Severn Hospice Limited

Severn Hospice Apley Site

Inspection report

Severn Hospice -Telford
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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	Good
Are services safe?	Good
Are services well-led?	Good

Summary of findings

Overall summary

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

- The service had enough staff to care for patients and keep them safe. The service had improved mandatory training/ training in key skills. They understood how to protect patients from abuse as managers made sure they completed the safeguarding training. Staff managed safety well. The service controlled infection risk well. There were improved arrangements for staff to assess risks to patients, act on them and ensure care records were reviewed and updated when required. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- There were systems in place to support leaders and managers to run services well using reliable and improved information systems. Staff were supported 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

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	**Outstanding** ☆	• See the main summary above for information.

Summary of findings

Contents

Summary of this inspection

Background to Severn Hospice Apley Site

Severn Hospice Apley is a service that operates under Severn Hospice Limited. Severn Hospice have another hospice within Shropshire and both sites work closely together sharing resources and a senior leadership team. Severn Hospice is a charitable organisation in Telford, Shropshire. Severn Hospice Apley has 11 beds and supports the community across Shropshire, Powys and West Midlands. Severn Hospice Apley will also accept patient referrals from outside the area.

The current registered manager has been registered with the CQC since 2019.

The service is registered to provide the following regulated activities: ensure the service was compliant with the regulations.

• Diagnostic and screening.

• Treatment of disease or injury.

Severn Hospice Apley was last inspected on 20 April 2021 and was rated as required improvement overall. Following this inspection, we told the service that it must take action to bring services into line with The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and issued the provider with three requirement notices and a Section 29 warning notice.

How we carried out this inspection

We carried out an unannounced, focused inspection to check that requirements we made at the last inspection including a warning notice had been done. We judged that they had.

We inspected the key questions: is the service safe and well led? We did not inspect effective, caring or responsive key questions. The inspection was carried out by one inspector. We spoke with twelve staff members on site and four staff were interviewed off site using telecommunications. There were eight patients using the service at the time of inspection and each of their care records were reviewed. During the inspection, we also looked at the training records, policies and procedures and records relating to quality assurance.

The inspection was overseen by Sarah Dunnett, Interim Head of Hospitals Inspection.

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

Areas for improvement

Action the service SHOULD take to improve:

- The service should ensure the mandatory training programme incorporates education in learning disabilities and autism.

Summary of this inspection

- The service should ensure all grades of staff are confident to report incidents.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Hospice services for adults	Good	Not inspected	Not inspected	Not inspected	Good	☆ Outstanding
Overall	Good	Not inspected	Not inspected	Not inspected	Good	Good

Outstanding ☆

Hospice services for adults

Safe	Good
Well-led	Good

Are Hospice services for adults safe?

Good

Mandatory training

The service provided mandatory training in key skills to all staff and arrangements were in place to ensure staff had completed it.

Nursing staff received and kept up-to-date with their mandatory training. Staff completed training either online or by face to face classroom training. Face to face training had been paused during the pandemic due to social distancing requirements but had recommenced. Managers told us their programme to ensure staff had received all mandatory training by 31 December 2021 was on track.

Medical staff received and kept up-to-date with their mandatory training. Medical staff compliance with mandatory training had improved and was above the service target. Junior medical staff whose training was overseen by the deanery had some of their training outside the service, but this was checked by the provider for suitability and that it had been done.

Mandatory training was comprehensive and met the needs of patients and staff. Topics covered clinical and risk based subject matter. The service had arrangements for staff to undertake most of their mandatory training online although face to face training was undertaken for some topics such as moving and handling, basic life support, syringe driver management and fire.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Staff were confident in their skills to support people with mental health and dementia common in the hospice environment but told us they had not received specific training in supporting people with the conditions of autism and learning disabilities. A senior manager said they had recognised a need for staff to receive training about learning disabilities and autism and this was being developed.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff and their manager received an email which identified they required an update in identified mandatory training. If training was not arranged staff and their manager would receive a further email reminding them to book their training.

