The Hospice Charity Partnership

Birmingham St Mary's 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?	Outstanding ☆
Are services well-led?	Good ●

Summary of findings

Overall summary

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

- Staff provided outstanding care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it.
- Staff prioritised working together as a team for the benefit of patients. Staff supported patients to help them to make decisions about their care, and patients had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- Key services were available 7 days a week.
- 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 managed infection risks 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.
- Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Staff demonstrated a lack of knowledge and understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, and the procedures and documentation used by the hospice to assess a patient's capacity.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
End of life care	Outstanding ☆	Our rating of this service 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 managed infection risks well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. • Staff provided outstanding 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. Staff mostly supported patients to make decisions about their care and had access to good information. Key services were available 7 days a week. • Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. • The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it. • Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Summary of findings

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Summary of findings

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Summary of this inspection

Background to Birmingham St Mary's Hospice

Birmingham St Marys Hospice provides specialist care for people living with a terminal illness. The service was registered with CQC in September 2021. The service operates under the charitable organisation The Hospice Charity Partnership following a merger with another hospice in the Birmingham area, John Taylor Hospice.

The hospice works with other partner organisations to provide high quality care to patients and their families. Funding is provided by the local NHS, charitable donations and grants. The hospice also provides training and education to local support groups.

The service cares for patients at the hospice location, in the community, or in their own homes.

The hospice provides care to adults through inpatient services, day hospice and community services. Bereavement and counselling services are also provided to patients and their families.

There is a registered manager in post and the service is registered to provide treatment of disease, disorder or injury and personal care.

How we carried out this inspection

We carried out an announced comprehensive inspection on 21 and 22 September 2023. The inspection team consisted of 2 CQC inspectors and a specialist adviser with a background in palliative care. We looked at all key questions including safe, effective, responsive, caring and well led.

During the inspection we spoke to 25 members of staff, 17 patients and their families and we reviewed 9 sets of patient notes and 4 staff files. We also attend 3 of the service handover meetings for staff and a system wide bed meeting. We also visited 4 patients in community settings with the clinical nurse specialist team.

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

Outstanding practice

We found the following outstanding practice:

- Staff provided outstanding care and treatment. Patients and their families praised the service and consistently gave positive feedback.
- The services at the hospice worked effectively together as a multidisciplinary team to support the emotional needs of the patients and their families and to ensure patients were able to die in their preferred place.
- The staff at the service went above and beyond to provide emotional and practical support to patients and their families.
- There were innovative approaches to providing integrated person-centred pathways of care which involved other service providers particularly for people with complex and multiple needs.

Summary of this inspection

- The hospice set up various community initiatives to help engage diverse communities and develop relationships with key leaders of groups who may not normally access hospice services for reasons of culture or accessibility.

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 are able to demonstrate knowledge and understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. (Regulation 11: Need for consent) (12(2)(i) Safe Care and Treatment).
- The service SHOULD make sure that staff who obtain the consent of people who use the service are familiar with the principles and codes of conduct associated with the Mental Capacity Act 2005, and are able to apply those when appropriate.
- The service SHOULD document accurately the assessment of a patient's capacity to consent to treatment. (Regulation 11: Need for consent) (12(2)(i) Safe Care and Treatment).

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
End of life care	Good	Good	Outstanding	Outstanding	Good	Outstanding
Overall	Good	Good	Outstanding	Outstanding	Good	Outstanding

Outstanding ☆

End of life care

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

Is the service safe?

Good

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

Mandatory training

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

Staff received and kept up to date with their mandatory training. All staff spoke positively about the training programme. The training academy and managers monitored mandatory training using an electronic system. and alerted staff when they needed to update their training. Staff told us if they fell behind with their mandatory training, managers would receive notification of this and would speak to them to arrange a time for completion.

Volunteer staff were included in training modules. New staff were provided with a programme of orientation and basic skills needed to fulfil their roles.

The service had effective systems to monitor staff's compliance with mandatory training. Staff received mandatory training in safe systems, practices, and processes. Mandatory training was split into job roles and staff would have a personalised list of training for them to complete. Mandatory training rates were 94.7% against the hospice target of 95%.

Training was delivered as a mixture of face-to-face training and online completion by staff. Training modules included fire safety, hand hygiene, safeguarding adults, children, preventing radicalisation, information governance and data security, privacy and dignity, the mental capacity act, deprivation of liberty safeguards adult and paediatric basic life support, learning disability awareness and equality and diversity. The online training included questions at the end of the course to help embed the course content.

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

The trust had a suicide and self-harm policy which gave guidance to staff and volunteers dealing with patients at risk of self-harm and or suicide, which staff were knowledgeable about.

Completion of mandatory training was linked to staff appraisals and any gaps were discussed and action was taken to ensure training was booked and completed.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. Staff received training in safeguarding adults and children; 95.9% of staff had completed their adults safeguarding training level 2, 92.9% of staff had completed adults safeguarding training level 3. This completion rate was lowered to 83.3% for medical staff having completed their safeguarding level 3 training. The completion rate for safeguarding children level 3 was 100%. Three members of staff were trained to safeguarding level 4 for both children and adults, and this had been completed to 100%.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff said they felt confident to recognise and raise issues with their managers and knew when they should make referrals to the local authority. The hospice had a safeguarding lead and staff were able to name the lead and knew how to contact them.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. They gave us examples of when they had raised safeguarding concerns and how they had actioned them. We saw evidence that safeguarding concerns had been discussed at staff meetings and actions agreed. The service also had a team meeting with social workers and could access advice and support.

Staff had the appropriate level of safeguarding training for their role and could recognise the signs of abuse.

Cleanliness, infection control and hygiene

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

Ward areas were clean and had suitable furnishings which were clean and well-maintained. All areas we visited were visibly clean and appeared well organised. For example, during our inspection we saw the housekeeping team working and checking all areas were clean.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Cleaning records were displayed and up to date. There was a good supply of cleaning materials available for staff to use.

Staff followed infection control principles including the use of personal protective equipment (PPE). There was a hand sanitising gel available in all areas we inspected, and we saw reception staff requesting that visitors use the gel before entering the main hospice. All staff adhered to the arms bare below the elbow policy. Staff wore PPE and washed and gelled their hands regularly; hand gel was readily available throughout the building and posters displayed the five moments of hand hygiene.

The hospice care after death policy detailed measures staff should take if the deceased had been suffering from an infectious disease. The policy detailed a list of infectious diseases, the appropriate infection control measures and the actions relatives and friends viewing the body should take.

