs of the local population. In 2018, the hospice commissioned a review to help them develop an understanding of the predicted population-based palliative and end of life care needs assessment of the local community. The hospice clinical strategy had been developed in response to this and the Greater Manchester 'Heath and Social Care Commitments and Framework' for those people with palliative and end of life care needs. The hospice had also undertaken a self-assessment baseline review of their palliative and end of life care provision against the national 'Ambitions for Palliative and End of Life Care – A Framework for Local Action'.

Hospice leads worked closely with other organisations to plan services and care, including close collaborations with the Greater Manchester network, local acute NHS Trusts and clinical commissioning groups. The hospice had worked with



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the local NHS trust to develop a seven -day specialist palliative care service, following guidance from the Association of Palliative Medicine, to provide a service in Salford. This was implemented as a charity funded development to test a 21 month transformation in 2018 and following the pilot was contracted as an ongoing service through the local CCG from April 2020. The service delivered face to face senior specialist palliative care review 365 days a year through an advanced community nurse specialist role delivered by senior nurse specialists. The aims of the service included to avoid inappropriate hospital admissions, provide an urgent response service, develop a process of mortality review and focus on quality improvement initiatives in areas of high need.

The hospice had taken action to address inequalities and meet the needs of the diverse population. They had an equality, diversity and inclusion strategy and steering group and devised an annual progress report. Personalised support had been provided to patients from hard to reach groups, which included supporting homeless patients to make contact with estranged relatives, access accommodation and financial support.

The Community Specialist Palliative Care Team (CSPCT) worked with a variety of groups to raise awareness and improve access to their services. For example, the hospice had led on a Salford wide working party looking at improving access to specialist palliative care services for patients with a learning disability. They also led on a Salford wide working party to improve the experience of patients from the Orthodox Jewish Community who were at the end of life. They worked collaboratively with local inclusion teams and hostels to improve access to specialist palliative care for the homeless population. The team also worked collaboratively with non-malignant groups such as heart failure, respiratory and dementia groups. They undertook joint visits with the specialist nurses from these non-malignant groups and were involved in delivering and undertaking training in non-malignant disease.

In recognition of the rehabilitative needs of the local community and patients cared for at the hospice, a culture of rehabilitative palliative care with a focus on personal priorities and goal setting had been introduced. This involved a team of therapists from a variety of disciplines including physiotherapy and occupational therapy. Complementary therapists had proactively worked with the Being You Centre to create new treatment plans to reach more diverse groups such as younger patients, dementia groups and patients with motor neurone disease. The aim of the rehabilitation service was to maintain or improve physical function as much as possible within the context of patients' declining physical function over time. The Lymphoedema service had been involved in the Macmillan Greater Manchester Lymphoedema working group; this group was working towards providing equitable service provision to patients in Greater Manchester with all types of lymphoedema. This was in recognition of the service provision for patients with lymphoedema as currently inequitable across the region.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. At the time of the inspection and because of the pandemic, patients were cared for in individual rooms or adapted bays to reduce the risk of infection. Ordinarily staff managed referrals into the service to ensure that patients were not cared for in mixed bays.

Facilities and premises were appropriate for the services being delivered. The service was accessible to patients with a range of disabilities and ongoing work was underway to upgrade the building. This included the development of a new coffee shop, spiritual space and family space. Work on the development of the building had included consultation events with staff, volunteers, patients and those close to them.

Staff could access emergency mental health support 24 hours a day seven days a week for patients with mental health problems, learning disabilities and dementia from the local NHS trust.



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The service had systems to help care for patients in need of additional support or specialist intervention. The hospice recognised areas of unmet need and worked collaboratively with other services to meet them. For example, in response to an issue where some patients with cancer were declining chemotherapy due to the cost of getting to a local NHS cancer service, hospice leads worked with the provider to develop a chemotherapy outreach service. This was due to be implemented in January 2022 and would allow patients to have treatment and blood tests closer to home.

