Prospect Hospice Limited

Prospect Hospice

Inspection report

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

Ratings

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

Summary of findings

Overall summary

Our rating of this location improved. We rated it as outstanding because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to keep as healthy as they could, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness and always respected their privacy and dignity. Staff recognised and respected the totality of their individual needs and went to great lengths to make final wishes a reality. People who used the service were active partners in their care. Staff were fully committed to working in partnership to make this a reality for each person. Staff helped patients and their families to understand their conditions. There was a strong, visible person-centred culture and staff provided emotional support to patients, families and carers in every way they could. Patients emotional and social needs were highly valued by staff and embedded in their care and treatment. The service considered itself as caring for the patient and those close to them and created systems to support care in this way. Staff supported and encouraged people to have a voice and realise their potential. Staff consistently respected choices made by the patient and those close to them and promoted this choice with other health agencies. Patients felt they were truly cared for and supported by hospice staff.
- The service planned care to meet the needs of local people, consistently took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it.
- Leaders had an inspiring shared purpose to deliver outstanding care. They ran services well and strived to motivate staff to succeed in enhancing their skills and improving care they delivered. Leads developed systems which encouraged and supported staff to innovate and put patients and families at the centre of their care. Leads had developed and used reliable information systems. Staff understood the service's vision and values and applied them in their work. Staff felt respected, supported and valued and were keen to let us know how leads and managers had supported them at difficult times. Staff were proud to work within the hospice as a team and felt there was no hierarchy. Staff were clear about their roles and accountabilities and felt leads engaged with them in a constructive way. Leads created ways for constructive challenge from people who use the services. The service engaged well with patients, staff and the community to plan and manage services and all staff were committed to improving services continually for the benefit of the patient.

However:

- Some groups of nursing staff had not received meaningful or consistent clinical supervision or one to one meetings since before May 2021.
- Not all staff who had contact with patients and families were trained in level two safeguarding children.

Summary of findings

Our judgements about each of the main services

Service	Rating		Summary of each main service
Hospice services for adults	Outstanding	☆	

Summary of findings

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Background to Prospect Hospice

Prospect Hospice is operated by Prospect Hospice Limited. It offers community and inpatient hospice care for people affected by life-limiting illness, and serves the communities of Swindon, Marlborough and North East Wiltshire.

There is an inpatient unit, a 16-bed facility which provides respite care, symptom control and care for patients at the end of life. During the COVID-19 pandemic, the inpatient unit closed from March to May 2020 and, after social distancing and infection control systems were put in place, re-opened six beds, accommodating patients in single rooms with access to outside space. During the pandemic, the service had begun to work differently, with much more crossover between teams and more focus on care in the community. Admission criteria for the inpatient unit was and continues to be focused on the provision of complex symptom control.

The hospice delivers end of life care in patients' homes and works closely with the hospice inpatient unit depending upon care needs of patients. There is a team of clinical specialist nurses, therapy services, bereavement services, a lymphoedema service and a single point of access team. Thre is a Prospect team of consultants and specialty doctors who support the inpatient unit and home visiting. Hospice staff work closely with clinical nurse specialists and medical staff at the local acute trust. The process helps in identifying patients and their families who may benefit from support by hospice services. These patients may also need specialist care provided by the local hospital trust. The clinical nurse specialist team also provides specialist end of life care to local nursing and care homes.

The service is registered with the CQC to provide:

Diagnostic and screening procedures;

Treatment of disease, disorder and injury;

Transport services, triage and medical advice provided remotely.

The current registered manager has been in post since April 2019.

We previously carried our focused inspections of the inpatient unit in February 2018 and August 2018 and took enforcement action on both occasions. We undertook a comprehensive inspection of all services in August 2019 and rated the service as requires improvement overall. We issued a warning notice because we had concerns about weak governance systems and poor oversight of quality, including patient experience, safety and risk. The service has been monitored and a focused inspection in November 2020 found the service had met all requirements of the warning notice.

How we carried out this inspection

This was a short notice, comprehensive inspection. They did not know we were coming until two days before our visit which was to allow staff to arrange patient consent for community visits.

We visited the inpatient unit, the Prospect@Home team (community team) and the clinical nurse specialist team. We held interviews with service leads and executives using virtual technology and held a focus group for staff to attend in the same way. The focus group was attended by 34 Prospect Hospice staff. Additionally, we spoke with 23 staff including nurses, health care assistants, doctors, consultants, reception staff, volunteers and trustees. We also spoke with 17 patients or their relatives who had experienced support from hospice staff. We observed care and treatment provided in patients' homes and in the inpatient unit, attended meetings, reviewed data about the organisation and reviewed patient care records.

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:

- It was evident that the person receiving the service was central to the process and had been an active participant in the way they wanted their care to be delivered, based on a mutual understanding of their physical, psychological, emotional, and spiritual wishes. Staff provided a service to suit the patient's needs as opposed to fitting patients in to services available.
- Caring for the patient included the whole situation of the patient and their family and was embedded in practice. Systems, policies and documentation were centred around patient choice, what mattered to them and included family input which promoted this holistic approach. Staff went to great lengths to make patients' last wishes a reality as well as providing for day to day choices of preferences.
- Staff were proactive and innovative in the way they responded to patient needs and choices. They developed new ways of working to meet those needs. One example involved creating a whole system of training, with new protocols so that carers could safely administer prescribed subcutaneous injections for their loved one. Carers fed back how they found this increased involvement in caring for their loved one a positive experience.
- Staff used patient stories at each team meeting to reflect patient and family experiences and use as a springboard for improvement.
- We saw that senior leaders engaged with the wider health economy and were engaged with appropriate networks aligned to their service and its future vision and strategy. We saw that the strategy aligned to local plans in the wider health and social care economy. Senior leaders shared a number of examples to evidence the sound relationships
- There had been a significant amount of investment, led by the executive team, in building relationships, trust, mutual respect and understanding amongst staff, this is a significant and substantial change since of last inspection. We found there were cooperative, supportive and appreciative relationships among staff. Staff and teams worked collaboratively, shared responsibility and resolved conflict quickly and constructively.
- Pain management was adapted to the personal needs and choices of patients and included alternative methods to the routine opiods. This included a project using virtual reality methods of mindfulness and meditation which had been personally supported by Sir David Attenborough.

Areas for improvement

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

Action the service SHOULD take to improve:

- The service should ensure staff attend level two safeguarding children training to meet the national guidelines.

Summary of this inspection

- The service should continue with plans to reinstate regular and meaningful clinical supervision for all staff.

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	Good	☆ Outstanding	☆ Outstanding
Overall	Good	Good	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding

Outstanding ☆

Hospice services for adults

Safe	**Good** ●
Effective	**Good** ●
Caring	**Outstanding** ☆
Responsive	**Good** ●
Well-led	**Outstanding** ☆

Are Hospice services for adults safe?

Good ●

Our rating of safe improved. We rated it as good.

Mandatory Training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. Mandatory training was comprehensive and met the needs of patients and staff. It included modules in health and safety, manual handling, infection prevention and control and basic life support. There were additional competency training modules available for staff to complete which included syringe drivers, wound care and leg ulcer management. Staff told us they were given time to complete these modules within their working hours.

Staff received and kept up-to-date with their mandatory training. Managers monitored mandatory training and alerted staff when they needed to update their training at monthly one to one meetings. Volunteer staff were included in training modules. New staff were provided with a programme of orientation and basic skills needed to fulfil their roles. Completion was overseen by their line manager.

Staff training compliance was reported to the executive team and to commissioners of the service. Compliance levels in each staff group were rated as red, amber or green to demonstrate where training had not been attended. A report for 21 July 2021 showed staff compliance for those on the inpatient unit ranged from 75% (bank healthcare assistants) and above 80% (all other roles). Other roles such as medical staff showed 69% compliance and above 87% for other patient facing roles. The executive team informed us that rates of training compliance had reduced during the COVID-19 pandemic and they had made a plan to improve compliance to meet the target of 80% where it was low.

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

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. However, safeguarding children training was provided to a limited number of staff and did not meet all national guidelines.

Leaders told us safeguarding training provision had been an operational decision in relation to service delivery needs and capacity of staff during the COVID-19 pandemic. Safeguarding training was provided for staff to level three in adults and level one for children. In July 2021, 100% of staff who needed to, had completed safeguarding adults training at level three. Only medical staff and social workers had been identified as needing to complete safeguarding children level two training. This did not meet the guidelines stated in the national document: Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff, January 2019. This states level two training should be completed by “all non-clinical and clinical staff who, in their role, have contact (however small) with children, young people and/or parents/carers or adults who may pose a risk to children”. The safeguarding lead for the service had raised this as an issue and a proposal to provide level two training for relevant staff had been accepted by the executive team in July 2021, with dates planned for delivery in August 2021.