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

End of life care

The service had an infection prevention control (IPC) lead who was also head of governance. There were trained link nurses in all areas including a band 6 nurse on the ward.

Environment and equipment

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

Patients could reach call bells and staff responded quickly when called. Where patients were unable to use call bells, we saw alternative arrangements had been made by staff so patients could call using a mobile device.

The design of the environment followed national guidance. The building was 2 storeys with offices, staff facilities and a large meeting room on the first floor. On the ground floor the hospice had the hospice had capacity for 19 patients and was funded for 16 patients. At the time of our visit there were 13 patients on site. There were 2 reception areas, a conservatory where patient groups were held, which was light and welcoming. The hospice had an area with seating for patients and families to buy refreshments, there was also a quiet area with a sofa and a room for families and loved ones to use.

There was an outside garden area with benches and a large shed which had been converted for patient activities. Patient rooms were clean and clutter free, there were large doors which opened out to the garden and awnings which could be pulled down during hot summer months. Families we spoke to told use the outside area was used frequently and was a nice place for patients to be able to go and sit. All the bathrooms and shower rooms were clean, and the furnishings were in good condition. Bathrooms had signs to show they had been cleaned and were ready for use. One room had a specialist designed bath for patients to use which lowered down and had a door opening so patients could access and leave the bath. Staff we spoke to explained this was more dignified for patients and that patients felt safer as they did not have to access the bath by stepping in.

Staff carried out daily safety checks of specialist equipment. Syringe pumps for the continuous administration and end of life medicines were kept on site, maintained and used in accordance with professional recommendations. We saw portable equipment had been safety tested and were within date.

The service had enough suitable equipment to help them to safely care for patients. The multidisciplinary team worked together to identify any equipment needed to provide care and treatment in the home. Staff disposed of clinical waste safely. There were sufficient clinical waste bins throughout the hospice.

There was a mortuary on the inpatient unit for deceased patients waiting for transfer by the funeral directors. The room was suitable for its purpose.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. All patients were monitored through the Australian modified Karnofsky Performance Status assessment tool scale (AKPS) and the Integrated Palliative Care Outcome scale, alongside clinical judgement. Any unexpected deterioration was escalated for review to the medical staff.

Outstanding ☆

End of life care

The clinical nurse specialist team reviewed deteriorating patients in the community with any unexpected deterioration referred to community palliative care consultants, appropriate health professionals or 999. Consultants carried out medical reviews most days; ward rounds were consultant led and occurred weekly.

Clinical staff completed an annual practical assessment on cardiopulmonary resuscitation, which is an emergency lifesaving procedure performed when the heart stops beating.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. Staff knew about and dealt with any specific risk issues. We reviewed 9 patient files and found staff had reviewed patients for risks, such as falls, pressure ulcers, mouthcare and hydration. Staff we spoke to told us they knew the action to take for a patient who was assessed as deteriorating. The service had a deteriorating patient policy.

Staff knew about and dealt with any specific risk issues. We saw that staff monitored patient risks such as falls, pressure ulcer and mouth sores. Staff were aware of the importance of monitoring these risks. Audits were carried out on these risks and findings shared at team meetings. We saw the findings from the patient falls audit for the period from November 2022 to March 2023 had been shared with staff. Possible reasons for the falls were identified such as muscle wasting or side effects of medicines. A presentation was given to leaders and staff following the audit to share learning with a plan to monitor the impact on patient safety.

The service had 24-hour access to mental health liaison and specialist mental health support from the local NHS mental health trust.

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

Staff we spoke with knew how to refer patients with mental health needs to the local authority mental health team, they told us as soon as a patient exhibited any suicidal ideation or self-harming intention, the first action was to ensure the patient was never left alone.

Staff shared key information to keep patients safe when handing over their care to others. We attended the team handover meetings and heard patient information being shared with other health providers, for example, GP services and other teams involved in patient care.

Nurse staffing

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

The service had enough nursing and support staff to keep patients safe. Leaders at the service told us they used bank staff only who were familiar with the service.

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. Leaders used a data-based decision-making tool to ensure the appropriate amount of staffing and staffing numbers reflected need. Ward managers safe staffing was then scrutinised at clinical governance meetings.

End of life care

The service used bank and agency staff to fill any gaps in service. The ratio of bank and agency staff used was 9.87% in July 2023, 12% in August 2023 and 15% in September 2023. Managers told us they would use bank staff in the first instance to fill any gaps but when this was not possible, they would use an agency. The hospice managers tried to source the same staff wherever they could.

The service had low staff turnover rates of an average of 1.7% over the 6 months from April 2023 to September 2023. The service had reducing vacancy rates and at the time of our inspection they had 1 vacancy. However, service leaders told us they would have 6 members of staff due to go on maternity leave and they were planning recruitment for these roles.

The service had an average sickness rate of an average of 7.17% over the 6 months from April to September 2023.

Managers made sure all bank and agency staff had a full induction and understood the service. Agency staff told us how they completed an induction which including being observed to complete initial tasks such as setting up syringe pumps.

Medical staffing

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

The service had enough medical staff to keep patients safe. All the consultants working for the service had substantive posts within the local NHS trust. The service also employed trainee doctors, doctors with specialities in palliative care and advanced medical practitioners.

The medical staff matched the planned number. The service had a good skill mix of medical staff on each shift and reviewed this regularly. The service planned the medical cover in advance each week.

The service had low rates of bank and locum staff. The service used locum staff to fill any gaps in service. The ratio of locum staff used was 1.78% in July, August 2023 and September 2023. Managers told us they would use bank staff in the first instance to fill any gaps but when this was not possible, they would use an agency. The hospice managers tried to source the same staff wherever they could.

Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work.

The service always had a consultant on call during evenings and weekends. Out of hours there was a first on call rota of clinicians responsible for covering inpatient care. The first on call clinicians were supported by a combined rota of consultants in palliative medicine.

Records

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

Patient notes were comprehensive and were stored on an electronic information system. Patient records we viewed were mostly comprehensive and up to date and staff were seeking consent from patients. However, during our inspection we found 2 Mental Capacity Act 2005 and Deprivation of Liberty Safeguards documents which were completed incorrectly. This documentation was used by the hospice to assess a patient's mental capacity to make decisions on a situation specific basis, for example, health or accommodation needs.

Some staff told us they felt more training was required on the electronic record. For example, we observed the mental capacity assessments on the electronic record appeared to be difficult to ascertain the full decision-making process by 2 of the staff who showed us as part of our inspection. During our inspection we raised the training need with the service, and we were assured this would be addressed.