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. There were dementia champions and learning disability coordinators working within the hospice. Supporting patients to access services was part of the clinical strategy. Support was available for patients living with dementia or a learning disability to create advance care plans, with input from those close to them. Examples of individual support included a patient with autism who was unable to eat anything other than dry textured foods. Catering and care staff worked together with the patient and their family to devise appropriate menu options to meet the patient's nutritional needs. A patient living with a learning disability was supported within the inpatient unit during the national lockdown. Staff explored different ways of supporting them and providing social and emotional interactions in the absence of regular visitors. This included individual pampering sessions, movie nights and organising a bell tent in the garden as an outside visiting space when restrictions eased. This meant they were able to have in-person interaction with friends and family in a space that was created for them on an individual basis.

There was a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that met these needs, which was accessible and promoted equality for people living in vulnerable circumstances and with complex needs.

A homeless project had been set up in 2020 to improve access to palliative and end of life care for this group of patients. The project was established in recognition of traditional palliative care services not being appropriate to meet the needs of this group. This included patients who, to date, had been unable to access general healthcare services due to their complex needs. The service provided support for people homeless or living in vulnerable housing to access support. This was through a dedicated coordinator from the hospice regularly engaging with homeless services to identify homeless people with potential palliative or end of life care needs. Support included advance care planning, advocacy for inappropriate housing, re-connecting with family and support to engage with mainstream services. Examples included a patient who was supported with legal advice to obtain more secure housing as they were unable to access cancer treatment due to the increased infection risks of living in shared housing.

The hospice had a learning disability coordinator focused on the Stockport locality and had successfully bid for an additional post in Salford as well as Lesbian, Gay, Bisexual, Transgender, Questioning plus (LGBTQ+) coordinator in Salford.

Staff went out of their way to support patients and families with complex needs. For example, a patient was admitted to the inpatient unit following a long term hospital admission after a cardiac arrest. The purpose of the admission was to support the patient and their family and to stop artificial feeding and other interventions to prolong their life, in line with



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a best interest decision that was made in collaboration with those close to the patient. The aim was to support the patient and family so they could achieve a peaceful death. Staff received training from the ventilation team at the local NHS trust and met with the patient and family prior to admission to understand what their needs were and how best to meet these.

The hospice social worker was based in the hospice and the community within the patient and family support team. This provided flexibility to provide consistent support. This included home visits to support patients and their family to organise lasting power of attorney, benefits applications and liaising with banks to support the management of financial issues when families were struggling with this. We also saw an example of a relative who was supported by the social worker to address their own health concerns, including the social worker liaising directly with the relative's GP.

The hospice rehabilitation service provided support with goal setting for patients at every stage of their illness. They were supported to improve function where this was appropriate, and to maintain function where the effects of illness and associated treatments threatened decline. The services were geared towards easing the transition towards decline in function where deterioration was inevitable. Support was aimed at meeting individual needs and included support to participate in valued activities such as sitting in a chair to spend time with family, helping patients to enjoy food, providing therapies and interventions to assist with relaxation and comfort, and, using non-pharmacological strategies to enable patients to better manage symptoms and participate in daily life. Members of the rehabilitation team worked with patients on goal setting aligned with their personal priorities.

The occupational therapy team had produced a suite of resources called 'taking charge' and these were aimed at supporting patients in one to one and group settings to gain skills in the self-management of their fatigue. They had also transformed the face to face 'breathing space' programme to a video series for patients not able to access face to face services at the hospice during the pandemic. Music therapy input included 'singing for lung' health sessions.

Staff supported patients to continue to access services despite the restrictions placed on them during the pandemic. The Being You service moved creative activities online. Staff and volunteers dropped off materials to patient's homes if they were isolating or unable to go out to get these for themselves.

Wards were designed to meet the needs of patients living with dementia. The hospice had made environmental changes to meet the needs of patients with cognitive impairment, including improved signage to help patients better navigate their environment.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. All staff had received training in caring for patients with dementia or a learning disability. Care records were individualised and included individual patient centred approaches.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Resources were available in easy read formats and the hospice used captioned video on their website when signposting people to services. Staff had access to visual prompts when communicating with patients. Staff and volunteers supported patients who were identified as non-verbal to access virtual social groups within the Being You service. This involved them having a volunteer to support them and the use of a white board so they could participate in social interactions.

