Severn Hospice Limited

Severn Hospice Bicton Site

Inspection report

Severn Hospice
Bicton
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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. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.

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:

Clinical waste skips were not always kept secure.

Mandatory training did not address the needs of people with autism or learning disabilities.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	Good 	Our rating of this service improved. We rated it as good because: The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service. 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 this inspection

Background to Severn Hospice Bicton Site

Severn Hospice Bicton Site is located in the town of Shrewsbury and is a location of Severn Hospice Limited, a charitable organisation based in Shropshire. At the time of inspection the hospice was providing ten beds and supporting the community across Shropshire, the West Midlands and eastern Wales. The service also accepts patient referrals from outside of the area.

The service is registered, under the Health and Social Care Act 2008 to provide the following regulated activities:

- Diagnostic and screening.
- Treatment of disease, disorder or injury.
- Personal care.

Under these regulated activities the hospice provided the following services:

- Inpatient services
- Community services
- Hospice at home

Other services, such as creative therapies and bereavement counselling were provided but these are outside of the scope of the regulations.

The service provides care for patients with cancer and non-malignant progressive disease and their carers during the palliative care phase of their illness at home.

The current registered manager has been registered with the CQC since 2019. Severn Hospice Bicton Site was last inspected on 20 April 2021 and was rated overall as Requires improvement We issued the provider with two requirement notices and a Section 29 warning notice as a result of the that inspection.

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 is the service well led? We did not inspect the key questions of effective, caring or responsive. The inspection was carried out by one inspector over one and a half days on site. We spoke with 22 staff members on site and three staff were interviewed by telephone. There were eight patients using the ward at the time of inspection and a sample of six 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, Head of Hospitals Inspection

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Summary of this inspection

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust 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 that staff continue to keep clinical waste skips secure and that there are sufficient keys to ensure that they can easily do this.
- The service should consider the mandatory training programme to incorporate education in learning disabilities and autism.

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	Good
Overall	Good	Not inspected	Not inspected	Not inspected	Good	Good

Good

Hospice services for adults

Safe	Good
Well-led	Good

Are Hospice services for adults safe?

Good

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

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. However, staff told us they did not receive specific training in autism or learning disabilities.

Nursing staff received and kept up-to-date with their mandatory training. Staff had completed mandatory training either on-line or more recently face to face as this had become possible due to fewer Covid restrictions being in place. All staff had received mandatory training at some time and where targets were not met this represented staff missing update training due to the exigencies of the pandemic.

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

The mandatory training was comprehensive and met the needs of patients and staff, however staff told us they had not received specific training in responding to patients with learning disabilities, autism. Staff were confident in their skills to support people with mental health issues and dementia which was common in the hospice environment. However, they told us they had not received specific training in supporting people with the conditions of autism and learning disabilities.

Managers monitored mandatory training and alerted staff when they needed to update their training. This system was seen to operate effectively with staff and managers receiving alerts that mandatory training needed to be updated. Training had been adapted to be delivered on-line to accommodate the social distancing requirements of the pandemic. More recently some training that was less effective in this format, such as manual handling and that for infusion devices had been reintroduced as face to face.

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.

Safeguarding systems and procedures and had significantly improved since the last inspection.

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 tool

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.

Staff received training specific for their role on how to recognise and report abuse. Staff confirmed 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 two 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 one.

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

Medical staff received training specific for their role on how to recognise and report abuse. Medical staff spoken with all confirmed they had recently received safeguarding level three training for adults

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Some staff told us of situations where they had reported suspected abuse and how it had been dealt with. When we visited the outreach team some staff were dealing, alongside the local authority and other agencies, with a concern that had been raised that morning. They spoke confidently and knowledgably about what was happening and those dealing with the issue were supported by their manager and colleagues.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. All staff who we asked were able to describe different types of abuse and those staff working in the community were particularly conversant with signs found in the home including self-neglect.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. All staff to whom we spoke were able to describe what they would do if they had concerns or suspected abuse including contacting the local authority or the police. There was a safeguarding champion on call 24 hours a day and staff valued having someone to talk to if they needed advice or support.