Records were stored securely on an electronic system. Staff needed a secure log in to access patient records. Staff told us they kept passwords safe, and we observed they locked computers when they were not in use.

All the information needed to deliver patient care in a timely manner and to understand the care, medical and spiritual needs of patients was detailed in the patient care plan.

Nursing staff visiting patients in the community had access to patient files using a laptop and they told us these were reliable, and they could easily access patient information, referral documents and risk assessments.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. The service had a pharmacist on site and a Pharmacy Technician.

All medicines were requested from one supplier which the hospice had a service level agreement with, this meant there was a consistency in the delivery and fulfilment of medication requests. Pharmacy staff were onsite Monday to Friday, if medication were needed outside of these hours, staff could refer to the pharmacy information folder which detailed the out of hours contact information.

There was a formal Medicines Management Committee who met quarterly. The committee discussed medicine incidence themes and learning. Potential issues with supplies and or costs were also discussed. Members of the committee included, a pharmacist, the medicines link nurse, medical team member and community nurse specialist and was chaired by the medicines management lead. The committee reported finding from audits and meetings to the clinical governance team.

The pharmacy team had a schedule of audits they completed which included fridge temperatures, missed dose audits, medication management and controlled drug storage. We saw fridge temperatures were checked daily and in line with national guidelines.

Staff stored and managed all medicines and prescribing documents safely. The hospice had appointed a controlled drugs accountable officer to be responsible for the monitoring and auditing of the management and use of controlled drugs. Controlled drugs were stored securely, and these audits were compliant, follow up actions had been noted such as revising policies on the correct completion of controlled drug charts for staff reference and updating training materials with examples. The team were also involved in a pain management audit working group.

The pharmacist attended the daily consultant ward round and offered advice on medicine management to staff and patients. Pharmacy staff were responsible for checking medicines for new patients to the service and for checking any take home medicines when patients were discharged.

The pharmacist was a non-medical prescriber and was able to prescribe medicines for patients in a community setting.

End of life care

There was a prescription policy for the secure and safe use of prescriptions. Prescriptions were stored in a lockable cabinet. There was also a policy for the disposal of medicines which were no longer required. These medicines were stored in a lockable cupboard until disposal could be arranged.

Staff followed systems and processes to prescribe and administer medicines safely. Daily checks were completed on any new prescriptions or dose changes. The pharmacy team were responsible for notifying staff of any medicine alerts such as drug recalls.

Staff completed medicines records accurately and kept them up to date. We reviewed 9 medicine administration charts and found staff had documented patients' allergies.

Medicines' charts were clear, in date, legible and prescribing was in line with current guidance and quality standards.

Pharmacists completed various medicine audits. We reviewed the latest audits for February and April 2023 concerning antibiotic usage, self-administration of medicines, missed doses, and the management of controlled drugs and found the hospice was compliant in most areas and where follow up actions were needed these had been documented.

The pharmacy team provided a comprehensive service to the patients and hospice staff.

Incidents

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

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with the service's policy.

Staff used an electronic system to report and review incidents. All incidents were investigated and reviewed for learning purposes.

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 evidence that duty of candour had been completed and patients had been made aware of investigations and outcomes; for example, we saw an investigation following an incident where the family had been informed of the incident and the findings.

Staff received feedback from investigation of incidents, both internal and external to the service. Following investigations and feedback from patient safety group meetings, posters were developed for staff areas to give staff an overview of incidents, outcomes and any updated learning or procedures.

Staff met to discuss the feedback and look at improvements to patient care. Information we received following our inspection, showed minutes from both the patient safety group and clinical governance meetings which showed incidents and improvements were discussed on a regular basis.

Outstanding ☆

End of life care

There was evidence changes had been made as a result of feedback. We saw evidence of discussions following incidents and the changes to be made to policies or procedures to improve patient safety. For example, we saw evidence of one investigation following a serious incident involving oxygen masks and oxygen management. The hospice had completed a thorough investigation, made recommendations for changes following the investigation and put an action plan in place with a timeline for completion. We saw evidence this incident had been discussed at the patient safety meeting.

Managers debriefed and supported staff after any serious incident. Evidence we saw in investigation reports detailed measures put in place to communicate and support staff after incidents.

Is the service effective?

Good

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff holistically assessed people's physical, mental health and social needs, and delivered care and treatment in line with legislation, standards and evidence-based guidance.

The hospice followed up to date guidance to ensure patients received effective and high-quality care. These included National Institute for Health and Care Excellence (NICE) guidance. This included but was not limited to; Care of dying adults in last days of life (NICE QS144 and NG31, QS13), Controlled drugs: safe use and management (NICE NG46) and Leadership Alliance for the Care of Dying People: One chance to get it right. The service also used NICE guidance for audits and clinical reviews.

The hospice delivered the priorities in a variety of ways such as through the provision of palliative study days, patient survey results, embedding of the Karnofsky performance status assessment tool scale and information provision for families and service design.

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

At the handover meetings and ward rounds we attended, we saw staff refer to the psychological and emotional needs of patients, their relatives and carers. Staff routinely discussed with patients any concerns they might have about the progression of end of life including preferred place of care or death, concerns about medications and side effects, emotional support for family members or friends and financial concerns.

Patients and their families had access to bereavement support services, financial advice services and they had access to a consultant or pharmacist to answer any questions they may have.

Outstanding ☆

End of life care

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs. 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.

Each patient had a detailed care plan with specific details on dietary, feeding and hydration regimes which was updated at every admission to the hospice. A food and drink plan was attached to the nutritional part of the care plan on the database.

Each patient's bed number and any nutritional or hydration needs were recorded on a whiteboard, which also included any food likes or dislikes, allergies and digestion difficulties. Drinking water was readily available to staff, patients and their visitors.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Records we saw detailed patients' fluid intake and any problems with eating. Patients could also be referred to a speech and language therapist who worked with patients to assess any speech or language difficulties, communication or eating and drinking difficulties. The therapist could then make recommendations.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition or obesity. It also included management guidelines, which could be used to develop a care plan. We saw the malnutrition universal screening tool (MUST) being used. We saw as part of the nurses' intentional rounding they regularly offered patients drinks and asked if they wanted anything to eat. Intentional rounding (IR) is the structured process whereby nurses in hospitals carry out regular checks, usually hourly, with patients using a standardised protocol to address issues of positioning, pain, personal needs and placement of items.