The service had information leaflets available in languages spoken by the patients and the local community. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. They accessed interpreters as needed. Examples included when assessing patients' needs, communicating with family



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members and providing counselling and support services. For example, when the family of patient visited from overseas and stayed at the hospice, interpreters were used to aid communication. Visiting restrictions were eased so that the family could stay at the hospice. Interpreters were also used when visiting patients in the community, particularly when assessing complex living conditions and supporting patients as part of the homeless service. This included situations where staff were supporting patients to re-engage with family members overseas.

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

Patients had access to spiritual support. Different faith leaders, including the local Bishop, Rabbi and Imam participated in 'forget me not' and 'light up a life' memorial services.

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 when they needed it. Managers monitored referrals to services and reported activity relating to accepted and non-accepted referrals. Inpatient dashboard data showed an increase in accepted referrals in 2020, at 78% compared to 62% in 2019. This was based on individual need and showed that appropriate referral decisions were made. The target for admission to the inpatient unit was within three days. We saw that this had been achieved for 75% of patients which was in line with the agreed threshold. On average patients were admitted to the inpatient unit within 1.3 days.

One of the strategic aims of the hospice was to improve access to the inpatient unit across seven days of the week, with senior clinical review at weekends. There had been 22 weekend admissions in 2020/21 and 28 weekend admissions in 2021/22 up until the end of October 2021, demonstrating an increase in line with the strategic aim.

The community specialist palliative care team had a threshold of 90% for responding to urgent referrals within two hours. Data from between April and June 2021 showed that this was achieved 99% of the time. The threshold for face to face assessments for non-urgent referrals was 90% and we saw that 91% was achieved during this time.

Preferred place of death was achieved for 91% of patients referred to the community specialist palliative care team, and for 89% of patients on the inpatient unit.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. The hospice rehabilitation team worked collaboratively with other teams to support patient's discharge. It was clear that staff consistently went out of their way to ensure that patients were cared for in their preferred place. Staff made allowances for patients to change their minds and they followed through on assessing and responding to people's needs irrespective of whether they thought a discharge was likely to happen or not. Staff worked with other services such as local fire and other community services to explore ways of getting patients home if that was what they wanted. We saw extensive examples of staff supporting patients who were vulnerably housed to receive care in their preferred place. This included the hospice, care homes, hostels and supported housing.

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.



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Patients, relatives and carers knew how to complain or raise concerns. There were various sources for patients and those close to them to provide feedback. Formal and informal complaints were encouraged by the hospice so that issues could be resolved quickly.

The service clearly displayed information about how to raise a concern in patient areas. Information on how to complain was available in patient literature and patients and those close to them were encouraged to raise concerns directly with staff.

Staff understood the policy on complaints and knew how to handle them. Staff told us that where concerns could not be resolved by frontline staff, these were escalated to managers.

Managers investigated complaints and identified themes. They reviewed records and information held, to identify areas for improvement. Issues were captured as feedback and collated to share with relevant staff and as feedback to the board to ensure oversight. An annual complaints report was produced with identification of contributing factors and circumstances leading to the complaint.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Four formal and seven informal complaints had been received by the hospice in 2021. It was recognised that this was an increase on the previous year and one action as a result was to provide training for more staff in complaints management. There were no particular themes identified as part of the review of complaints. The complaints we reviewed had been responded to and resolved quickly and in line with the hospice's complaints policy.

Managers shared feedback from complaints with staff and learning was used to improve the service. Feedback was given to staff working in the department where the complaint originated. Records showed that relevant staff were involved in reviews and information from this was shared with the wider team to ensure learning.

Are Hospice services for adults well-led?



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

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 demonstrated high levels of experience, capacity and capability. They understood the challenges and priorities of the service and proactively sought to address them. They worked collaboratively with partner organisations, stakeholders and other services to deliver high-quality and patient centred services.