Referral systems included risks of safeguarding issues and alerts could be raised on the paperwork and electronic systems for staff to be aware. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff provided us with examples of how they had supported patients, families and carers according to their individual choices.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. We were provided with examples of how staff had supported and protected patients and their relatives from potential harm from abusive situations. This had been managed sensitively and all family members and carers had been considered in the situations.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The safeguarding lead had completed relevant training for their role and staff found them supportive and approachable.

Staff followed safe procedures for children of patients receiving care. This included their exposure to upsetting situations and finding the most suitable way to support them in the inpatient unit and in the community service.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

We saw equipment had stickers to identify they had been cleaned and were ready for use. Furnishings were kept clean and suitable for their use. An external cleaning company was contracted to complete general cleaning of all areas. Staff could raise any areas of concern with this team and staff said they were very responsive to cleaning requests. This included times when a room needed cleaning quickly to accept a new patient. Community staff cleaned and labelled equipment after patient contact to show when it was last cleaned. We saw I am clean stickers on equipment, and because equipment was only ever in the patient’s home, there was little risk of it being used by any other patient.

Areas of the inpatient unit had been repurposed to reduce risks of COVID-19 transmission from people visiting the unit. These spaces were used to allow visitors to the unit to be tested for COVID-19 and maintain the required two metre distancing from others. Individual rooms were used for inpatients and all had access to outside space and fresh air. This supported patients to see visitors outside and maintain distancing of two metres if they wished.

The service used infection control measures to prevent the spread of infection before and after the patient died. The hospice had a cold room to store the deceased person before the undertakers arrived. This was adjacent to a room relatives could use to view the deceased.

Staff on the inpatient unit followed infection control principles and were bare below the elbow, followed hand hygiene protocols and changed personal protective equipment (PPE) between patient contact.

Community staff followed infection control principles including the use of PPE. For every community visit, staff changed all PPE before entering the house and removed it once outside and disposed of it in sealed plastic bags.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Clinical staff completed monthly audits of all areas of the inpatient unit, in tandem with a lead from the cleaning company, to ensure areas were not missed.

Incidence of infections was monitored and there had been no incidences of hospice acquired infections from September 2020 to April 2021.

Environment and equipment

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

Staff segregated clinical waste and stored it securely away from unauthorised access until contractors removed it for final disposal. There were facilities for patients to call for support when on the inpatient unit.

We observed patients could reach call bells and staff responded quickly when called.

The design of the environment followed national guidance. All clinical areas had floor coverings which were easy to clean. Rooms where medicines were stored were kept at appropriate temperatures and checked daily. This included fridges for the storage of medicines.

The service had enough suitable equipment to help them to safely care for patients. Staff carried out daily safety checks of emergency equipment. Equipment used for emergency situations was appropriate and accessible for staff access when needed. We saw this was logged as checked daily and equipment was within ‘use by’ dates.

Consumables were stored securely and were not accessible to patients or their visitors. We checked five items and found them all to be within ‘use by’ dates and in good condition. Equipment was accurately labelled and accessible for staff.

Electronic and mechanical equipment was maintained by an external contractor and were within their service dates. The service had a comprehensive register of all equipment. Any repairs needed between service dates were acted on promptly and staff followed hygiene protocols in cleaning equipment for repair and labelling it as needing repair.

The service had suitable facilities to meet the needs of patients' families. Rooms were spacious and equipped with bathroom facilities which were easy to access if mobility was an issue. Chairs were fully adjustable and could be used by relatives/carers if they were staying for longer periods of time. Rooms had air conditioning and patients were able to easily access outside space if they wished.

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. The service had developed a system of triage using the Single Point of Contact (SPoC) team. Any referral would be triaged by specialist nurses in this team. They used nationally recommended tools to assess all elements of care needs. They also used the Pepsicola assessment tool to assess all needs and the Karnofsky score to help predict length of survival and prioritise care needs. Pepsicola was an acronym to headline focus points for assessment. This included physical, emotional, person, social, information communication, control and autonomy, out of hours, living with your illness and after care. It acted as a memory aid for staff and created consistency in assessing patient needs in a person-centred way.

During the COVID-19 pandemic staff had offered alternative services for patients. Patients were triaged using telephone contact where possible and face to face if necessary. All patients were reviewed every four weeks as a minimum and, as care needs progressed, reviews became more frequent.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately and in line with patient wishes. At our previous visits to the hospice, staff had been reviewing and using their clinical knowledge to identify deteriorating conditions in patients. At this inspection, staff were implementing the use of a National Early Warning Score (NEWS) system. NEWS is a system which provides an indicator and advice for action depending upon patients' vital signs such as blood pressure, respiration and heart rate. Clinical leads had reviewed the national tool and adapted it where the copyright allowed, to include patient choice, when receiving hospice care. Staff were receiving training in its use and a policy had been written for staff guidance.

Staff completed risk assessments for each patient on admission to the inpatient unit, using a recognised tool, and reviewed this regularly, including after any incident. We saw medical and nursing staff completed joint assessments on admission to the unit. This allowed patients to tell their story only once but still have any risks assessed. Patient records showed risks were assessed and up to date. This included, but was not limited to, risks of falling and developing pressure ulcers. Care records were updated as needs changed.

There was effective assessment, action planning and review for community patients which was understood by the patient and their family and supported patient choice. We visited three patients in their own home with the clinical nurse specialists and Prospect@Home teams. We saw patients were treated with compassion and dignity. They allowed time for the patients and relatives to ask questions and to listen to their concerns. Advanced care planning and preferred place of death were both discussed.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients including if they were thought to be at risk of self-harm or suicide. The service had a clinical psychologist who provided support for hospice patients and their families. Patients could also access the local mental health trust for further support.

Staff shared key information to keep patients safe when handing over their care to others. Staff used an electronic system within their service and liaised with external services to share information.

Shift changes and handovers included all necessary key information to keep patients safe. Nursing staff completed a handover sheet for staff to use and refer to if needed. This gave key information including patient choice of care. Clinical leads had found the information to be basic and were using quality improvement methodology to improve the information provided. The project was in its infancy at the inspection and would be monitored using staff feedback once put into use.

Medical staff completed handover sheets daily which all medical staff received. Medical staff were informed of any changes in care needs and were able to provide more streamlined care for patients. It also provided the medical director and consultant with oversight of care being provided.

Staffing

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

The service had enough medical, nursing and support staff to keep patients safe. Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

Managers monitored rates of sickness, staff turnover and vacancies, including reasons for any increases rates. The COVID-19 pandemic had presented challenges for staffing the service and created opportunities for reviewing skill mix of staff within teams. Nursing team structures had been reviewed to provide a more responsive service for patients. This had led to the agreed staffing establishment being reviewed and recruitment of clinical nurse specialists and healthcare assistants.

Managers had reduced the number of inpatients accepted in the unit at any one time in response to shortages of healthcare assistants due to long term sickness. This ensured safe staffing numbers followed national guidance. The service had kept commissioners and stakeholders informed of these decisions and actions they were taking to recruit additional staff. New staff had been recruited and patient numbers would be increased once the newly recruited staff had completed a comprehensive induction programme. A new therapist had been recruited to fill the remaining vacancy in that specialty. The service used a bank staff system for staffing needs at short notice and to cover any staff shortages.

Medical staffing had been reviewed and an additional consultant had been recruited to the service. Other support was provided on a part time basis by GPs who had a special interest in supporting hospice care patients. Each GP committed to covering one day a week and the service had medical support for seven days a week.

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. This was an improvement since the previous inspection.

Patient notes in the community and the inpatient unit were comprehensive and all staff could access them easily. Records we reviewed had individual assessment and care plan documents which were personalised and included patient choices and consent to share information. We reviewed four sets of notes and found they were all compete and legible. Clinical nurse specialist notes were stored electronically and could be printed if needed to be taken to the patient residence.

Effective handovers between shifts were supported by a redesigned template with records stored and updated electronically. This template included a safety brief and the system was embedded in practice. Health care assistants showed us handover notes which were recorded contemporaneously and transferred to the central electronic notes system.

When patients transferred to a new team, there were no delays in staff accessing their records. Full assessments were made, and detail was included in any referral documents sent to other services.