Staff showed a clear understanding of the difficulties this patient group could have with nutritional intake where often their appetite was poor or oral intake could be difficult due to swallowing problems. There was an extensive 4-week dietary plan available which we saw and a more individual menu available for patients where needed, or smaller plates of food so as not to be overwhelming. There was provision for patients who did not want regular meals or who did not want to eat at set times. Staff told us they always kept a selection of sandwiches, soups and cereals for patients.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff used pain tools appropriately, the Abbey pain scale was readily available if needed. The Abbey pain scale is a tool designed to assist in the assessment of pain in patients who are unable to articulate their needs for example if they have any communication issues. Staff recorded information around patients' pain in a pain care plan when needed. The morning ward round was attended by the consultant and pharmacist and other clinicians. We saw pain and symptom relief was discussed with each patient and recommendations made where changes were needed. Patients were reassured about pain control and the plan for management of pain moving forwards.

End of life care

Patients received pain relief soon after requesting it. Patients and their families told us nursing staff administered medications on time and reacted quickly to requests for pain relief or management of other conditions. They told us nursing staff checked patients' pain levels and asked if they needed further medication.

Staff prescribed, administered and recorded pain relief accurately. The medicine and drug charts we viewed were all completed and dated and signed correctly. Staff prescribed the correct medicines and understood the importance of pain management. The service had commissioned a Quality Improvement Programme to review the management of pain. The aim was to improve the assessment of pain for patients and to see increased compliance using recognised and validated assessment tools throughout a patient's admission. The programme had been commissioned following an audit in June 2023, which had shown documentation was not always being completed correctly and pain scores were not always being recorded. However, the audit showed there was always a pain plan in place and there was good compliance with documenting a daily pain care plan using the electronic record system. There was good compliance with the medics recording rationale if analgesia management plans were adjusted and exploring the effectiveness of treatment. The improvement plan was due to be completed in April 2024 with further audits being completed during the programme to check improved compliance.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. The hospice took part in local and national audits and benchmarked itself against other services in the area and nationally. They took part in the Executive Clinical Leads in Hospice and Palliative Care audits. Benchmarking compared areas such as discharges, bed occupancy, pressure ulcers and medication errors.

The Integrated Palliative Care Outcome Scale (IPOS) tool was used to help the service focus on what matters most to patients and their families and provide quality care focused on these areas. This tool helps the hospice provide a service which is more person centred. The tool asks patients to score various areas of their health and lifestyle including pain, appetite, mobility, mental health and any practical issues. However, the service has reported to us that the use of IPOS across the service was inconsistent. Therefore, the service had planned to relaunch the use of the IPOS tool within its service and work with other providers of hospice services to do the same. There had been issues with the electronic patient system and extracting the outcome data, the service has worked with other organisations to resolve these data problems. Internally the service had relaunched the IPOS tool for collection of patient outcomes and used other data sources to provide information on patient care. Therefore, this data was not available.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The service held a clinical group audit meeting, and a 12-month plan of audits was in place. Audit outcomes were discussed at the meetings and action plans put in place.

The hospice had audited the number of patient falls for the period from November 2022 to March 2023 and 22 falls were examined. Of the falls examined 73% had occurred between 9pm and 8am with the most common time of fall being between 7am and 8am. They examined the most common type of fall which was from bed or from a standing position. Possible reasons for the falls were identified such as muscle wasting or side effects of medicines. Following the audit, plans were put in place to stagger staff shift starting times to the most common time of falls, to arrange referrals to occupation therapists and for medicine reviews to be completed. A presentation was given to leaders and staff following the audit to share learning with a plan to monitor the impact on patient safety.

Outstanding ☆

End of life care

Outcomes for patients were positive, consistent and met expectations, such as national standards.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The service ensured staff completed training appropriate to their role, clinical staff also had an internal clinical skills training programme which included syringe driver training, cardiopulmonary resuscitation and manual handling. The service gave all staff an induction suitable to their role. The service had clinical nurse specialists who supported patients in their own home. Staff we spoke to said they felt that the training they had for their role was appropriate and that the service also did extra training when needed such as training on different end of life needs of diverse cultures.

The specialist pharmacist in palliative care had delivered bespoke training courses around medicines symptom management.

Managers gave all new staff a full induction tailored to their role before they started work. All new staff were given an induction pack which explained the service vision and goals, useful information and a checklist for managers to complete. Volunteers to the service were also given a full induction and a training pack.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff we spoke to said they had a yearly appraisal, there was also clinical supervision for clinical staff. Staff said they had opportunities for learning and were able to develop in their roles such as becoming leads for specific areas of interest or to support other staff. Staff said they accessed clinical supervision and found this helped them with learning and support. The counselling team were receiving supervision which was suitable for their roles.

The clinical educators supported the learning and development needs of staff. The hospice had an education team which was led by the Medical Director for the service and a supporting 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. We saw good examples of multidisciplinary team working, for example during the ward round, which was attended by the medical team, ward nurses, occupational therapist, physio therapist and pharmacy team. The daily huddle we attended for the clinical nurse specialist team was attended by the inpatient team and there were good conversations around patient care and needs.

Within the service the multidisciplinary team worked very well. This included the social care team, physiotherapists, occupational therapists, pharmacy team, management, governance, the referral team and the Hospices of Birmingham and Solihull (HoBS) team.

Staff worked across health care disciplines and with other agencies when required to care for patients. We joined the bed meeting which is attended by the local providers where bed allocation and availability across the region is discussed. There was a good exchange of information and team working.

Outstanding ☆

End of life care

Where appropriate, staff shared information with other service providers such as GP surgeries, care homes and mental health teams. Staff referred patients for mental health assessments when they showed signs of mental ill health and / or depression. Staff we spoke to knew how to access the local mental health team and other providers for support, such as substance misuse teams.

Seven-day services

Key services were available 7 days a week to support timely patient care.

Patients could access the service 7 days a week, 24 hours a day if needed. Specialist nursing and medical support was available seven days a week and patients were reviewed daily. Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, 7 days a week.

There was medical and nurse support 24 hours a day seven days a week as an on-call rota was in place.

The hospice at home team of nurse and health care assistants provided care at home from 8am to 8.30pm, 7 days a week.

HoBS operated between 8am to 8pm seven days a week. Outside of these hours the clinical nurse specialist handed over to the inpatient unit who would provide any support remotely overnight.

Housekeeping staff were on site seven days a week.

Physiotherapy and occupational therapy services were available were available to patients in the hospice and the community from Monday to Friday.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards. Patients had access personal health budgets (PHB's) which they could use for a range of things including purchasing equipment and had helped prevent delays in getting people home. This supported patients to remain in their own homes and achieve their preferred place of death.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff showed a clear understanding of the difficulties patients accessing hospice services could have with nutrition and maintaining a healthy diet. There was an extensive dietary plan available with healthy and nutritious food available.