There was a clear management structure with defined lines of accountability. The day to day management of the service was the responsibility of the hospice leadership team. This included the chief executive, head of clinical services,



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director of clinical services, medical director, director of strategic initiatives, director of organisational development and support services, and, the director of business development. They were supported by a senior leadership team that included department leads and senior clinical staff. The hospice leadership team was accountable to the board of trustees.

Trustees were kept well informed of what was happening within the hospice. The hospice committee structure ensured that information was appropriately shared and cascaded, with clear lines of accountability. Nominated trustees chaired sub-committees, for example, the clinical quality and performance committee.

Staff we spoke with told us that leaders were visible, approachable and supportive. There were development opportunities for staff to enhance their skills. Staff had the opportunity to attend additional training to improve their competence and develop skills to take on senior roles and responsibilities. Staff told us there were good training courses available and that the senior leaders supported them to achieve their aspirations. Data showed that 16 staff members had completed Inspire and Aspire leadership training in the last year.

Vision and Strategy

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

The hospice had a vision to 'strive to put patients and their loved ones at the heart of everything we do' and a purpose 'to provide excellent care and support to people living with or affected by life-limiting illnesses'.

There was an organisational and clinical strategy with five strategic aims; world class innovative care; organisation of choice; values based culture with high performing individuals and teams; appropriate environments and outreach services for world class specialist care; and financial viability.

There were clear priorities identified as part of the strategy and a working action plan to deliver on these which was reviewed on an annual basis. These priorities included 'seven day access' where progress had been made with additional investment for medical staff, including consultant cover, and advanced nurse practitioner hours for face to face reviews at weekends. 'Widening access for community services' was another priority. Progress included the development of the Being You Centre following a review of day services and the implementation of consultant-led outpatient and visiting services and day therapy services tailored to individual need. 'Hard to reach groups' was a focus, with a five year project to streamline services for the homeless community, the delivery of vulnerable population workshops and training, and increased focus on support for patients with a learning disability. Education, training and development was another priority, progress included the development of a nurse competency framework, support for care homes and external training and input into local conferences.

The vision and strategy were aligned with local plans within the wider health economy and had been developed in line with the commitments to palliative care within the Greater Manchester Health and Social Care Partnership.

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.



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Staff we spoke with were positive about working at the hospice. They felt supported and worked within the hospice values – inclusive, professional, compassionate, respectful. They were involved in the development of the values which were currently under review.

There was a staff involvement group where staff from different departments within the hospice contributed to the development of services and had a forum to be heard.

There were opportunities for career development with leaders and those aspiring to lead had completed leadership training in the last year. There were additional training opportunities and dedicated competency frameworks for staff to develop their careers.

Staff wellbeing was a priority for the hospice. A wellbeing festival was held with virtual sessions for staff, that included methods for supporting staff in the delivery of the service and beyond. This involved specialist blogs from members of staff, relaxation sessions with the hospices complementary therapists and sessions with the Greater Manchester Resilience Hub. Support was on an individual basis with staff and on a department level, providing support through team meetings.

Staff felt able to provide feedback to shape upcoming priorities of the service. The equality, diversity and inclusion group had a focus to increase workforce diversity. There were 10 trained mental health first aiders amongst the staff team. Regular 'wellbeing matters' newsletters were produced, signposting staff to support and resources.

Staff surveys, measured across the last three years, showed an improvement in staff feeling informed, communication and having confidence in the senior management team and board of trustees.

Schwartz rounds were held within the hospice every two months. The purpose of the rounds was to understand the challenges and rewards that were intrinsic to providing care, rather than to solve problems or to focus on the clinical aspects of patient care. The rounds involved clinical and non-clinical staff. These sessions started with a mindfulness session led by counsellors. Patient stories were used with storytellers invited by facilitators to speak, focusing on particular themes. The focus was to provide emotional and social support for staff and was based on the principle that staff who regularly attended Schwartz Rounds feel less stressed and isolated at work.