Verbal handover was provided, followed by written records of patient needs and journey through the services. Relatives and patients told us staff discussed the patient record with them and they could read them any time they wanted. The service was in the process of transferring to an alternative electronic record keeping system which would link with GP records and provide more efficient information sharing. This was planned to be implemented within the next six months.

Medicines

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

Staff stored and managed medicines and prescribing documents in line with the provider’s policy. Stock medicines were stored securely in all areas we visited. Access to these medicines was restricted to registered nursing staff. Nursing staff ensured there were enough medicines available for patient use. Nursing staff contacted the patient’s GP to provide a prescription for patients in the community who required an emergency prescription or a restock of ‘just in case’ medicines. Five clinical nurse specialists had completed non-medical prescribing courses and were able to prescribe medicines from a defined list. A sixth clinical nurse specialist was nearing completion of the training. In these cases, nursing staff actioned the prescription and informed the relevant GP. Staff ensured someone could collect the medicine on the patient's behalf.

Prescribing stationery was stored securely and tracked in line with national guidance. This was an improvement since the last inspection. Prescription stationery was logged by number and held in lockable storage when not in use. Small numbers of prescription forms were held by staff who could prescribe when visiting patients. These were stored in lockable areas when not in use. The service was purchasing smaller lockable storage capsules for staff to use when travelling.

There were suitable arrangements for ordering and storing controlled drugs. Two registered nurses checked the balance of controlled drugs each day and community nursing teams completed additional checks.

The inpatient unit had locked cupboards on walls within patient rooms, and cupboards within locked rooms which were temperature controlled. We saw checks on temperatures were completed and logged by staff daily and stocks of medicines were checked by registered nurses.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. The service completed medicines audits which included checks on staff compliance with policies, medicine errors and antibiotics prescribed. We saw action plans and progress against actions documented for improvement of practice. Incidents involving medicines were investigated and actions to improve practice were monitored to prevent a recurrence of the incident.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. We saw a clinical nurse specialist assess a patient for a syringe driver to reduce pain and discomfort. Staff were implementing a new approach to administering medicines by supporting carers to administer subcutaneous injections to the patient. This was supported by gaining consent of the patient and the carer and providing training and support. Clinical leads assessed patients for suitability of other forms of therapy to reduce reliance on opioids and pharmacological methods of pain control. This included therapies such as using virtual reality devices to support meditation techniques. We heard of many examples where this approach had successfully reduced patient’s reliance on strong medicines and improved their quality of life.

Staff followed current national practice to check patients had the correct medicines. We saw staff checking the right medicine was provided to the right patient, at the right time, in the right way and in the right format by checking prescriptions and patient identity.

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 raised concerns and reported incidents and near misses in line with provider policy. Staff knew what incidents to report and how to report them. Staff informed us of incidents they had reported and feedback they had received regarding actions taken. A new electronic system was being implemented to make the incident reporting system more efficient.

Staff received feedback from investigation of incidents, both internal and external to the service. Managers shared learning about incidents with their staff and included learning from other services. Prospect Hospice was a part of a network of hospice providers across the region and they shared learning and good practice at regular meetings. Staff met to discuss the feedback, identify trends and look at improvements to patient care. Information was cascaded to staff at team and department meetings. We saw actions that had been taken following incidents. This included liaising with external services, amending electronic processes, medicines processes and manual handling practices. Managers debriefed and supported staff after any serious incident. Staff told us and we saw records of support offered to staff after upsetting incidents.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. We saw how patients and relatives were kept informed of actions taken after incidents.

Safety Performance

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff. From April to June 2021 there had been no never events, three clinical incidents and one near miss. We saw these had been reported and reviewed by senior leadership team and safety actions were shared with staff at team meetings.

Are Hospice services for adults effective?

Good ●

Our rating of effective improved. 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. National programmes for best practice were used to create policies and deliver patient care. This included National Institute for Health and Care Excellence (NICE). Ambitions for Palliative and End of Life Care and the Gold Standards Framework were embedded in policies for practice. Staff had recently completed a self-assessment on how they were meeting national dementia standards. This had created actions needed to improve dementia care in the service and included collaborating with local organisations, creating a dementia strategy and a training plan.

Policies were updated within their review dates and staff followed them to plan and deliver high quality care according to best practice and national guidance. Staff used a system for documenting patient choice in the event of a life-threatening event and how they would like to be treated. An alternative system called ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) was being discussed at the regional network for end of life care. Hospice leads were promoting the ReSPECT system to provide greater clarity and consistency of choice across the region.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Psychological needs were documented and considered by staff at every contact. Staff understood how their condition could affect their mental wellbeing.

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. Staff regularly checked if patients were eating and drinking enough to stay healthy and help with their recovery. They worked with other agencies to support patients who could not cook or feed themselves. We saw Prospect@Home healthcare assistants monitored and documented urine output in care records to ensure patients were not becoming dehydrated.

Two of the community patients we visited told staff they were eating and drinking less due to the current heat wave and their illness. We saw nurses talk to patients about diet supplements and told us the service had dietitian support one day a week from the local NHS trust but could also refer directly into the service if the patient needed input quickly.

Staff on the inpatient unit contacted dietitians if needed and supported people with their preferences. We heard how the hospice chef met with patients to discuss preferences and created individualised menus from their discussions.

Staff fully and accurately completed patients' fluid and nutrition charts where needed and encouraged intake in line with patient wishes.

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.

We saw staff used pain assessment tools and observation of the patient to assess and document the level of pain relief required. Patients had access to pain relief when they needed it. Anticipatory medicines were prescribed for patients on the inpatient unit and 'just in case' medicines in the community for symptom control. These were medicines prescribed to be administered as needed and not as a regular prescription. For example, medicine for nausea and stronger pain relief. We found 'just in case' medicines were prescribed and given as needed.

The service admitted patients to their inpatient unit to fully assess how their symptoms could be effectively controlled. The assessment was based on information the patient had provided about how they wanted to live their life and activities they would like to undertake. High levels of opioids and strong pain relief medicines had caused patients to be drowsy and less alert than they would like. Alternative methods were used to manage pain symptoms. This had included techniques of visualisation and meditation. The medical director developed an application for use with a virtual reality headset which when used by patients, supported the therapy. We were told there had been great success with their use and patients had fed back how their quality of life had improved. Patients reported they had been able to interact more with family, care for their children and be more independent after using the therapy. These applications were tailored to the patient needs and on their interests, and supported a variety of symptoms such as respiratory distress, as well as pain.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. Service leads monitored patient outcomes using the Palliative care Outcome Scale. This had been used previously but effectiveness depended on how well it was completed. Its use had been discussed at the weekly inpatient unit meeting and a decision was made to re implement the use of the tool. It had been in use for a week before our visit so there were no results to review at that time.

Managers and staff used the results to improve patients' care and treatment. The service audited how many people achieved their preferred place of death, had their decision documented and reasons for not achieving their choice. From 1 April to 30 June 2021 a high percentage had their choice documented (93%). Actions to improve the outcomes were identified and included creating greater emphasis on advance care planning in the community.

Outcomes for patients were positive, consistent and met expectations. Relatives fed back their views of care and consistently informed us the service provided followed patient choice and exceeded their expectations. The service had enrolled in the feedback website 'I Want Great Care' to provide further feedback on how well outcomes had been achieved for their patients and the software was in the process of being implemented.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The service had a plan of annual audits which were reported to the executive team and commissioners. Improvement actions were identified following these audits and demonstrated how staff compliance with practice had improved. Medication audits between May and July 2021 demonstrated how staff compliance had improved to 100%. Any new initiatives were audited for effectiveness and reviewed by managers and service leads. The Single Point of Access team audited a range of metrics including time from referral to first contact and onward referral.

Managers shared and made sure staff understood information from the audits. We saw information was presented to staff in formats which clearly showed audit results and where improvements were needed.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. All new staff, including volunteers, completed a full induction tailored to their role, before they started work. Staff shadowed other staff as part of their induction and until they were competent and felt confident. Managers supported staff during their induction with one-to-one conversations to review progress and further support needed.

Managers supported staff to develop through yearly, constructive appraisals of their work. Managers monitored staff appraisals and rates of completion. The COVID-19 pandemic had caused a delay to some appraisals and the executive team had made a decision to relieve staff of additional pressure and extend the time allowed for staff to complete their annual appraisals. At the time of our visit 76% of appraisals had been completed and 90% had dates booked before the end of August 2021. Staff told us appraisals were of good quality, used a standard template and identified training and development needs.