The service displayed information for patients on eating well, self-care and there was a wellbeing service.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff helped patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. However, they did not always know how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Outstanding ☆

End of life care

Staff did not always understand how and when to assess whether a patient had the capacity to make decisions about their care. Staff we spoke with as part of our inspection demonstrated a lack of knowledge and understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, and the procedures and documentation used by the hospice to assess a patient's capacity. For example, we looked at two mental capacity assessments completed within the previous 6 months, both were completed incorrectly.

Staff did not always understand how and when to assess whether a patient had the capacity to make decisions about their care. For example, we were told by 1 member of staff, that all patients entering the hospice should have a mental capacity assessment, but it would take too long to do so. The legislation states that before a mental capacity assessment can be undertaken, there must be 'Reasonable belief' the person lacks capacity. To undertake a mental capacity assessment on all patients entering the hospice regardless, would therefore be unlawful.

The service undertook an audit of mental capacity assessments in June 2023 in which 20 mental capacity assessments were audited, 2 were found to have been undertaken on patients where there was no 'Reasonable belief' they lacked capacity.

We were shown the mental capacity template on the trust electronic computer. This did not always appear clear to the inspectors or the staff on how to guide the person to undertaking a mental capacity assessment correctly, or record the decision made.

During our inspection we were told by the nursing staff the doctors undertook mental capacity assessments, however, we were also advised by the senior staff that it was the job of all staff to complete mental capacity assessments, this appears to have led to some confusion as to who was completing them.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff we spoke with understood the importance of consent when delivering care and treatment to patients. We observed staff seeking consent from patients prior to examination, observations, and delivery of care. In most cases this was implied consent and not documented. However, when an intervention was required, formal written consent was sought. Staff clearly recorded consent in the patients' records.

Conversations about care often included family members where their views were also gathered. Staff gained additional consent from patients and their relatives to allow them to document this consent on the patient record.

We looked at 7 do not resuscitate orders (DNACPR) forms during our inspection. All were completed correctly and where appropriate were discussed with the patient.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Data showed that 97.4% of staff had undergone training on undertaking mental capacity assessments against the trust target of 95%.

Is the service caring?

Outstanding ☆

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

Outstanding ☆

End of life care

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Patients and their families praised the service and consistently gave positive feedback.

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

We observed staff interacting with patients in a way that enabled them time to ask questions, gain clarity and an understanding of treatment and care. Patients said staff were very kind and caring and treated them with dignity and respect. Patients told us that staff always had time to have open and honest conversations about their prognosis even when these conversations were difficult to have.

Staff understood and respected the personal, cultural, social, and religious needs of patients and how they may relate to care needs. For example, staff were able to accommodate appointments around patients' work schedules, and religious activities such as prayer times for those of Islamic faith. Staff told us they were able to seek support if they were unsure of the cultural needs of any patient.

All of the patients and their families we spoke with during our inspection gave positive feedback about the care they had received. Patients told us of the 'phenomenal' and 'amazing' care they had received. Staff had organised special events such as fish and chip evenings and seaside afternoons by bringing sand, buckets and spades into the hospice day room.

The family room at the location allowed patients with young children to stay with them in a private flat which allowed them all time together.

During visits we attended with the hospice at home team, we saw how compassionate and caring the staff were to patients and their families. Family members told us of the support and advice they had received and how responsive the team where to their concerns. Community nursing staff took time to offer psychological support to patients and their families as well as medication advice.

Staff followed policy to keep patient care and treatment confidential. During our inspection we saw no paper files and all information was stored on an electronic system. Staff locked their electronic devices when not in use or unattended and the service had a data protection policy.

Emotional support

Staff provided emotional support to patients, families, and carers to minimise their distress. They understood patients' personal, cultural, and religious needs. The staff at the service went above and beyond to provide emotional and practical support to patients and their families.

Staff gave patients and those close to them help, emotional support and advice when they needed it. All staff demonstrated a deep understanding of the emotional impact living with a life-limiting condition had on patients and their relatives and consistently took account of this when providing care and treatment. During our inspection we were told by staff, emotional support came in different forms depending on what was required by the patient and those close to them. The services at the hospice worked together as a multidisciplinary team to support the emotional needs of the patients and their families.

Outstanding ☆

End of life care

We saw staff were positive and attentive to the needs of patients at the hospice. We observed staff providing kind, thoughtful, supportive, and empathetic care, support, and advice. Relatives also commented on how supportive the staff were. 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. The service emphasised that family or a caregiver's emotional needs were equally important to that of a patient. The service put both patients and their family at the centre of their care and made sure people received the support they needed. Staff promoted support for patients as well as the needs of family or caregivers. Activities at the well-being centre were available for both patients and their families such as aromatherapy massage. The service had a social activity group which had been set up to help anyone connected with the hospice who may be feeling lonely or isolated and would benefit from support and company of other patients through a shared interest or hobby.

The hospice also had a befriending service supported by volunteer befrienders. They offered phone calls, face to face visits or home visits. The volunteer befrienders provided companionship to the patient and respite for carers and family members.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Staff we spoke with told us how helpful this training was and there was access to emotional support for staff out of hours for if they needed it.

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.

The hospice had a pre and post bereavement service provided by their on-site social work team, there was no time limit on how long after a bereavement people could access the service. Patients also had access to palliative care social workers who specialised in working with adults who are at the end of their life. The palliative care social workers could complete assessments for care and support for patients and their families in areas such as housing, benefit advice and will writing. They brought social care expertise and perspective to situations to ensure that people got the support they needed.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Staff were fully committed to working in partnership with patients, involving them in decision making processes about care and treatment. Staff made sure patients and those close to them understood their care and treatment and supported patients to make advance decisions about their care including preferred place of death and ceiling levels of treatment. The ceiling level of treatment was the "upper limit" of treatment for a patient in the eventuality of the patient becoming acutely unwell or deteriorating from a chronic illness.

The relatives and loved ones of patients actively sought out inspectors during our inspection to let them know how wonderful and caring the staff were. One comment an inspector received was "the staff are angels without wings".

Outstanding ☆

End of life care

Relatives of patients we spoke with felt they and their loved ones had received the information they needed to understand and make informed decisions about their care. Information was explained gently and with sensitivity, questions were never ignored or remained unanswered. We were told they were kept fully informed, staff had time to answer questions and would answer in a way they could understand.

Is the service responsive?