On the day of our inspection we noted that the senior nurses had been discussing, in the light of recent events, the security of the cold store and whether changes might be needed. They said that this was because they expected to be asked about it at an upcoming board meeting. Following our inspection, we were told that enhanced security was to be introduced.

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. All areas of the hospice in use by patients were seen to be clean and tidy. The building and furnishings were suitable and lent themselves to Infection Prevention and Control (IPC) including cleaning. There were sufficient facilities for handwashing. Sanitiser dispensers, which were noted to be full, with suitable signage and instructions were distributed around the building including all entrances. All patients were accommodated in single rooms and these were deep cleaned between patients.

Staff had a weekly Covid 19 Polymerase Chain Reaction (PCR) test and also self-tested twice a week using a Lateral Flow Device (LFD). The service monitored the results of these tests and suitable action was taken in the event of a positive test.

All patients admitted from the community were PCR tested on admission and patients were managed as being positive until the results were obtained. Patients admitted from hospital were tested if they had not received a negative test in the last seven days. The service also monitored patients for signs of symptoms of Covid 19, such as temperature and they were tested and isolated until a clear result was obtained.

Staff were observed to be socially distancing and taking suitable precautions, for example in cleaning keyboards between use. However, it was noted that despite room occupancy assessments having been carried out these were not displayed in the rooms and staff were unsure of the numbers themselves. We drew this to the attention of the registered manager on the first day of our inspection and we noted on the second day that the issue was resolved.

There was a suitable cold store to accommodate deceased patients for a short time until they were transferred to the care of an undertaker.

The service generally performed well for cleanliness. We saw that IPC audits took place. The most recent for April 2021 was comprehensive and did not identify any serious concerns. At the time of our inspection in mid November 2021 that month's planned audit had not been carried out, but we noted that it was to be done using an improved audit tool as had been carried out at the provider's other location.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Cleaning was carried out to a schedule and specification by a contractor and audited records were kept.

Staff followed infection control principles including the use of personal protective equipment (PPE). Patients with infections could be isolated in their single rooms and there were effective processes in place for infections including Covid 19. Rooms were deep cleaned between patients.

PPE was suitable, sufficient and staff were trained in how to use it. All staff wore suitable clothing and those who had patient contact or worked in clinical areas were bare below the elbow. We observed that staff used the PPE provided and washed and sanitised their hands as required. There were also clear expectations that patients and visitors adhered to the required practices.

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

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff usually managed clinical waste well, however some outside bins were not kept locked.

Patients could reach call bells and staff responded quickly when called. Call bells were available in all patient's rooms and staff were noted to respond.

The design of the environment followed national guidance. The Bicton Hospice was purpose built and had recently had an additional building added to house staff who provided the outreach and hospice at home service as well as some other facilities that did not fall within the scope of regulation. The clinical areas were well designed, and all patients were accommodated in their own ensuite room. However, there was a lack of storage space and we saw surplus equipment, such as furniture, stored in empty side rooms and a bathroom used as an equipment store.

There was a local team of maintenance personnel known as "stewards" and they told us they had the resources to carry out their role properly. Specialist contractors were used for fire protection systems, heating, hot water and emergency lighting and we saw sample contracts.

There were safety checks of specialist equipment. The maintenance of most medical devices was carried out by the equipment management department of a local NHS trust and equipment was labelled both as having been checked and with an expiry date. Patient hoists and other lifting equipment was maintained by a specialist contractor in line with the relevant legislation.

The service had suitable facilities to meet the needs of patients' families. The hospice had been designed with this in mind and there were places for relatives to meet patients in homely environments such as sitting rooms, conservatories and gardens. There was a café located on the site, which was open to members of the public, as well as facilities to make drinks in the main building. There were also quiet areas, which were available to patients, relatives and staff, .