Safeguarding

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

Safeguarding systems and procedures and had significantly improved since the last inspection. Staff correctly described the principles and processes they would follow if they had any concerns or if they suspected abuse. Staff told us there was a safeguarding champion manager available 24 hours a day to give them safeguarding advice and support. Staff

and managers gave examples of when they had raised a safeguarding concern and told us they felt confident in the process and the way in which concerns were managed. Staff told us safeguarding concerns would be raised with the safeguarding leads. When required, referrals were managed in accordance with the Severn Hospice policy and recorded on the electronic incident reporting system.

Safeguarding champion managers were available 24 hours a day. There were safeguarding leads for both adults and children who would provide safeguarding advice and support.

All clinical staff received training specific for their role on how to recognise and report abuse. Safeguarding training included modern slavery, child sexual exploitation, gang culture, honour-based violence, forced marriage, female genital mutilation and domestic abuse.

The service provided care and treatment primarily for adults over 18 years. The Intercollegiate document on safeguarding guidance revision identifies which clinical staff require level 3 safeguarding children. Required staff had this training.

As of November 2021, all clinical staff had received safeguarding children level 2 and most staff had received an update in this training. The service had identified all staff would have completed an update by the end of December 2021. Non-clinical staff had received safeguarding children level 1.

Safeguarding leads were trained to a level four which was in line with intercollegiate guidance.

Staff gave examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff were knowledgeable about safeguarding and gave us examples of actions taken when potential safeguarding had been highlighted.

The safeguarding leads received clinical supervision from an outside agency to ensure current and safe practice was met. Safeguarding concerns were discussed during team meetings, handovers and multidisciplinary meetings. The ward manager confirmed arrangements were being set up for safeguarding supervision to be available for all staff. In the staff rest room, there was a display about safeguarding which included information about staff safeguarding supervision.

There were robust recruitment processes in place for staff and volunteers including Disclosure and Barring Service (DBS) checks. The service had recently reviewed its policy for the level of DBS checks based on the government's on-line took kit and checks were now made in accordance with this. We saw that there were accurate records kept and there was a system in place for staff to be rechecked every three years. We discussed the provider's policy on the recruitment of people who had disclosed convictions and it was clear that each case was confidentially considered on merit by senior managers and a trustee.

Nurses professional registration was confirmed and ongoing checks of renewal of registration was undertaken with the regulatory body (Nursing and Midwifery Council).

Cleanliness, infection control and hygiene

The service controlled infection risk well.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. Housekeeping staff kept the premises clean and there were schedules and checking systems in place to ensure all areas were cleaned as indicated in the identified cleaning schedule. There were facilities to support good infection prevention control in all patient rooms and in the corridors outside patients' rooms and clinic rooms. All patient rooms were single occupancy and were deep cleaned between patients, which included equipment, furniture and the room.

Hospice data showed compliance with infection prevention and control training had improved.

The service had recently commenced weekly polymerase chain reaction (PCR) testing for staff in additional to the twice weekly lateral flow tests to effectively monitor staffs' COVID-19 status. The service had a policy in place to monitor staff compliance with COVID-19 lateral flow tests. Staff who tested positive for COVID-19 knew they needed to share these results with the service and appropriate action was taken in response to positive tests.

The service tested all patients admitted from the community for COVID-19 on admission. Patients who were admitted from hospital were tested if they had not had a negative test COVID-19 within the previous seven days. All patients had daily temperature checks, any patients who had a temperature had a COVID-19 test and were isolated until a negative result was confirmed. This was seen in practice during our inspection.

Staff observed social distancing whenever possible. Risk assessments were in place to identify the maximum number of people who should be in each room to comply with social distancing requirements.

The service generally performed well for cleanliness. The service provided infections control audits the most recent dated 21 October 2021. The audit was comprehensive and did not identify any serious concerns.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Cleaning services were provider by an external contractor. Domestic staff had a programme of work which identified areas and items to be cleaned and the frequency of cleaning required and signed to confirm it had been cleaned , Domestic staff signed to confirm the area had been cleaned and these records were displayed. Weekly audits were undertaken by the contractor and were made available to the service.