The hospice had been awarded the Investors in People gold award in 2021 and was working towards the platinum award. Feedback as part of the award included that 'your people are engaged, motivated, valued, empowered and appreciated for the expertise, knowledge and skills they bring to their roles, and have an enthusiasm for achieving the best for patients and their families as well as the hospice as a whole'.

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 structures, processes and systems of accountability and a clear governance framework to support the delivery of the hospice strategy. The hospice leadership team were accountable to the board of trustees. Service leads reported to the board of trustees through board papers submitted as part of board meetings. Agenda items included progress reports and activities relating to areas of hospice management such as progress against the strategy, workforce planning, risk management and the quality of services.



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A member of the board of trustees chaired the clinical, quality and performance meeting. Other meetings regularly held included safety and assurance group, quality improvement group and information governance group. A range of monitoring and quality performance data including quality improvement and assurance audits, safety incidents and risks, training compliance, staffing, complaints and patient experience feedback were reviewed at these meetings.

Staff were clear about their roles and accountabilities and who to report to. Staff were committed to improving the quality of service and maintaining high standards of care. They were involved in discussions about the performance of the service and were encouraged to report issues and work together to learn and develop the service.

There were arrangements in place to manage and monitor contracts and service level agreements with partners and third-party providers. Contract reviews were informed using quality indicators and feedback.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

There were clear processes for identifying and mitigating risks. There were risk registers for clinical and operational risks. Risks were subject to regular review and actions were identified to help manage them. We saw that risk ratings had been identified and reviewed once mitigating actions had been implemented. Clinical risks were reviewed at the clinical quality and performance meetings that had representation from the board of trustees, head of clinical services, director of clinical services, and the quality and governance lead.

Individual risk assessments were carried out for each patient on admission and reviewed regularly during admission. Risks from falls and pressure ulcers were mitigated with appropriate measures such as the use of safety and pressure relieving equipment.

Environmental risk assessments were undertaken by internal facilities staff and external contractors. There were effective arrangements in place to mitigate the risks from fire, legionella and slips, trips and falls. Health and safety walk arounds were undertaken by facilities staff as part of the process to identify risks and ensure that mitigating actions were consistently applied.

Current and future performance was monitored through a range of information and we saw evidence of this in quality and performance reports. Information included safety measures, feedback and performance against key performance indicators. This information was shared with commissioners as part of ongoing performance monitoring. There was evidence of improved performance in identified areas, in line with the hospice's strategic priorities. This included an increase in patients being admitted to the inpatient unit at weekends and improved access to hospice services for patients who were homeless or vulnerably housed.

The hospice reviewed services and took action to make changes where risks to sustainability were identified. They had developed a clinical services roadmap to recovery that focused on building on learning during the pandemic to transform the delivery of clinical services and in response to the 'roadmap out of lockdown' devised by the government. This included a phased reopening of all face to face clinical services. Action included expanding the use of digital platforms, safely reintroducing aerosol generating procedures (AGPs), reintroducing volunteers, introducing smaller group activities and ongoing strict infection control and screening processes.



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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.

There was a holistic understanding of performance. Integrated management information systems were used to support informed decision making. Clear performance measures were evaluated and reported on. Staff had access to integrated quality and performance data. This included incidents, staffing, patient and family feedback, complaints and service activity performance. Service performance was tracked over time to support the identification of areas for improvement. Where variations in performance were apparent, action was taken to make improvements.

There were effective arrangements to ensure data and statutory notifications were submitted to external bodies, as required. This included local commissioners and the Care Quality Commission (CQC). Quality dashboards were shared with commissioners to report on performance.

Staff had access to up-to-date information about patients' care and treatment. The system was aligned with those used by local GPs and community services to ensure integration and access to information. The information systems were secure, with systems encrypted and password protected.

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 worked in partnership with other services to ensure the end of life care needs of the local community were met. The service was actively engaged with the wider health and social care system across Greater Manchester and Eastern Cheshire. Services were developed collaboratively across the local network and staff routinely worked with other providers in the delivery of services.