Outstanding ☆

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

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care. The service worked well with other service providers to provide the best care for patients. The service was flexible and planned and provided care in a way that met the needs of local people and the communities served.

Managers planned and organised services, so they met the needs of the local population. There were innovative approaches to providing integrated person-centred pathways of care which involved other service providers particularly for people with complex and multiple needs. The hospice inpatient unit provided 24-hour care for specialist palliative care patients and South Birmingham home from home patients. Specialist admissions could be for symptom control or end of life care.

At the start of the COVID-19 pandemic the service, along with other providers across the wider Healthcare system had set up the Hospice of Birmingham service (HoBS). This service had continued after the end of the pandemic, providing access and support to patients in need of hospice care and support. The service operated from 8am to 8pm, 7 days a week, 365 days a year and patients could access community nurse specialists for advice and support.

HoBS created a centralised referral mechanism and a rapid response service that was able to prevent hospital admissions, to support the regional ambulance trust, the community nurses and GPs. The service provided a one point of contact for patients, their families, and other professionals. Patients and their families could access holistic hospice services, including medication advice, therapies, social work teams and pre-bereavement and bereavement support.

From 8am to 8pm HoBS was operated by 3 band 6 nurses and clinical administration support for the call handling function. Clinical administration assistants signposted calls to the correct area and there was access to support from 3 urgent response nurses and 3 health care assistants to provide home visits where needed. From 8pm to 8am the HoBS service was supported by 1 urgent response nurse and 1 health care assistant to manage calls and coordinate overnight response.

The hospice provided a service for patients in the community. The hospice employed community clinical nurse specialists who provided psychological support and specialist symptom control advice in patients' homes 7 days a week.

The service had a community development team and had recruited the team to reflect the diversity of the local population. The hospice set up various community initiatives to help engage diverse communities, and develop relationships with key leaders of groups who may not normally access hospice services for reasons of culture or accessibility. They had held events to reach out to other communities and gain a better understanding of their end-of-life

belief systems and ways to support them to access services. The team had organised events for the Sikh community to discuss supporting end of life and accessing other services. This was a 12-week programme and planned to be developed and adapted for use with other communities. They had also produced a Myth Busting Brochure which explained some of the misconceptions about hospice services. For example, the services at the point of delivery as with other NHS services, that access to the service for relatives visiting family members is not restricted and culturally appropriate meals were available.

The team had also engaged with staff at His Majesty's Prison Birmingham to offer staff bereavement training, end of life awareness courses and to support staff where prisoners have an end-of-life prognosis or following the death of a family member.

The community development team had recognised the deaf community was an underrepresented group within hospice services, there was no main staff training in British Sign Language (BSL) which impacted on their ability to access support and counselling services and for family members to access grief services. Wellbeing Volunteers within the service had supported this initiative to improve access to services for this patient group and recruitment was in progress at the time of our inspection.

The community development team told us they aimed to be able to provide services for all and to make a difference to the community.

The service had an on-site complimentary therapist, who offered a variety of therapies to patients and staff including Reiki and aromatherapy massage, aroma sticks and meditation. The therapist had a room where patients, relatives and staff could be seen, or they would go to the patients on the inpatient unit if more appropriate.

Facilities and premises were appropriate for the services being delivered. The service had spacious rooms, areas for group support meetings and a coffee area for spending time with family and friends plus quiet rooms. There was a large garden area and ample free onsite parking.

Managers monitored and took action to minimise missed appointments. Managers ensured patients who did not attend appointments were contacted.

Community nurse specialists reviewed their caseloads every 12 weeks and any patients who did attend a home visit or clinic appointment would be contacted to try and establish a reason. If unable to speak to the patient a check would be made on all the hospital electronic portals to check for admission to hospital. If this was unsuccessful, an attempt would be made to ring community nurse or GP. Patients who did not attend Living Well sessions, which were support sessions, would be contacted by staff.

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.

The hospice had a pre and post bereavement service provided by the on-site wellbeing team. The bereavement service offered support and counselling to family and friends of patients. There was no time limit on how long after a bereavement people could access the service. Patients also had access to palliative care social workers who specialised in working with adults who were at the end of their life. There was a counselling service available for patients to access for support.

End of life care

The service had a faith room with facilities available to people of all faiths and those with no faith to use, the room had a book of remembrance for friends and families to use and a Wudu washing station. A Wudu wash station provides for the washing of hands, face and feet during the ablutions before Islamic prayer.

The service also offered complimentary therapies to patients and staff, and this area was clean and appropriately furnished.

The service had suitable facilities to meet the needs of patients' families. The hospice had separate accommodation where service users could stay with their family members. The hospice had a catering team onsite and each morning patients were asked what they would like to eat and if there were any special dietary needs. There were several different aspects to the food served by the kitchen. For example, culturally appropriate, vegetarian, vegan and specific diets concerned with food allergies. Catering staff told us they were passionate about providing the best possible nutrition to their patients. We attended the evening meal service, and saw that meals were served at different stages and not all at once. This meant that food did not arrive with 3 courses on one tray but when each course had been finished and when the patient was ready for the next course, this allowed patients time to digest one course and not feel rushed into starting the next course. Family members could also have an evening meal for a small charge and for those who stayed overnight there were free hot drinks, and a sandwich or toast.

Patients and their family members told us the food and the catering staff were of a high standard and staff took time to make mealtimes as pleasurable as possible. One patient told us when they were admitted to the hospice they had not eaten properly recently as they had very little appetite, however, the food was so delicious and so well presented at the hospice they had been eating very well.

Patients had access to personal health budgets (PHB's), which they could use for a range of things including purchasing equipment and had helped prevent delays in getting people home. This supported patients to remain in their own homes and achieve their preferred place of death.

Staff made sure patients living with mental health problems received the necessary care to meet all their needs. Staff could make referrals to the local mental health teams for patients in need of support and there were other support services available. The service had a clear referral process for patients in need of support for mental health problems and staff were able to explain the process to us.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. The hospice had a dementia lead who was able to give staff advice and information for patients with communication needs. The service had developed an education programme of early interventions for people living with dementia as they had recognised this patient group often attended in crisis. Staff told us most patients living with dementia or with learning disabilities were seen in their own home environment by the hospice at home team.

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

Staff were able to demonstrate how translation services could be accessed when needed. If the need for an interpreter was recorded at the point of referral these would be pre-booked prior to appointments.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Patients' dietary needs were recorded, and assessment and catering staff were made aware of any specific requirements. Menus had options for culturally appropriate food and drink, vegetarian, vegan and specific diets concerned with food allergies.