The service ensured that the health and safety of everyone who had contact with the deceased person's body after death was protected. The area where the deceased person remained before going to the funeral directors was kept locked and not visited. Domestic staff had recorded when it was cleaned on the main doors. Staff confirmed it was well maintained, cleaned and suitable until the deceased was collected by funeral directors.

Staff followed infection control principles including the use of personal protective equipment (PPE). There was sufficient stock of personal protective equipment. (PPE) and this was stored correctly. Staff were observed using appropriate protective equipment such as gloves and aprons to carry out procedures and personal care activities. Staff were observed to be 'arms bare below the elbow'. Handwashing sinks and hand sanitizer dispensers were accessible and were available throughout the service. Information about effective handwashing was displayed at handwashing sinks signs. We observed staff washing their hands and using hand sanitiser when going in and out of rooms of patient's rooms.

Severn Hospice had infection control link nurses and an infection control lead nurse who had a role to promote and audit infection control and prevention practice.

The link nurses had commenced hand washing/hygiene assessments on the clinical staff. The results of these assessments were not available.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Green labels were used to identify equipment that was clean and ready to use.

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.

The design of the environment followed national guidance. The environment of the service provided suitable facilities to meet the needs of patients and their families. The building was a purpose-built hospice which opened in 2008 to provide end of life and palliative care.

The service had a maintenance support team called stewards with a general responsible for the building and grounds. Severn Hospice used approved contractors for planned maintenance and servicing and reactive needs such faulty equipment.

The clinical areas were suitable and appropriate for the service.

There was a secure locked cold area within the service for deceased patients until they were collected by funeral directors.

1. Staff carried out safety checks of specialist equipment. The service had a contract with the local NHS trust to service, repair and maintain specialist medical equipment. Staff said this arrangement worked well with timely collection and return of the equipment.
2. Equipment safety check records were kept at the service head office. In addition, records of maintenance checks on site were undertaken at the required frequency by staff on site such as; fire alarm testing and water temperatures checks.

The service had suitable facilities to meet the needs of patients' families. Quiet rooms and areas with tea and coffee making facilities were available in the service for patients and their families to use.

The service had enough suitable equipment to help them to safely care for patients. Staff reported that equipment was readily available and suitable for the patient's needs.

Staff disposed of clinical waste safely. Clinical waste was segregated from domestic waste and disposed of and collected regularly. Clinical waste bins were kept locked and were in a locked enclosure.

Assessing and responding to patient risk

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

Staff used a recognised tool to identify deteriorating patients and escalated them appropriately. Staff completed and updated risk assessments for each patient and removed or minimised risks. The service had developed a tool with a national charity to identify sepsis for palliative care services. The service used an early warning score for inpatients who were not end of life and had not completed a do not attempt resuscitation (DNACPR). Risk assessments identified patient's wishes such as when they requested whether to receive further care in hospital.

Staff managed emergencies in line with policy and procedures. Patients sometimes required an emergency or unplanned transfer to hospital via 999. Doctors were available off site out of hours and at weekend on an on-call basis. Staff contacted the on-call doctor out of hours to review or in hours by a member of the medical team. Doctors came into the service to review patients when required and take appropriate actions which were aligned to the patients pre agreed wishes.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. Risk assessments were reviewed at least weekly and more frequently when patients needs had changed. A multi-professional review of risks was undertaken weekly.

Staff knew about and dealt with any specific risk issues. Staff had updated risk assessments when the patients' needs had changed, and they were identified to be greater risk. For example, a patient who had fallen, staff had reviewed their falls risk assessment and put additional actions in place to mitigate against increased risk of falling. Risks assessments for pressure ulcers identified additional actions required when patients skin was reddened, and they were at increased risk of pressure ulcers.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients when needed. Referrals were made to the clinical psychologist to ensure patients and their loved ones received appropriate mental health care and support to keep them safe.