Staff were supported to maintain and update their knowledge and skills. Staff attended additional training which supported their roles and specialties. Managers encouraged staff to attend external and university led education and training. The patient services director encouraged staff to use their learning to improve practice. Conversations with staff after attending courses included how staff would take their learning forward. Staff we spoke with felt motivated to transfer learning into practice and spoke of many projects which had been instigated as a result. Leads told us more staff were identifying training and conferences they would like to attend and were requesting these through their managers. The medical director, lead consultant and other clinical leads, family support and social workers provided lunch and learn sessions for all staff to attend if they wished. These were held using remote technology and attendance was usually around 20 to 30 staff. Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. This was provided for all new staff recruited to the hospice service.

Managers supported most nursing staff to develop through regular, constructive clinical supervision of their work. Most staff received clinical supervision/one-to-one meetings on a regular basis. At our previous inspection we found staff were receiving some clinical supervision. On this inspection, some staff told us they were not receiving consistent clinical supervision. Staff told us the person in charge of providing clinical supervision had retired in March 2021. Service leads had developed a plan to provide regular supervision for staff and this had been planned to start in July 2021 but was delayed due to ill health of the facilitator. Leads were keeping the plans under review and would seek alternative provision if facilitation was delayed any further. Group supervision sessions had been held in July 2021 for healthcare assistants to promote professional support and competence in their roles.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Meetings had a standard agenda for discussion, sharing learning and providing a voice for staff to represent their views to the executive leadership team. For example, agenda headings included actions from previous meetings, incidents and complaints, with learning, risks, how staff were feeling and what was worrying them and feedback to the executive team. Team meetings also promoted patient centred care by presenting patient stories at these meetings. This prompted discussion and feedback was discussed at leadership meetings.

Managers identified poor staff performance promptly and supported staff to improve. Where support was less successful further support was provided by the leadership team.

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. These were held weekly and attended by all disciplines within the hospice. Staff discussed how they could best support patients and contacted external support if it was needed.

Staff worked across health care disciplines and with other agencies when required to care for patients. Clinical nurse specialists visited GP surgeries regularly to attend meetings which discussed patient care and identify those who may benefit from accessing hospice care. The local NHS trust included the hospice in meetings regarding end of life care for their patients. Community nursing staff from the local community NHS trust worked closely with hospice staff to provide coordinated care for patients. Staff referred patients for mental health assessments when they showed signs of mental ill health. The services of the local police force and other community services were used when needed, to keep patients safe and locate them if they were not at their usual location.

Seven-day services

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

Prospect@Home services were available 24 hours, seven days a week, and often comprised of multiple personal care visits, plus the option of night sits when requested.

Specialist nursing and medical support was available seven days a week and patients were reviewed daily. Specialist consultants were available for advice at all times.

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. These were often provided by other services and hospice staff knew how to access the support.

Health promotion

Staff gave patients practical support and advice to live well until the end of their life. The service had relevant information for patients to use and make choices. Staff discussed options with patients giving honest information and impacts their choices would have on their wellbeing. Emphasis was given to how patients wanted to live their lives and methods of meeting those choices. Therapy teams supported people to maintain or improve their independence. The family support team provided support including emotional support, for patients and their families. Therapy programmes such as respiratory workshops supported people to manage their symptoms.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Conversations about care often included family members and their views were gathered. Staff gained additional consent from patients and their relatives to allow them to document this consent on the patient record.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Meetings were held to discuss best interests and included family members. Staff used a check list to ensure they followed correct process. Staff clearly recorded consent in the patients' records. Staff made sure patients consented to treatment based on all the information available. We saw how staff communicated with patients and their families to explain the impact of their decision.

Consent was audited and issues raised if any were found. This included external partners in care. Patients' consent for referral to the hospice was documented. Hospice staff audited this process each year and fed back results to referrers. Treatment escalation plans were audited and results fed back to staff each year. If issues were identified audit frequency was increased with information provided for staff to improve their record keeping.

Staff understood and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Managers monitored attendance and reminded staff when training was due for renewal. Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them.

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. Staff implemented Deprivation of Liberty Safeguards in line with approved documentation.

Access to information

Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system that they could all update. If staff needed to take paper records with them for reference, they printed copies of the relevant record and transported them securely. Patients in the community had their records within their home. Prospect hospice staff contributed to records for NHS trust community nursing staff so they could review any updates in care.

Outstanding ☆

Hospice services for adults

Are Hospice services for adults caring?

Outstanding ☆

Our rating of caring improved. We rated it as outstanding.

Compassionate care

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

We saw all staff introduce themselves and explain who they were and their role. Staff demonstrated genuine empathy and an understanding of both the patient's and relative's situation. We witnessed staff using a tone of voice which was tender, respectful and showed genuine compassion for the patient.

Staff were discreet and responsive when caring for patients. They took time to interact with patients and those close to them in a respectful and considerate way. We saw care delivered in peoples' homes through the Prospect@Home programme, clinical nurse specialist visits and the rapid response team. In all instances, we observed staff who delivered care with skill and sensitivity. The patient's needs and wishes led the care that was provided, and personal care was described by a carer as being "second to none". We heard how relatives described staff as being like angels and could not praise them loudly enough.

Patients and their families told us staff treated them well and with kindness. We spoke with 10 relatives and four patients, and all told us staff were caring, kind and took time to listen to the patient and their family. One relative told us they would not know what to do without the daily visits from the hospice and told us how the hospice had stepped in to take over and coordinate some specific care following a poor experience with another service. Relatives described how staff had worked with the patient to find a solution to a problem and had agreed to speak with the other service provider on behalf of the relative following an upsetting phone call. Relatives told us how staff anticipated patient needs and responded to requests with skill and care. This included when patients changed their mind about preferred place of death and when raised anxieties were experienced by patients.

Staff supported families and those close to the patient and offered emotional support. Relatives told us how they had been supported by hospice staff and could not have asked for any more support. Relatives who were children, had specific needs, learning difficulties or were particularly anxious, were supported to visit their relative in the hospice unit. The support was provided according to the relatives' individual needs and allowed them to visit with minimum distress. We were told how staff had invested a lot of time outside of the unit and their input had reduced the stress and anxiety for the patient and others close to them. A patient told us they had received a call from a staff member outside of their usual working hours to offer support. This was in addition to the arranged support and the family felt this was truly going the extra mile.

Staff understood and respected the individual needs of each patient and their loved ones. Staff we observed, without exception, showed understanding and a non-judgmental attitude when caring for patients and their families. Staff considered the holistic needs of the patient and their family and used the "what matters to you?" approach to fully understand individual preferences. This included when discussing patients' mental health needs and patients with complex health needs such as homelessness, substance or alcohol dependency, families with autistic siblings/children and those with learning difficulties. We saw how staff went to great lengths to make patients' final wishes a reality. Staff gave us numerous examples of how they had found innovative ways to meet peoples' needs. Staff expressed this was 'just what they did' as an embedded part of their practice. Stories included occasions when staff had taken time in their personal time to seek out hand bells, teach staff how to play them and the team performed a musical piece for the patient. Cars and motorbikes featured in providing what matters for patients. This included working with therapists to help a patient have a ride in a sports car, revving a motorbike up outside a patient's room so they could smell and hear the engine. One staff member created a personalised card of a seaside scene, when she was on holiday. This was for a patient who loved the beach and seaside but would not be able to go there.

We saw staff involved patients and families in discussions and supported them to make decisions with sensitivity. This included when best interest decisions needed to be made on behalf of the patient. We saw meeting minutes which documented patient stories to demonstrate caring aspects of the service, what went well and what could be improved. Service leads used results from the patient survey held in May 2021 to further understand patient and family experiences of using the service and how they could be improved. Relatives told us how staff gave strength and encouragement without giving false hope.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff provided care after death, which included honouring spiritual and cultural wishes of the deceased person and their family and carers. Patients were asked if they had any spiritual or religious needs and we saw this documented in the care plans. Staff undertook online learning for spiritual needs of patients and their families. An executive director had expanded the availability of spiritual support by making links with a network of spiritual leads within the community. This system had replaced the spiritual coordinator role which was previously in place. Additionally, bespoke staff training on spiritual needs of patients was planned to be delivered in October 2021. The service had close links with organ donation providers and respected the wishes of the patient after death.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress in any way they could. They understood patients' personal, cultural and religious needs and always took them into account. There was a strong, visible person-centred culture.