Outstanding ☆

End of life care

Access and flow

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

The hospice had a clear referral process, and these were processed in a timely manner. Staff triaged the referrals and were able to prioritise patients in need of urgent care and request support from nurse specialists when needed.

Data showed from April 2023 to August 2023 of the patients who had stated their preferred place of care or death, 84% had achieved this. In the instances where this had not been achieved, we saw follow up investigations had been undertaken by the hospice. Results showed several different reasons, for example if the patient had been too unwell to travel or had been admitted to another hospice.

Managers monitored waiting times and made sure patients could access services when needed and receive treatment within agreed timeframes and national targets. Availability of beds was discussed at the bed meeting we attended and in the period January to March 2023 prior to our inspection, the service had an average bed occupancy of 75%. In comparison, the average occupancy of other hospices was 84%.

During the referral process, patient needs, and level of care was recorded. We saw at the bed meeting and the handover meetings we attended, patients with the most urgent care needs were prioritised and their treatment needs were discussed. New admissions and bed availability were also discussed at these meetings.

Managers and staff started planning each patient's discharge as early as possible. They worked with patients and their families and linked in with the on-site social work team to arrange any home care packages and to ensure a safe discharge home. Discharge planning meetings were held with the patient, family member and the multidisciplinary team.

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. The service displayed information on how to make a complaint and patients were given advice on the process when needed.

The service had a patient experience group. Previous feedback to the service from patients and their families had been that they would like the chance to discuss their experience or complaints face to face with the service rather than electronically. The group was had commenced in June 2023. This group was focussed on learning from patients and their families.

Staff understood the policy on complaints and knew how to handle them. Staff were able to explain the complaints process to us and the procedure for handling complaints. Complaints were recorded on the service's electronic recording system.

The service clearly displayed information about how to raise a concern in patient areas. A copy of the service complaints procedure was available in the reception area and the website for the hospice detailed ways of contacting the service and the complaints procedure. A booklet was given to all patients at the start of their treatment journey, which contained a satisfaction survey and asked patients for their feedback.

Outstanding ☆

End of life care

Managers investigated complaints and identified themes. Minutes we saw from the Quality Governance Committee meeting showed that complaints were discussed at this meeting and investigations undertaken.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff were given a training session on patient engagement on how to be 'Be open and honest and always follow the Duty of Candour Principles'. Staff were also given training on conflict resolution.

Is the service well-led?

Good

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

Leadership

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

The service had a clear management structure and staff we spoke with said the senior leadership team were visible and accessible. Staff told us they felt they knew who to go to with concerns and they were able to raise issues with confidence.

Leaders had the skills, knowledge, experience, and integrity they needed to provide effective leadership. They worked with other organisations to address any issues and manage their priorities. The leaders of the service had a clear understanding of the priorities for the service and the challenges they faced.

The executive management team included a chief executive officer, director of clinical services, medical director, income generation director, director of finance & IT and director of people and culture. The service also had a head of governance and head of community development & partnerships. The hospice had a board of trustees which met every quarter of the year. All trustees held the post in a voluntary capacity and had varying skills and expertise.

In August 2021 the hospice had merged with another hospice to become the Hospice Charity Partnership. This merger was complex and had meant some changes to the structure and working of the service. Leaders at the service told us the way they had communicated the merger information and changes to staff and had taken action to alleviate concerns as much as possible. This had been a challenging time for all levels of staff but most of staff we spoke to felt they had been well informed, and they had understood the rationale for the merger and the processes. Some staff we spoke to had found the process of the merger difficult and felt the systems and changes were still being embedded.

Vision and Strategy

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

The hospice had a clear strategy of what it wanted to achieve and the actions it needed to take to achieve its vision of 'A future where everyone with a life-limiting illness will live and die with dignity and in comfort'. The hospice had a clear set of values:

- Kindness
- Respect
- Innovation
- Positivity
- Togetherness
- Openness

Following from the merger with another local hospice in 2021, the service was keen to keep the heritage of the original hospice but also to develop new services and embrace the changes from the merger and have one identity.

The strategy for 2022 to 2027 adopted the principles of build, grow and refresh. Actions from the strategy included growing the collective understanding of the needs of Birmingham's diverse communities, increasing supporters to grow a sustainable voluntary income, adapting services to meet the needs of the community and refurbishment of the hospice site.

The hospice was working on a strategy to engage and meet the needs of many people from ethnic minorities who did not access specialist palliative care and end of life. The hospice had plans to work with the wider health system to understand the barriers and how best to access these communities.

The service had a community development team to deliver this goal and an income generation team to be able to fund innovation and new services.

The service had an equality, diversity and inclusion group, the aim was for everyone in the community to be able to access support at the service. The service had worked to and achieved an Investors in Diversity award 2023.

Culture

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

Staff we spoke with said they felt supported and valued and were proud to work for the service. Staff told us they had been given opportunities to develop in their roles and felt they could give feedback to management without fear.

The hospice was awarded the "Investors in Diversity" Silver award in July 2023. Equality and diversity were discussed at all management levels with plans in place for retaining and improving the diversity of the staff workforce.

The service had a freedom to speak up guardian who staff could contact if they had any concerns or felt they needed support. The service had trained 12 members of staff to be mental health first aiders and staff could talk to one of the team after any incident or situation where they felt they needed support. Staff could access clinical supervision and peer support to discuss patient cases and share learning. Staff could also use the holistic therapies provided by the service. Staff were also able to access the counselling service for support.

The hospice had a staff recognition award, staff could nominate their colleagues who they felt had displayed the service values. There was a winner of the award every 3 months and staff could nominate 1 winner for the whole year.

Staff we spoke to told us that all teams worked well together and tried to find solutions to help each other with workloads and to improve outcomes for patients.

End of life care

There was a lone worker safety application for staff working in the community for their safety during home visits.

Staff had yearly appraisals which included the service values and vision and some objectives for staff to meet were developed around these and around their career development and learning needs.

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.

Structures, processes, and policies were in place to support the delivery of good quality services and the hospice strategy. The hospice had a governance lead and various groups that fed into the board. For example, there was a patient safety group attended by the multidisciplinary team who discussed incidents, safeguarding, deprivation of liberty, complaints, medicines management, patient safety alerts and policies.