Staff shared key information to keep patients safe when handing over their care to others. Staff worked closely with health and allied health professionals and other agencies to ensure they had the all required information about their patients, their care and support needs. During the inspection staff liaised with clinical nurse specialists both in the community and the acute hospital trust, the local authority and local care homes to arrange safe admission and discharge of their patients.

Shift changes and handovers included all necessary key information to keep patients safe. There was a nursing staff handover at the beginning of every shift. We observed a staff handover. Each patient was discussed and all their care, treatment, information such as visits from friends and family and risks identified, such as increased risk of skin damage or falls. There was also a multidisciplinary team handover daily Monday to Friday which we also observed. Representatives from all care teams attended to discuss patients and their care needs. In addition, the service also had a full weekly multidisciplinary meeting which included a consultant in palliative care.

Staffing

The service had enough staff with the right qualifications, skills and training 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.

Outstanding ☆

Hospice services for adults

The service had enough nursing and support staff to keep patients safe. Alongside nurses, health care assistants and medical staff the service also employed a physiotherapist, complementary therapists, a chaplain, a part time pharmacist and administration staff to support patient care.

Managers and staff told us they were supported to receive additional training which included palliative care. Information provided by the service identified 42% of nursing staff had end of life training, 19 staff also had a post graduate qualification in palliative care. All consultants had additional palliative and end of life qualifications and experience. The medical director had arranged for doctors to receive additional palliative and end of life training doctors who had a permanent position within the service.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift to meet patients' needs on an ongoing shift by shift basis.

The managers could adjust staffing levels daily according to the needs of patients. A staffing tool was used to identify baseline staffing requirements. Rotas were planned but staffing numbers were flexed to respond to increasing dependency and complexity of the patients. Staffing was flexed based on the needs of the service. Deployment of staff took place across both locations, and if it was clear that a patient's needs could not be met because of staffing then the patient would not be admitted. There was always a band seven nurse on call, and it was required that they would staff a shift if needed.

The service had invested in trainee nurse associates (TNA). One nurse associate had almost completed their training and a second had recently commenced it. This was to support the nursing workforce and provide career progression for existing members of care staff.

The number of nurses and healthcare assistants matched the planned numbers. The numbers on duty accurately reflected requirements and staff on duty was displayed on the inpatient ward.

The service had low vacancy and turnover rates. The service had one registered nurse whole time equivalent vacancy at the time of the inspection. Turnover was minimal with most staff employed by the service for several years.

The service had low sickness rates. Managers said they had relatively low levels of staff sickness and absence whilst staff had to self-isolate. Staff said managers were supportive and gave examples how they had been supported to return to work from sick leave. Managers confirmed they supported staff but when required would commence sickness absence policy.

The service had low rates of bank staff. The service had its own bank of staff who were familiar to the service to support substantive staffing. The service did not use agency staff.

Managers made sure bank staff had a full induction and understood the service. All bank workers received the same identified initial induction programme. In addition to the initial orientation bank workers were also required to complete Severn Hospice statutory and mandatory e-learning modules, moving and handling training.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep patients safe. Severn Hospice employed five palliative care consultants who supported both inpatients units and community services. One consultant with a specialist interest in neurology worked four days a week.

A consultant had left and at the time of the inspection, the medical director with a community consultant were providing consultant cover for the service. A new consultant had been appointed who was to start employment in January 2022.

Severn Hospice Apley had doctors with experience in palliative and end of life care.

The medical staff matched the planned number.The medical director said the staff mix enabled time off and training.

The service had low sickness and vacancy rates for medical staff. The service had a current consultant vacancy which was currently being advertised. Doctors said Severn Hospice appointments and secondments were sought after. The medical director said appointments to senior roles had been made for doctors who had undertaken previous training with Severn Hospice.