Staff gave patients and those close to them help, emotional support and advice when they needed it. They recognised when this was needed and did not wait to be asked. We saw staff sitting with and listening to patients and families. Staff supported patients and relatives and provided answers to questions wherever they could. We observed staff using a caring and considerate manner when conducting comprehensive assessments of patients' and family needs. Staff checked they had understood information provided by, and given to, patients and their families and gave opportunities, in an unhurried way, to ask any questions. Feedback provided by community staff from partner agencies confirms how effective and empathetic hospice staff were and how they had much they had learnt by observing their practice. Staff spoke to patients and their families on a personal level and knew the names of loved ones. They took care to gain knowledge of hobbies, cultural and religious preferences and things the patients enjoyed and supported patients to access these activities wherever they could. We heard from a relative how hospice staff had actively supported a patient's religious beliefs at the end of their life and helped a patient to have the "best death" they could have had. In one instance we saw a nurse add a note for a patient to have audio books made available to them when they went into the inpatient unit at the hospice. This was because they loved reading but had declining eyesight. Staff cared enough to think about patient preferences outside of their working hours. We saw staff bring favourite snacks in for patients because they had seen the snacks at the local shop and knew what patients liked. Staff helped a family to fulfil the wish of their mum to see them dance outside of her room. Staff arranged for the family to attend, for the music to play, cleared a snowy patio outside of the room, and recorded the dance for future enjoyment.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Patients and relatives were able to use quiet rooms on the inpatient unit if they needed a time of reflection, were upset or needed space for difficult conversations.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff had honest conversations with families about treatment and care options and how it might affect patients and their families. Assessment documents were detailed and encouraged staff to explore individual situations for patients and their families. Staff used the information and responded to changes in situations with empathy. All staff we spoke with described how they cared for patients and those close to them. Relatives fed back to us how they had been supported and felt staff had a full understanding of emotional impacts on patients and their families. Relatives provided written feedback to hospice staff expressing the positive impact their care had made. Relatives also described situations where staff had responded to changing and complex needs of families and effectively supported them with empathy and respect. We heard feedback from families about how they had been supported by staff throughout their loved ones' illness and how Prospect "always had their arms around you".

Understanding and involvement of patients and those close to them

Staff supported, and were committed to involving patients, families and carers as partners in their care. They helped patients, families and carers to understand their condition and make decisions about their care and treatment and achieve their potential in challenging and unusual situations.

Staff made sure patients and those close to them understood their care and treatment. Before the COVID-19 pandemic, staff facilitated support groups at the hospice. Since the onset of the pandemic the format of these support groups had needed to change. This had caused some disruption due to lack of premises and attendance by relatives/carers. Staff continued offering support by making regular calls to patients' homes and their carers/relatives and offering individual support with signposting to other services, organisations and voluntary groups in the community. Other activities, such as, walking groups, a bereavement group for mums who had experienced the death of an adult child and a range of complementary therapies were being offered and facilitated by hospice staff, to promote additional emotional support.

Staff actively supported patients' relatives to visit patients when they were using inpatient unit services. Staff talked about how they cared for the whole family and those close to the patient. Staff gave us examples of how they had worked to make bespoke care packages to fit the patients and their families' needs instead of fitting them into available processes. Hospice staff and patients' relatives gave us examples of how staff had overcome complex situations with their determination to provide care in the best way for patients' and their families. All of the examples had required staff to seek out alternative support methods, which included using alternative forms of communication and ensuring they knew and respected patient choice, even when the choice was unwise. Patients who were homeless were supported to live the lives they wanted to but were still able to receive hospice support.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff supported patients to make informed and advanced decisions about their care. Nursing staff always asked families what they thought was happening to their loved one. Staff explained, they felt this was a gentler way of approaching the subject as most relatives already knew what was happening, and in saying it themselves, lessened the shock. We saw this in one instance and by the end of the visit, a decision to admit the patient had been made which was welcomed by both family and patient. Relatives told us how staff had used drawings and simple discussions to help younger relatives understand what was happening. Relatives described how this had reduced much emotional stress for the patient as well as the family. Families gave feedback expressing how they had felt supported and understood by hospice staff: "knowing someone understood what I was going through was a massive help"

Outstanding ☆

Hospice services for adults

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The provider made a decision to improve the number and quality of patient feedback to inform service provision. They conducted a patient experience survey in May 2021. The survey, 'What matters to you matters to us' was held over a two-week period. The majority of responses were positive and service leads used the information to further understand the experiences of patients and their relatives and identify areas of improvement. Staff responded to comments with actions such as setting up a social chat group to keep relatives informed of a patient's condition. The survey asked if the person completing the survey would like to discuss their responses further.

Are Hospice services for adults responsive?

Good ●

Our rating of responsive improved. We rated it as good.

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the changing needs of the local population. This was a significant improvement since the previous inspection. The service provided end of life care for individuals requiring care and support outside of their NHS care.

The community and the inpatient unit services offered a flexible and responsive service to meet the needs of the patients who used the service. Managers told us there was varied demand for services for both community and the inpatient service. Managers would work with individuals and offer appointments to suit the needs of patients. Community services were available early in the morning, later in the evening and offered an overnight service to accommodate patient need.

Executive leads and medical director were working with local commissioners, NHS trusts and primary care providers to plan hospice and end of life care for patients in the region. Service leads and managers attended strategy meetings and offered services to support where there were gaps in this provision.

The 'what matters to you matters to us' engagement survey used information provided by patients and families, to involve people further in the design and running of the service. Service leads had made changes for improvement in response to comments made. This survey was to be repeated before the end of 2021.

The service had engaged actively with different faith groups in the local community and had a plan to develop this further to look at how to reach the range of faiths within the community.

Facilities and premises were appropriate for the services being delivered.

The hospice was designed to meet the needs of families and relatives of patients. There were kitchen facilities to cater for visitors' refreshments needs and relatives were able to stay by the patient's bedside if needed. All patient rooms had access to external space such as a patio which led to the garden. Relatives told us how they had used this to spend some reflective time and how tranquil they were.

The inpatient unit had reduced the number of beds available to create safe distances between patients, staff and visitors during the COVID-19 pandemic. Staff had been redeployed across community services to ensure patients were cared for. Executive and service leads were analysing the demand for the service during this time and reassessing how many inpatient beds were needed.

The COVID-19 pandemic had created problems with people attending the hospice and alternative provision was made using local premises such as village halls to hold smaller support meetings. However, they had not been well attended and engagement with patients and relatives had revealed they were reluctant to attend indoor groups. The hospice responded by using alternative support systems. One successful initiative had been a carer walking group, which was to continue as a support for carers. Complementary and alternative therapies such as Reiki and the ‘M’ Technique were given by qualified practitioners who volunteered their services. With Reiki the therapist places their hands either on or just above certain points of the body to channel energy and to help achieve improved balance in mind, body and spirit. The M technique is a light massage on hands and feet. The service also offered complementary therapies to the carers of patients and bereaved relatives of patients to help their wellbeing.

The service had systems to help care for patients and their relatives who were in need of additional support or specialist intervention. Service level agreements were used by staff to help patients access other services as needed. The hospice offered psychological support for families and mental health services were available for further specialist support. Relatives told us how they had received timely support from the hospice bereavement service following the death of their loved one.

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 kept detailed records of patient preferences including developing Advance Care Plans and treatment escalation plans, which documented how they wanted to be treated at the end of their life. This was an improvement since the last inspection. Where referrals to their service did not have a record of this type of choice, staff fed this back to the referrer and provided education on how to complete the information. We saw a patient assessment being completed which involved, patient, carers, nursing and medical staff and choices were documented.

Nursing staff coordinated their visits with community nursing staff who were also providing care for patients. Where they could, they provided care, which community nurses would have otherwise delivered, to prevent duplication of visits. Staff also provided care in challenging and complex situations, where community services had withdrawn support but where the patient required symptom relief. Staff documented care provided and contributed to the records of the community nursing teams to ensure they had up to date information on care needs. All patients had a care assessment and plan booklet which remained in their homes.

We saw clear records of individualised care plans. It was evident that the person receiving the service was central to the process and had been an active participant in the way they wanted their care to be delivered, based on a mutual understanding of their physical, psychological, emotional, and spiritual wishes. We saw that people had been asked about their preferences and wishes in relation diet, exercise, psychotherapy, relationship and spiritual counselling. Records showed conversations had been held about what was important to that individual, such as relationships, to day-to-day activities and the patient's favourite mug.