Staff views were sought and acted on. There was a hospice engagement group with representation from all services and departments within the hospice. The hospice participated in a national staff survey where they were benchmarked against other hospices. Results were largely positive, with the hospice benchmarking at similar levels to other hospices across 29 indicators. They were slightly below in two indicators relating to the hospice focus on environmental impact and how poor performance was managed. There was evidence of clear action on improving the way that performance was managed within the hospice, including leadership and coaching training for staff in senior roles. The hospice performed better in 16 of the 47 indicators, including satisfaction with standards of care, feeling proud of their work, making a difference and enjoying their work and the people they worked with.

There was a whistleblowing policy in place with clearly identified 'speaking up' guardians and champions so that staff knew who to contact if they had concerns. Staff we spoke with told us they felt able to raise concerns without fear and believed that their concerns would be listened to and acted on. We saw evidence of this when reviewing the actions taken by the hospice to address concerns as they arose.

Patient and family views were collated through a range of surveys and feedback mechanisms including real time feedback, the Friends and Family Test and analysis of comment cards, compliments and other feedback forms. Results from surveys of patient and family views were consistently positive about their experience within the hospice.



Hospice services for adults

Learning, continuous improvement and innovation

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

There were a range of quality improvement activities within the hospice and staff actively participated in these. We saw that services were regularly reviewed to ensure they met the needs of patients and the local community. There were clear quality improvement aims within the annual quality account that included safety, patient experience and effectiveness. The quality account was reviewed and updated annually.

Innovation was at the heart of delivering high quality end of life care and staff and leaders worked collaboratively with other providers in the local community to develop these. They worked in partnership to identify health inequality within the wider health system. Improvement activities included increasing access to services for patient groups that were underrepresented. This included a dedicated five year service to support the homeless population of Greater Manchester to access palliative and end of life care services. In the first year of the project, implemented in 2020, 28 patients had been supported to access services and 42 people impacted by loss had received psychological/emotional support. The hospice shared learning from the project, for example, through an NHS England dying matters webinar 'dying to be heard' and the Stockport Excellence in Palliative Care inequalities lecture series. The project coordinator participated in a local university project advisory group to support research for services for people with drug and alcohol related issues at the end of life. In 2021 the service coordinator had received a special recognition award by the high sheriff of Greater Manchester and the service had reached the finals of the Greater Manchester Health and Care Champion Awards (Inclusion).

Other innovations relating to increasing inclusion for underrepresented groups to support greater access to palliative and end of life care included the development of learning disability and LGBTQ+ coordinator roles. Community staff actively worked to engage with groups, including cultural groups such as those within the Orthodox Jewish community, in order to improve understanding and recognition of dying and to improve access to services. Staff worked actively to involve these groups within discussions about how the hospice could better meet their needs.

The hospice had implemented an enhanced seven-day specialist palliative care nursing service across the community and acute service, with the development of advanced clinical nurse specialist roles with an aim to avoid inappropriate hospital admissions and provide an urgent response service. This was implemented together with improvements to the specialist palliative care medical support for the hospice, to improve access to care at weekends for enhanced seven-day consultant review. The service had been embedded following an evaluation of different support models. The community specialist palliative care team had been a finalist in the Nursing Times workforce of the year award in 2019, in addition they had been a Health Service Journal finalist for the same work.

The community specialist palliative care nurses worked to lead improvements to palliative and end of life care in the community through education and support. They had developed a '10 in 10' approach to sharing expertise, in recognition that district nursing teams had a need for knowledge but lacked time to attend more formal training. They provided multiple 10-minute training sessions, based on sharing 10 facts in 10 minutes. They developed reminder cards to share with community staff and worked with hospital specialist palliative care nurses to develop and deliver the sessions.



Hospice services for adults

Since 2013 the hospice had supported the development of palliative care services in Lithuania. This included regular visits to the country and speaking at conferences. The hospice supported medical staff, nursing and psychological support staff from Lithuania with placements at the hospice. These had been suspended due to the pandemic; however, staff had continued to provide remote support during this time.