The service always had a consultant on call during evenings and weekends. Doctors were on site Monday to Friday and on call evening and weekends. A consultant was second on call for doctors and specialist nurses to call when required.

The service also employed a physiotherapist, complementary therapists, a chaplain and administration staff to support patient care.

Records

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

Patient notes were comprehensive, and all staff could access them easily. The service mainly used electronic patient records, risk assessments were now in paper format. The electronic patients' records could be accessed and completed by all staff. Each staff group completed their own tab within the electronic record which then populated the ongoing record for all staff to refer to when needed. The electronic system meant information could easily be identified for all staff groups and ensure continuity of care provided.

We reviewed eight sets of patient records and each contained all the appropriate information.

Information provided by the service showed the records audit in August 2021 identified 97% compliance.

All clinical services used the electronic patient record system so when patients transferred from one service line to another, their records were easily accessible. If records were received in paper format, for example the do not attempt cardiopulmonary resuscitation decisions form (DNACPR) this would be scanned into the electronic system for reference by all staff, the paper record was also retained which could then be given to the patient when they were discharged to another service.

The service had access to information about their patients from the local NHS trust. Clinical staff were able to view outpatient letters, imaging and pathology results when patients received their care at Severn Hospice Apley to ensure continuity of care.

On discharge from the service, all patients were provided with a clinical letter for their GP, with copies sent to key clinicians.

Records were stored securely. Electronic patient records were password protected and so access was restricted to those who were authorised to use the system. Paper patient records were kept in a locked trolley.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Medicines were prescribed by doctors and administered and recorded by nursing staff. Medicine records seen showed that medicine administration was recorded following policy. We checked patient records and prescription charts for five patients. Appropriate arrangements were in place to prescribe and record administration of patient medicines including a reason if medicines were not administered.

There were safe and secure storage arrangements for medicines including intravenous fluids. The room, cupboards and fridge where medicines were stored were all locked with keypad access.

Controlled drugs are medicines which require additional arrangements for their storage and administration under the Misuse of Drugs legislation (and subsequent amendments). We observed robust controlled drugs checks were in place, with checks undertaken and recorded at each staff handover. There was a controlled drugs accountable officer for the service to ensure safe management. Any controlled drugs incidents were both reported to the medicines safety committee and the local controlled drug local intelligence network (CDLiN).

The service had three monthly medicines audits which included a review of the prescribing, storage and management arrangements of medicines. Audits identified when compliance was not met, and improvement were identified. The medicines audits were reviewed by the medicines safety group and shared with the clinical governance group to provide oversight.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. A pharmacist was available 15 hours a week to review medicine arrangements and provide advice support to the team. Medicines were provided by the local NHS trust which included a weekly medicine top up service.

Staff stored and managed medicines and prescribing documents in line with the provider’s policy. Medicine guidelines and policies were available which had been approved by the clinical governance group.

Staff followed current national practice to check patients had the correct medicines. There were appropriate processes for medicines reconciliation when patients were admitted. This was completed by doctors and checked for accuracy by another staff member. The reconciliation and appropriate prescribing were also checked by the pharmacist at their next visit. There were appropriate systems in place for ensuring that patients and other healthcare professionals who would be looking after them, had suitable information about their medicines on discharge from the inpatient unit to support their ongoing care.

The service had systems to ensure staff knew about safety alerts and incidents. Any alerts relating to medicine incidents, themes and trends were circulated by the pharmacists to all service leads to ensure safe practice. Information was also displayed on the noticeboard in the treatment room. Allergies were recorded on the main treatment and prescription charts for all patients.

There was a medicines safety group which had started since our last inspection. Meetings were monthly and discussed medicine incidents and any necessary actions. We saw medicines incidents which had been reported were reviewed and monitored, so that lessons could be learnt, and improvements made if necessary. Information from the meetings were both shared by the ward manager and the pharmacist.