Relatives told us how staff responded promptly and effectively when a patient changed their mind about preferred place of death.

Staff adapted care to meet individual needs of patients and their families and carers as an embedded part of their service. Staff consulted and recorded in detail, the wishes of the patient and those close to them. This included how patients wanted to live the remainder of life they had left. Staff told us how they had supported patients who were homeless, using alternative methods of communication to contact them, and liaising with other services to make sure the patients received the care they needed and wanted. Staff made every effort to fulfil their wishes wherever they could. We heard of incidences where patients had been prescribed medicines that limited their cognitive function and where lack of mobility had been reduced their independence. The whole hospice team worked together to improve patients' quality of life. Staff told us of examples where therapists supported patients to improve mobility and independence, support teams helped patients to be cared for in locations closer to their loved ones. Staff provided alternative methods of pain management to improve the patient's cognition, reduce drowsiness and helped them to interact more with their families and children.

Staff created a system of supporting relatives to be more involved in the care of their loved one in response to a specific patient need. The patient needed a regular injection each day to administer a prescribed medicine into subcutaneous (just under the skin) tissue. Nursing staff trained the carer to safely administer the injection and offered additional support if it was needed. The whole process had involved developing a policy, protocol and training programme for carers to take on the role. The carer fed back to staff how they had felt much more involved and useful in the care of their relative and found it a positive experience.

Patients were given a choice of food and drink to meet their cultural and religious preferences. The chef at the inpatient unit consulted with patients to provide a diet which suited them and provided taster pots and individualised menus. We saw how staff attended to detailed needs of patients, such as when a nurse used a teaspoon to feed liquids to a patient who had swallowing difficulties. This was in a gentle and unhurried way and included the patient's favourite tipple.

Managers made sure staff, and patients, loved ones and carers could get help with communication when needed. Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Relatives told us how staff had supported their siblings with additional communication needs by using sign language. The service had information leaflets available in languages spoken by the patients and local community. Additional support could be arranged through an external company over the telephone.

Access to right care at the right time

People could access the service when they needed it and received the right care promptly and within national guidelines.

Service leads were working with external services in the region to support identifying patients in their last one thousand days of their life. This would enable them to identify and provide hospice care at a time when patients and families needed it.

The Single Point of Contact (SPOC) team accepted and managed all patient referrals from the community (from patients, families, and healthcare professionals). The team monitored referrals and ensured patients met the referral criteria and had consented to the care. They contacted each patient or carer and prioritised their need using a triage system. Data provided by the organisation showed that all referrals were managed within set timeframes. This team operated 24 hours per day, 7 days a week, to ensure it was accessible and responsive to the needs of people needing a service, carers and commissioners, providing referral management triage, and the completion of a holistic needs assessment, tailored to the health and care needs of the individual.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes. We saw how staff managed a rapid response referral for a patient who was approaching the final hours of their life. This was responded to within a few hours of receipt with contact from the clinical nurse specialist team. Other relatives we spoke with also told us when they had needed urgent support, the service had responded by visiting within 24 hrs.

In March this year, the provider participated in a CQC led, provider collaboration review (PCR) into how cancer services were delivered to people living in Bath, Swindon and Wiltshire during the pandemic. During the review the provider was able to provide strong, corroborated examples of how they had worked with other key stakeholders, such as a local NHS trust, the clinical commissioning group and the local ambulance trust to ensure people nearing the end of their life received care and treatment in a timely, safe way, resulting in good, high quality outcomes for people, based on their wishes. Initiatives included, with patient consent, consultant to consultant led discussions about the most appropriate place for treatment, pain relief and what was in the patient’s best interests. The NHS trust lead involved in the CQC PCR review told us the relationship with the provider was strong, collaborative and very much prioritising the needs and wishes of the patients, working in partnership to achieve the right outcomes for people needing services.

Managers and staff worked to make sure patients did not stay in the hospice longer than they needed to. We saw one nurse discuss options with a patient and persuade them to come into the hospice for a short time to allow medical staff to adjust their pain medication and improve the management of symptoms.

Managers monitored patient moves between services and actively liaised between services to prevent duplication of care provided. Staff supported patients and their families when they were referred or transferred between services. We saw staff reassure patients and their families of the standard of care a service would provide and what to expect as an inpatient at the hospice.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. Leads monitored and investigated complaints and responded by identifying actions to resolve them. Between April 1 and June 30, 2021 there had been three complaints regarding patient services, and all had been responded to within required timeframes. We heard how leads used any information as opportunities for improvement actions. Complaints and comments had prompted actions and complainants were invited to be involved with improvement plans. The service clearly displayed information about how to raise a concern in patient areas.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff understood the policy on complaints and knew how to handle them. Complaints were a standing agenda item for each team or department meeting and progress against actions were discussed. Wherever possible staff acknowledged concerns and worked to resolve them before they became formal complaints. Staff could give examples of how they used patient feedback to improve daily practice. This included patient stories which were discussed at team meetings. Staff used the story to identify how they could improve any aspect of the patient/carer experience.

Are Hospice services for adults well-led?

Outstanding ☆

Our rating of well-led improved. We rated it as outstanding.

Leadership

The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care.

Prospect's leadership structure comprised Trustees, Executives, Leadership Team and Clinical Leads. There was compassionate, inclusive and effective leadership at all levels. Leaders demonstrated the required levels of experience, capacity and capability needed to deliver high quality and sustainable care. Trustees acted as critical friends for executive leads to drive improvement. Patient and family experience were always taken into account.

Staff told us on numerous occasions that the leadership team was visible and approachable and how this was an improvement since the leadership team had changed. We were told and could see, there were strong channels of communication from board to operational levels which ensured the voices of, patients, carers, volunteers and staff were heard, listened to and acted upon.

The Trustees and members of the senior leadership team (SLT) (which included executives) were stable and worked cohesively across all levels. Together, with the staff team, the senior leadership team had made significant improvements to the leadership and culture of the service. For example, staff at all levels had undergone a pay and job role review that ensured equity of workload and reward across the service. Governance, risk and reporting structures had been reviewed, reorganised and strengthened, furthermore the culture within the organisation was inclusive, supportive and cohesive. We heard staff stories of support offered by executive team members and how helpful the support had been.

The SLT reported to the chief executive officer. Leaders included a director for community development, director for finance, medical director, director of people, head of volunteering, learning and inclusion. The hospice's SLT reported to board who in turn reported directly to the hospice's trustees.

The chair of the board of trustees was well informed of the skill mix of the board and had identified areas where the board could be further developed in line with the ongoing vision of the service. Trustees told us they were well informed and had strong, professional relationships, not just with board members but with the wider staff team. Trustees completed an induction programme to familiarise themselves with what the trustee role entailed. The chair and senior leaders confirmed the trustees provided an appropriate level of challenge to reports presented to them.

The senior leadership team and the trustees understood the quality and sustainability challenges facing the hospice. These included, although were not limited to, sustainability of financial streams. Trustees maintained their understanding of quality and safety of care through attendance at governance sub-committees. We met with a group of the trustees who spoke with clarity and confidence about how they met their governance responsibilities and demonstrated a sound understanding of the quality and safety of care.

The whole of the senior leadership team, management and trustees were committed and passionate about patient care and a high-quality service. They spoke highly of the staff and volunteers and told us about the mutual respect held. They understood the challenges the service faced, in particular, the funding challenges experienced by the pandemic, and the delivery of the organisation's strategy, including the expansion of the ‘Prospect without Walls’ (further details of the strategy are included in the Vision and Strategy section below) service and the impact, challenges and opportunities this could have for the service.

Revenue generating streams, through the hospice fundraising and trading arms, were continually reviewed to ensure sustainability, cost effectiveness, and best use of the existing resources. The senior leadership, along with operational teams were looking at developing further services and revenue generating uses of its online retail presence.

There was a clear leadership strategy. The board and trustees met regularly to review, develop and evaluate this. There was succession planning with a number of leadership development programmes for managers within the organisation. There was a board development day planned for later this year with an external facilitator to work with the leadership team to build on their skills and the scope for further organisational development.

Staff told us they felt well supported by the management. Staff told us there was strong leadership, who were a cohesive friendly and approachable team. Staff felt confident in approaching them regarding issues to do with their professional or personal life. Leaders within the service went out of their way to ensure they were visible and approachable. Staff told us leaders from all levels within the organisation were approachable and supportive. That members of the senior leadership team and the trustees could be seen regularly on the inpatient unit and always had time to share ideas and answer any questions.