The service had a Quality Governance Committee and held meetings quarterly. In attendance at these meetings were trustees for the hospice, chief executive officer, directors of clinical services, head of governance and other key members of staff. Standard agenda items for the meeting covered areas such as but not limited to; future planning including seasonal pressure, serious incidents, performance data and operational risks. Minutes we saw from the meeting detailed actions to be taken and responsibilities for these actions. Meetings were held to learn from deaths within the service and the wider integrated care system. These meetings were led by the lead nurse for the clinical nurse specialist teams. The Wellbeing team also attend team to ensure a holistic view is maintained. A sample of deaths that occurred on each Inpatient Palliative Unit, and community teams was discussed, and any learning shared. The meeting reviewed preferred place of care and death for patients as well as any hospital admissions that could have been avoided.

A Medicine Management Safety Group was chaired by the medicines management lead for the hospice and reviewed any medicine associated incidents, audit and investigation outcomes and highlighted any learning or training needs.

The service had a programme of clinical and internal audits to check quality and systems to identify where staff should be taking action. There was an audit calendar and an action plan tracker. The service benchmarked themselves against other hospices and submitted data to the local clinical commissioning groups.

We saw service level agreements were in place and leaders attended contract group meetings; the hospice provided commissioners with required information.

The hospice had a people team who oversaw the human resources processes. During our inspection we reviewed 4 staff files. These files were all correctly completed and had the relevant employment documentation.

Management of risk, issues and performance

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

The service had a quality assurance process for the reporting of incidents. The governance team were notified of all incidents via an electronic incident risk management system. The governance team reviewed all incidents and identified actions to be completed. Incidents were rated according to level of harm and escalated accordingly for investigation. We saw the service incident log for the 12 months prior to our inspection, 159 incidents had been reported 26 no harm, 86 low

harm, 7 moderate harm, 20 near misses. There were no incidents reported as severe harm (any incident that results in permanent harm to one or more persons) or Catastrophic/Death (any unexpected or unintended incident that directly resulted in the death of one or more persons). We could see from the log that the incident description and actions taken had been detailed.

The service had a dedicated risk register which reflected current risks within the service. Risks included but were not limited to staffing levels. All risks had dedicated owners, risk and effect, control measures and risk ratings.

We reviewed the risk register during our inspection. There were 18 current open and ongoing risks The risk register contained information on when the risk was raised, the date of review, category of risk, the risk score which was rag rated, and who owned the risk and any mitigation of risk.

We saw evidence the risk register was reviewed and updated at the monthly management meeting. At this meeting, risks were identified and discussed, and a plan put in place to eliminate or reduce them. The risk register for the service was a standing agenda item.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff recorded information via an electronic incident risk management system, and this was reported in the quarterly integrated quality assurance report. Managers graded the incidents and investigated each incident individually to identify any learning.

Staff were able to access computers and the hospice intranet and shared drives. Computers were password protected and staff locked them when they were not in use. Staff working in the community were also able to access systems while off site.

The hospice submitted data to external organisations as required. Some staff we spoke to felt the systems still needed to be integrated fully and they needed further training on the new systems which had been implemented since the merger with another hospice location.

Engagement

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

The hospice worked in partnership with other services to ensure they effectively met peoples' needs. For example, they worked with the local NHS trusts, clinical commissioning groups, other hospices and palliative care teams as could be evidence by the work completed as part of the Hospices of Birmingham and Solihull service.

The hospice gathered and acted upon people's views and experiences, they were acted upon to shape and improve services and culture including people in different equality groups. For example, the hospice had also set up various community initiatives to help engage diverse communities, develop relationships with key leaders.

Outstanding ☆

End of life care

Managers used feedback from people who used services to inform improvements and learning. Complaints were discussed in staff meetings and patient stories and surveys were discussed in different forums.

Arrangements were in place to ensure staff could raise concerns safely; there were whistleblowing and disciplinary policies in place. The hospice was committed to freedom to speak up and had a speak up guardian in post.

Managers sought and acted upon the views of staff in the service. Staff gave feedback via the staff engagement survey; we saw the results the November 2022 surgery, 69% of staff had responded to the survey and the service scored well on staff feeling motivated and proud to work for the service. Score for leadership and organisational goals were lower, the service had an action plan in place to address these lower scores.

Learning, continuous improvement and innovation

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

The hospice had groups and strategic teams to monitor patient safety and outcomes and implement improvements. There was a Learning from Deaths Meeting, Clinical Audit Group, Patient Safety Group and a Clinical Governance Committee. Minutes from learning from deaths meeting details recommendations for improvements such as improvements on data collection.

The service had held a patient safety day in September 2023, which looked at themes like active listening with patients, involving patients and their families in their care, educating patients, reviewing decision making processes and learning from incidents. There was also a session on engaging patients and staff learning slides.

The service had several initiatives, for example, they used a system called Learning from Excellence for capturing examples of good practice in healthcare. This was used alongside the existing incident reporting systems and was aimed at learning what works well in other organisations and provide positive staff feedback and implement changes.

The service obtained information on areas for improvement by using patient feedback from surveys and patient outcome tools. The hospice used a patient feedback tool called FAMCARE which an Association for Palliative Medicine audit which seeks family feedback following care and death of a patient known to the hospice services. It is a national survey allowing some benchmarking against other services and some individual feedback in the form of free text comments. Surveys were sent out during June, July and August 2022 to families who were recently bereaved. Both the inpatient team and the hospice at home team score highly for the way in which the palliative care team respected the patient's dignity, Palliative care team's attention to the patient's description of symptoms and the way in which the patient's physical needs or comfort were met.

The service was taking part in a Chealsea II trial with a small group of consenting patients who met the criteria. The trial assessed whether giving patients in the last days of life fluids through a drip (clinically assisted hydration, CAH) is effective at preventing them from developing delirium. The results of this trial were not available at the time of our inspection and is ongoing.

Outstanding ☆

End of life care

The service monitored patient outcomes for preferred place of death and learned from instances where this had not been achieved. Data showed from April to August 2023 of the patients who had stated where their preferred place of care or death, 84% had achieved this. Leaders told us they have a learning from deaths monthly meeting and before the meeting a report was sent to the service leaders and so they could examine the data for patients who achieved their preferred place of death and how best outcomes could be achieved for patients.

The hospice had taken part in the National Care at the End-of-Life Case Note review which hospices across the region had submitted case notes for auditing and feedback, this is good practice as it allows an external organisation to review and give feedback.

The service took part in an implemented audits both internally and by external agencies. Areas covered by these audits were pressure ulcers, slips trips and falls, medication errors and discharges. The service general performed well in comparison to other services.

The hospice personal health budget team supported patients across Birmingham with support ranging from household chores, to providing beds and linen so people could die at home in comfort and with dignity surrounded by their loved ones. The hospice had undertaken presentations and shared how to refer patients for the government initiative with many external professional teams.