The service had 21 medicine incidents reported between May 2021 and November 2021. Senior managers as part of the medicine's safety group reviewed numbers and trends of incidents. Medicines incidents were mainly around administration and including non-administration of medicines (13 incidents). Incidents were investigated, and considerations identified to improve practice. Managers identified actions as a result of learning from these incidents (see information within incidents below).

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Treatment was assessed by the multi-disciplinary team (MDT) as part of the weekly MDT meeting to ensure patients received appropriate medication.

Incidents

The service managed patient safety incidents well. Most 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.

Most staff knew what incidents to report and how to report them. The service used an electronic incident reporting system. Qualified nurses said they had reported incidents onto the system. Health care assistants said they were unsure how to report but would ask a qualified nurse to report on their behalf.

Staff raised concerns and reported incidents and near misses in line with provider policy. Staff recognised incidents and near misses and reported them appropriately.

The service had no never events. Staff said managers shared learning about never events that happened elsewhere.

Staff reported serious incidents in line with the service's policy. There had been four serious incidents reported from May 2021 to November 2021. These incidents all related to pressure ulcers identified as grade 3. Three incidents related to patients admitted with a pressure ulcers from either their own home or another care setting. One pressure ulcer had developed whilst they were an inpatient within the service, and this was being investigated. Notifications and investigation reports were shared with staff and other agencies when required. Staff discussed how serious incidents such as grade three pressure ulcers had been shared and identification of lessons learnt.

Staff understood the duty of candour. Patients and their families were informed and kept up to date of any incidents or accidents that had occurred. The service was open and transparent and gave families a full explanation when things went wrong. All incidents, accidents and complaints were initially reviewed by a senior manager to check whether they met the criteria for a duty of candour. Incidents and complaints were also discussed at clinical governance committee to ensure all required actions were taken by the service.

Outstanding ☆

Hospice services for adults

Staff received feedback from investigation of incidents, both internal and external to the service. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Managers ensured that actions from patient safety alerts were implemented and monitored. Staff said the incident form identified when the staff requested feedback about the incident. Staff mainly said they had feedback when requested, one staff member said they had not received feedback when they had requested feedback.

Staff met to discuss the feedback and look at improvements to patient care. Staff gave examples of improvements which had been made to patients care following incidents such as pressure ulcers and falls.

There was evidence that changes had been made as a result of feedback. Managers identified learning from medicine errors when had resulted when staff were busy and had been distracted. Staff administering medicines wore a red tabard and there was a red light on the treatment room door which alerted others not to disturb them as they were administering medicines.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Investigation reports were available and shared with staff and families when appropriate.

Managers debriefed and supported staff after any serious incidents which may distress staff.

Staff said senior managers and managers were always visible and accessible. The relationship between the senior leaders and trustees was positive and supportive.

Are Hospice services for adults well-led?

Good

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

Leadership

Leaders 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 department structure in place, with an overview which included chief executive, director of finance and information / company secretary, medical director, director of care and director of income generation. This clearly identified who was responsible for each area. Senior managers had a good understanding of the challenges within the service.

Staff said senior managers and managers were always visible and accessible. The relationship between the senior leaders and trustees was positive and supportive.

The senior leadership team had identified shortfalls in their management arrangements with a need for additional roles within governance and safeguarding. The new arrangements assisted managers to identify priorities and issues faced by the senior leaders had supported staff to develop and keep patients safe.

Staff had been appointed to take on senior governance roles to develop the service. Senior managers were proud of their staff succession to senior posts.

The Severn Hospice board identified in April 2021 a requirement for the eight hospice sub-committees to each have a trustee as chair. Many of the trustees had a background or expertise in health or social care or its supporting services.

The service had two safeguarding leads and a trustee with a lead safeguarding role who was the board representative for safeguarding.

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 was aligned to local plans within the wider health economy.

The service had a vision for what it wanted to achieve and plans to turn it into action. The vision identified was:

Our vision is a world where people are cared for at the end of their life as well as they were at its beginning.

Managers and staff identified as part of this model was a vision and associated strategy of care closer to home.