Concerns raised by staff were always acted upon by leaders, feedback was given, and we could see that learning was key, embedded and always disseminated to staff.

All staff felt valued and told us they enjoyed working at the hospice. A great number of staff told us they were proud to work at the hospice, were proud of their peers and leaders and appreciated strong, support and collaborative relationships.

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 strategy and supporting objectives and plans were stretching, challenging and innovative, while remaining achievable. Strategies and plans were fully aligned with plans in the wider health economy, and there was a demonstrated commitment to system-wide collaboration and leadership.

Leaders labelled their future strategy 'Prospect Without Walls' which was designed to provide care across the region for all patients who needed hospice services. The aim was to support staff to lead the service and contribute to how it would be delivered in the future. The service strategy was developed with engagement from the local community to reflect their needs. The strategy recognised current and future funding arrangements and had identified areas of prioritisation, challenge and opportunities.

The vision, values and strategy had been developed using a structured planning process in collaboration with staff, people who use services, and external partners. Staff knew and understood what the vision, values and strategy were, and their role in achieving them. Both staff and leaders spoke with clarity and confidence about these and what it meant for service provision and delivery.

There was a demonstrated commitment to system-wide collaboration and leadership. The strategy from 2021 onwards was due to start being re-developed by the board and the executive team. A plan was to be further built upon and developed with system wide collaboration through the new partnerships and networks forged by the service.

We saw that senior leaders engaged with the wider health economy and were engaged with appropriate networks aligned to their service and its future vision and strategy. We saw that the strategy aligned to local plans in the wider health and social care economy. Senior leaders shared a number of examples to evidence their sound relationships, engagement and their being an active participant with external stakeholders. Senior leaders attend key system partner meetings to be involved and to influence positive change and better outcomes for people using services. These included meeting with the local integrated care system (ICS) for Bath, Swindon and Wiltshire, the local authority and the overview health scrutiny committee, to gain a better understanding of the social demographics, deprivation, poverty and health inequalities of the population they serve.

The provider had also recently engaged with primary care networks locally to look at being a full system partner in a project whose mission is for services to be leaders in 'maintaining a quality of life, till the end of life'. This project will look to involve the hospice in providing education around making dying accessible and comfortable in schools, further education and the community as well as ensuring parity of service for vulnerable and harder to reach groups of people, such as those experiencing poor mental health and those living with a learning disability. The chief executive told us the hospice staff were committed to making this vision into reality and would continue to work with other agencies to achieve this goal.

The provider had recently collaborated with other end of life providers/service leads and had engaged with the Bath, Swindon, Wiltshire (BSW) Palliative and End of Life Care Oversight. This was to provide input into a report to seek the support of the Population Health Board on, what will provide improved health outcomes for all people and their families who require palliative and end of life care, across both place and the system and are based on:

1. National and local policy and strategies in particular the existing clinical commissioning group (CCG) strategies/ contracts for end of life and the Ambitions for Palliative and End of Life Care document.

2. Quantitative analysis of local demographic and outcome data supplied by the CCG.

3. Qualitative feedback received from an ongoing survey of patients and family's experiences of end of life care across Bath, Swindon and Wiltshire.

4. Mapping of local services against items 1, 2 and 3 above.

5. An ambition to deliver services that are both value for money and delivering demonstrable positive outcomes for the local populace

The BSW Palliative and End of Life Care Oversight group, of which the provider is a key stakeholder of, has had some early successes in agreeing a “population health” approach, mapping the services across the system and setting up a working group to review the use of ReSPECT (ReSPECT records that information so as to make it accessible rapidly to professionals who need to make immediate decisions about care and treatment in a crisis). By being involved the provider is able to actively contribute in discussions and next steps arrangements in relation to decision-making capabilities to discharge these roles effectively, within a clear but flexible accountability framework that enables collaboration around funding and financial accountability, commissioning and risk management.

Arrangements with partners and third-party providers were governed and managed effectively to encourage appropriate interaction and promote coordinated, person-centred care. For example, the organisation had commissioned the work of an external provider to support the facilitation of further work with colleagues within the Integrated Care System (ICS) on the strategic direction for End of Life Care across Bath, Swindon and Wiltshire. This was to work within the National Context: Ambitions for Palliative and End of Life, Care1, which sets out six ambitions developed in partnership with the statutory and voluntary organisations who lead the delivery of palliative and end of life care.

Progress against delivery of the strategy and local plans was monitored and reviewed at board level and shared with staff and stakeholders.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Leaders had a deep understanding of issues, challenges and priorities in their service, and beyond. There were comprehensive and successful leadership strategies to ensure and sustain delivery and to develop the desired culture.

We spoke with a range of staff during our visit, including members of the leadership team, trustees, managerial staff, doctors, nurses, healthcare assistants, therapists, domestic, catering, community and inpatient staff. Without exception, staff we talked with were proud to work for the hospice. Staff members told us the hospice was an excellent place to work and was made of up individuals who all have one common purpose, to provide high quality, person centred care.

A number of staff also went out of their way to contact us to share their experience of what it was like to work at the hospice. We received a number of emails from staff who told us, “We are led and the style in which we are led is unrecognisable from before, as too is the culture. There has been so much focus on improving culture”. Another person told us “there is strong leadership from our chief executive who is approachable, open and honest. She makes a real effort to connect, listen and know staff, attending team meetings, spending time being present around the hospice setting, and giving regular updates to name a few examples. Indeed, the whole executive team work so hard to be accessible and inclusive and communicate probably more than they even need to with staff and volunteers. The gap between management has long disappeared in the organisation and there is a feeling of ‘all being in this together’. The executive team are genuinely well liked by staff, and are more connected to our services, which is a result of their efforts and relentless hard work to make this change”.

All staff we spoke with were positive about working for the hospice. They described feeling valued and supported in their role. Staff who worked remotely said they felt connected to the team and to the organisation. The service supported and valued the contribution of its volunteers.

Multiple staff told us about how valued they felt by the service leads.

Staff and volunteers at all levels in the hospice, were committed and focussed on improving the experiences and care for all patients who used the service. This included recognising, acknowledging and apologising when things went wrong. Staff we asked were aware of the hospice's being open policy and the being open principles of the duty of candour.

The duty of candour confers on the organisation a duty that, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred, a health service body must notify the relevant person that the incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.

The hospice's being open policy provided a framework for managers and staff to meet the requirements of the regulatory duty of candour. Operational staff were aware of the need to be 'open and honest', and senior leaders were aware of the regulatory requirements of the duty.

The service had a whistleblowing policy which was available to all staff and staff we spoke to knew how to raise concerns.

There had been a significant amount of investment, led by the senior leadership team, in building relationships, trust, mutual respect and understanding amongst staff, this was a significant and substantial change since our last inspection. We found there were cooperative, supportive and appreciative relationships among staff. Staff and teams worked collaboratively, shared responsibility and resolved conflict quickly and constructively.

We saw many examples of positive cross-team working to provide joined up, holistic care for patients. Staff worked closely together in order to put people using the services as central to all decision making processes. Staff told us, and we saw, their priorities, individually and as a collective team was to ensure high quality, person centred and holistic outcomes, based on individual need and wishes. There were particularly strong links between those working in therapies, the community and inpatient staff, meaning that patients received a seamless service.

There were well embedded mechanisms for providing all staff at every level with the development they needed. These included high-quality appraisal and career development conversations, and personal development and career enhancement through leadership programmes and individual mentoring and coaching.

Staff told us, and we saw in board papers and staff survey analysis that there was a strong emphasis on the safety and well-being of staff. There was effective support to staff who were caring for people at end of life/with distressing symptoms. For example, by providing psychological support as well as supportive supervision, where staff could discuss the emotional aspects of caring for people at the end of their lives.

There was strong collaboration between the hospice and the wider health system in order to improve the provision of service to the local population and provide sustainable joined up care.

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.

Since our last inspection an effective and clearly defined governance structure had been developed. This was well embedded and was in place to ensure individual, team, and overarching accountability and delivery of the strategy was maintained. Staff, senior leaders and trustees told us the effectiveness of the system was regularly reviewed and independent chairs assigned to each board sub-committee to ensure consistent and appropriate challenge at all levels.

Board committees were chaired by a Trustee and other Trustees allocated to each Committee depending on skill set. Clinical Governance committee fed into the Patient Services Committee which reported to the Board. The Board of Trustees had regular individual meetings as well as quarterly meetings with the Executive Team. Six weeks prior to the Board meetings the Chairs and members of the Exec team met to discuss agenda topics.