The service had engaged with families, the wider community and stakeholders to identify the vision and strategy for the service. Engagement had identified a request for increased access to the service within patients own homes.

The service strategy was aligned to local plans in the wider health and social care economy, and how services were planned to meet the needs of the population. Managers and staff worked closely with local hospitals, commissioners and other NHS partners to support families. Staff knew and fully understand the vision, values and strategy, and their role in achieving them.

The strategy to achieve the vision included the further development and increased availability of community staff both to support patients in their own homes and to support other professionals with increased palliative education and advice.

Managers said their strategy included ensuring equality of access to service and highlighted the use of the “Community bus” to both provide a clinic environment closer to home in accessible places such as a local supermarket car park whilst also advertising the availability of the service.

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

There were high levels of satisfaction across all staff. There was strong collaboration, team-working and support and a common focus on improving the quality and sustainability of care and people’s experiences. The culture of the service centred on the needs and experience of the patients and their families who used services. Staff at every level were passionate about delivering high quality care and treatment for patients requiring palliative and end of life care and their loved ones.

Staff told us they were proud to work for the service and the high-quality care they provided. Staff without exception said they would recommend it as a place of care for their families and friends as well as recommending Severn Hospice Apley as a place to work. Several staff gave us examples of how they had been supported with their career development.

Managers put staff wellbeing central to support them to provide quality end of life care. Severn Hospice had a Wellbeing and staff support policy. The purpose of the policy was to ensure there was a system in place to provide staff and volunteers with appropriate support. Managers identified staff support was paramount to ensure the well-being of staff and they felt valued. The service provided up to six hospice counselling sessions for each staff member annually, mental health first aiders, clinical supervision and peer support to support staff and their wellbeing.

Staff we spoke with felt supported respected and valued. Staff told us how supportive their immediate line manager was and told us they also had support from senior leaders. Leaders ensured patients received care and treatment which was safe and of the highest quality. This was demonstrated in the care being delivered, the focus on ensuring lessons were learned when issues arose and the attitude of staff we spoke with. The culture encouraged openness and honesty at all levels within the organisation, leaders understood the importance of staff being able to raise concerns without fear of retribution.

Staff felt able to raise concerns and told us there were no barriers when escalating incidents or complaints. Staff said they were open with patients and carers when things went wrong and were encouraged to do so by leadership. Appropriate learning and actions were taken when concerns were raised. Counselling services were available to support staff individually in group sessions or on the telephone if needed. Staff also received ad hoc safeguarding, clinical and restorative supervision to reflect, address any clinical issues and the emotional impact these may have had on them.

Governance

There were systems and processes to support governance arrangements within the service. 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.

The senior management following our last inspection identified a need for more robust governance arrangements. Governance arrangements have now been coordinated into a central team to increase quality monitoring, policy development and review and risk management and provided better scrutiny and analysis of service delivery. When needed action plans were identified and put in place to improve practice and performance.

Since our last inspection there were improved systems in place to review policies and procedures to ensure they met best practice, new legislation, national standards or latest guidance. Information provided by the service following the inspection confirmed all policies had been reviewed and updated.

The trustee board and clinical group governance group met on a quarterly basis to review quality and safety for the service. The clinical group reported to the board of trustees. The service had separate committees and groups met more frequently and fed into the clinical governance committee and leadership meetings for example, there was a medicines management, infection prevention and control, health and safety and audit and risk group (which included learning from death reports). The membership of the groups included operational and leadership staff. Meetings were summarised and presented at the clinical group governance meetings. Senior managers met with head of department monthly. These meetings discussed operational information about the service including staffing, risks, incidents, complaints and patient feedback. Minutes of the meetings were taken and circulated afterwards.

We reviewed clinical governance meeting minutes for April 2021, July 2021 and October 2021. Each meeting had standing agenda items which included but were not limited to activity monitoring and audit, risk management, reported incidents (including medicine incidents), complaints, safeguarding, service reviews and patient and carer feedback. Actions were identified and were discussed at subsequent meetings.

There were quarterly trustee board meetings which reviewed the performance and development of the service, finance and funding arrangement, risks, incidents and complaints. The main trustee board received minutes from each of the trustee board governance committees. They also received service update papers, updates on strategic priorities, financial information and sometimes a presentation on a service area and/or an issue for debate and discussion. The senior management team were present for the whole board meeting. The leadership team attended clinical governance committee meetings and information was fed to staff at team meetings, in the form of minutes and emails.

There were bimonthly matron meetings and bimonthly clinical lead meetings which included the senior managers of all services. There were minutes recorded of these meetings with standard agenda items. Managers shared feedback from these meeting with their staff within team meetings or via email.

The service continually monitored safety performance. Managers reviewed incidents which informed safety data. The ward manager had displayed safety information which included pressure ulcers, medication errors and falls in staff areas for information.

Management of risk, issues and performance

Leaders and teams had improved systems to manage performance. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

Improved governance arrangements provided greater assurance for identifying, recording and managing risks, issues and mitigating actions. The service had a risk register where there were clear mitigations and review processes. These were reported to the trustee board, reviewed regularly and acted on.

The clinical governance group played a key role and function in the management of risks within the service. This committee reviewed key information about risks within the service and ensured action was taken to mitigate them. The committee looked for themes and trends and actions taken to reduce the risk of recurrence. An example of this was the review of incidents and themes such as medicine errors. The trustee board received reports regarding different streams of risk including clinical risks and operational risks. This gave the trustees a broad and full picture of risk within the service.

There was a programme of clinical and internal audit which was used to monitor quality and operational processes, and results were used to identify where improvement action should be taken. Most staff confirmed they received feedback from audits.

Most staff confirmed they received feedback on risks, incidents, issues and performance in a variety of ways, such as team meetings, noticeboards, newsletters and email.

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. Data or notifications were submitted to external organisations as required.

Service performance measures were reported and monitored. Staff, managers, the trustee board and commissioners had access to quality and performance data through the Severn hospice report. The service was in the process of developing a dashboard of intelligence which identified performance and quality indicators, such as incidents including pressure ulcers, medication errors and patient falls, staffing, service user feedback, complaints and audit activity. This data had previously been available, but the new dashboard meant information was more accessible for managers, commissioners and other statutory bodies outside the service.

Data or notifications were now submitted as required to external organisations.

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.

The leadership team were enthusiastic and proud of the engagement work that the service undertook, both internally, with external organisation and with service users.

The medical director and chief executive regularly gave interviews on local radio stations to highlight the work the hospice does to increase awareness within the community of Severn Hospice and the services provided.

The service used patient feedback, including formal and informal complaints, concerns and complements, to shape the services moving forward. For example, carers fed back they did not have time to relax at carer events as they still had to provide care. Therefore, the service changed the approach to ensure care staff were available to allow carers time to themselves.

The leadership team told us about a cross-organisation approach to creating and implementing a joint local strategy for palliative and end of life care across Shropshire. The group was led by the medical director at Severn Hospice and influenced decisions about palliative and end of life care within the county and local community.

Managers told us how they engaged with other services to support them to improve and develop end of life and palliative care. The medical director was a visiting professorial chair of a university and as part of this role had developed educational programmes for doctors and health professionals. The medical director identified palliative care education programmes improved palliative care and end of life care for the wider population and was proud of the work undertaken.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

Managers said ensuring equality of access to service within a large geographical area and diverse communities had highlighted the need for a “Community bus” to provide improve the service provided. The community bus will provide a clinic environment closer to home in accessible places such as a local supermarket car park whilst also advertising the availability of the hospice service in the areas it visited. Funding arrangements for the community bus were being discussed, no timeframe for its implementation had been identified at the time of the inspection.

The medical director identified the importance of continual learning for the ongoing development of end of life and palliative care for professionals who worked both within Severn Hospice and other external professionals who provided palliative and end of life care.