The governance structure included board, clinical governance, clinical standards, hospice wide governance, clinical services and team-based meetings. We reviewed meeting minutes from all groups and saw that performance, staffing, finance and incident information including was discussed at each level. Committees received and reviewed the minutes and actions of related subcommittees.

Levels of governance and management functioned effectively and interacted with each other appropriately. Governance within the hospice was overseen by the board of trustees and executive management team through the quality and integrated governance framework. The framework, and supporting policy, provided the structure for managing and reporting on a range of auditable metrics to the board and to the clinical commissioning groups. Board-led sub-group committees, all of which were attended by a trustee, included the finance and income generation committee, clinical governance committee, the People and Resources Committee and the audit and risk committee.

There was a programme of clinical and internal audit to identify areas of risk and improvement and actions were taken to improve performance.

The service had plans to ensure continuity of care in the event of an emergency

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 ensure financial pressures did not compromise the quality of care.

There were clear and accountable arrangements for identifying, recording and managing risks. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

The executive management team and the trustees were able to describe the service's main risks, and these matched the risks identified on the hospice's risk register. The risk register covered all areas of the service. The risk register was laid out in a way that risks were listed by the staff member responsible for overseeing the risk. Risks were rated by the impact that it could have upon the safety or provision of the service. We saw actions listed against highly rated risks.

Staff we spoke with could articulate the main risks to the service with funding being the main risk to the hospice. Staff at all levels could describe the actions taken to mitigate the risks these posed to the service. Managers thoroughly assessed the risks involved in the development of and supporting new care programmes and initiatives across the wider health system. Performance data was analysed and presented at both committee meeting and board meetings.

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.

The service collected a variety of data and analysed it to understand performance in specific areas, make decisions and improvements.

There were well established arrangements to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards. We saw a paper in respect of an organisational review against the General Data Protection Regulation (GDPR) was presented to the board in May 2021. The paper had been previously reviewed at the audit and risk committee. It was noted there had been an increase in GDPR incidents each quarter and actions had been implemented in March 2021 to address these. It was noted there had been an increase in staff awareness of their role and responsibility in this area. Spot checks to ensure compliance against the regulations were being implemented. Face-to-face training had also been reinstated and the board were assured the hospice was on a positive trajectory of compliance against the GDPR regulations.

An audit was completed over a 12-month period, concluding in May 2021 to check the recording of awareness and consent within the referral process to the hospice. This was undertaken to ensure the referral process was recorded electronically with the overall aim to improve data collection and increase accuracy in recording of awareness and consent. The audit found some areas for further development, which had been acted upon.

There were effective arrangements to ensure that data or notifications were submitted to external bodies as required. We saw the organisation reported bi-annually to the Bath, Swindon and Wiltshire Clinical Commissioning Group against the eight regional dementia quality standards designed to improve the care and experience for patients with dementia and or delirium, and their carers. A review of these standards took place in March and April 2021, led by a senior experienced nurse, who followed the NHS Improvement dementia assessment and improvement framework. This provided a good overview of the high quality of work and positive attitudes that all services managed by the hospice provided for dementia patients, customers and significant others.

Engagement

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

Leaders had an inspiring shared purpose and strived to deliver and motivate staff to succeed. There were high levels of satisfaction across all staff.

The service engaged well with patients, staff, volunteers and the public and local organisations to plan and manage appropriate services and collaborated with partner agencies effectively.

Patient experience stories were embedded in the service as an opportunity to share learning, create improvments and shine a light on good practice.Staff shared patient stories at board meetings, staff and team meetings and staff forum meetings to highlight patient views and feedback.

A patient and family feedback exercise was launched in May 2021, in the national dying matters week, to patient and families across all parts of the service. Cards were designed for people to record their feedback and clinical staff invited people in their care to complete and return their comments. We saw 51 people responded to the feedback exercise, with high levels of satisfaction recorded and included people who wished to be further involved in service redesign and development. We saw information from this exercise was used to make improvements for patient services.

A number of staff told us that the staff forum had gone from strength to strength especially before and during the pandemic. We could see the forum was very active and passionate about gathering staff views and being a voice for people in discussions with the senior management team. Over the past few years the organisation had worked hard on culture and behaviours and after meeting with staff to explore how they wanted the hospice to move forward, as a team, they collectively developed the ASPIRE values of which staff told us they took ownership and were proud. ASPIRE stood for authentic, specialist, person centred, inclusive, resilient and excellent. The values were well known by staff and we saw these were embedded within all aspects of the organisation, such as recruitment and staff development. The values had been included within staff forum discussions with the management of change within the organisation. The staff forum had also been involved in the pay review, new lighting in the car parks, smoking policy and much more.

A staff pulse survey was undertaken each year. In June last year 118 people (60% of employees) responded to the survey while 130 people (approximately 75% of employees) responded to the January 2021 survey. This included responses from people working on site at the hospice, those working in the community, those working from home or partially working from home, and those furloughed.

Leads of the organisation undertook an equality impact assessment to ensure those in vulnerable population groups were identified, known and supported. The organisation was aware that people from Black, minority ethnic (BME) groups were at higher risk of COVID-19 and conducted individual risk assessments with each BME staff member to better understand how they could be supported to minimise the risks. The organisation also worked closely with members of staff who had health concerns which may have made them more vulnerable. The organisation was particularly alert to the impact the pandemic and current challenges had on mental health and the pulse staff survey specifically sought feedback on how staff were feeling in terms of their mental health.

We saw the service responded to any comments made to improve the quality of the patient’s experience. There was regular communication with staff via the staff newsletter and individual one-to-one meetings. During the pandemic the chief executive had a weekly interactive session for all staff, to provide an opportunity to deliver key messages and for staff to raise queries, concerns or ideas. This had recently moved to be a bi-weekly session. Staff told us they found these sessions to be informative, inclusive and of value.

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.

The hospice leads were committed to improving palliative service provision across the local area. They were a strategic partner in developing and improving the palliative care provision across the Bath, Swindon and Wiltshire areas.

Hospice services for adults

The hospice leads were committed to further share work locally. The Chief Executive was co-Chair of the End of Life Alliance for BANES Swindon and Wiltshire.

Staff were supported to attend and present research at national and international conferences. Staff told us this had enabled them to maintain their own continued professional development, had encouraged them to develop further skills and share learnt knowledge with others. They told us attendance at such conferences and other external learning opportunities made them feel valued and invested in.

There were systems to support improvement and innovation work, including objectives and processes for evaluating and sharing the results of improvement work. We were told by a number of staff how involved they were in respect of the 'if money was no object' initiative. This was a programme by which senior leaders invited all teams and individuals to submit their ideas and suggestions to the board. With the aim to improve the quality, breadth and safe delivery of services. We saw ideas such as delivering a service to patients and their families, including that the multi-disciplinary team would be responsible for ensuring the patient was able to remain at home, their preferred place of death, with symptoms, equipment, wound care, catheter care etc. managed within Prospect@Home service. Staff told us they felt empowered, inspired and listened to, which in turn motivated them to further evaluate and look at ways of improving the services delivered.

Leads of the service were committed to improving services by learning from when things went well or not so well and promoted training and innovation. The service was committed to providing regular training opportunities to staff. We saw information about education sessions for clinical staff, health care assistants and others, which had been delivered during the pandemic.

We heard about a patient with complex health needs being admitted to the inpatient unit, and one of the physiotherapists made a training video for staff who were faced with new equipment they were not familiar with. The whole team embraced the teaching session and this enabled a smooth transition and safe use of equipment for the patient.

We saw from board papers that patient and staff stories were shared at board meetings. These provided an opportunity to hear directly from people about their experiences of using and delivering services. We saw these stories were impactful, reflective and informative. We saw leaders shared these stories, took actions where there was a need to develop the service and improve people's experience.

We also saw the patient services committee presented an update to the board in May 2021, where staff were commended on delivering an inspiring social work presentation highlighting the great social work that the hospice staff have undertaken, including development and insight of education and safeguarding processes.

Hospice staff had developed innovative methods of managing symptoms. They had developed methods where patients used virtual reality applications to manage the symptoms of pain. The organisation had three recordings from Sir David Attenborough, with accompanying visuals and were looking to develop other virtual reality experiences for fatigue, breathlessness and anxiety.

Staff were provided with opportunities to develop their skills and knowledge and worked on research projects with universities in the region. One such project related to the impact of consultations in palliative care.