The service had enough suitable equipment to help them to safely care for patients. The equipment was noted as fit for purpose and staff told us they always had access to enough.

Staff did not always dispose of clinical waste safely as some outside skips were not kept locked. The service held a contract for the disposal of clinical waste with a suitable contractor. There were clinical waste bins throughout the building and these, together with those for sharps were secure and not over full. Clinical waste was disposed of into suitable "skips" at the rear of the premises which could be locked using a key and those that were full were noted as secure. However, those in use were not locked and in one case a piece of wood had been taped to the lid to defeat the self-locking mechanism. This posed a risk that unauthorised persons could access the material or that it could be retrieved and spread about by animals. We drew this to the attention of senior staff and the matter was quickly resolved.

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. We saw that staff were using suitable assessment and scoring mechanisms to identify patients who were at risk of deterioration. This included a sepsis identification system. Decisions on how to treat or whether to escalate care were made on the basis of each patient's individual circumstances and known wishes. This included, for example, whether a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision had been made or the patient was in the last days of life.

Staff completed risk assessments for each patient on admission using a recognised tool, and reviewed this regularly, including after any incident. Risk assessments were carried out on admission or at first contact in the community, and

we saw through our review of records that these were repeated after a prescribed number of days or if the patient's situation changed. For example, if a patient became more at risk of, or had suffered a fall then the relevant risk assessment would be reviewed. Staff managed emergencies in line with policy and if an unplanned or emergency hospital admission was needed patients were transferred to hospital by ambulance using the 999 service.

Staff knew about and dealt with any specific risk issues. Specific risks such as sepsis, venous thromboembolism, falls and pressure ulcers were recorded in care records and we noted that they were discussed at shift handovers and between community team members.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff were familiar with the psychological effects such as anxiety and depression of their diagnosis on patients and referred them to the in-house psychological services as needed.

Staff shared key information to keep patients safe when handing over their care to others. The record keeping systems facilitated the handover of care both within the hospice services and with external partners. We noted from the records we saw how liaison took place between the community outreach, hospice at home and inpatient services as a patient's need changed.

Shift changes and handovers included all necessary key information to keep patients safe. There was a handover meeting at the start of every shift. We observed a handover meeting and it was clear that staff were very familiar with the condition of every patient and the plan to meet their clinical and social care needs was discussed and passed to the next team. There was a weekly multidisciplinary meeting which was attended by all care teams and disciplines. During this meeting staff discussed all patients across both of the provider's locations and this was noted as effective by the inspection team who attended.

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. There were enough staff in the nursing establishment to provided sufficient staff for each shift and to support patients in the community

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 and managers could adjust staffing levels daily according to the needs of patients. A planning tool was in use to identify the staffing needs of the inpatient unit as it changed due to patient numbers and acuity. Staffing was flexed on the basis of this need, including the deployment of staff across the provider's 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. However, we were told that because staff were flexible in their approach this had never been needed.

The number of nurses and healthcare assistants matched the planned numbers. Staffing was provided to meet the requirement of all recent shifts and the current staffing requirement and actuality were displayed on the ward.

The service had low vacancy, turnover and sickness rates. Many staff had stayed with the provider for a long time which, they told us, reflected their satisfaction with their jobs and the standards of care that they were able to deliver. While there had been some increased sickness during the pandemic it had not affected care and did not represent a cause for concern.

The service had low rates of bank and did not use agency staff. Managers limited their use of bank staff were familiar with the service. All bank staff had a full induction and understood the service. No agency staff were used. Bank staff were experienced staff who worked their hours flexibly and so were fully trained and familiar with the services provided.

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 and the medical staff matched the planned number. The service had low vacancy and sickness rates for medical staff. Five medical staff were employed across both of the provider's locations and community outreach services.

A consultant had left and at the time of the inspection the medical director with a community consultant was providing consultant cover for both Severn Hospice Bicton and the other location in Apley. A new consultant had been appointed who was to start employment in January 2021 and then medical director would return to Severn Hospice Apley.

The service had low and/or reducing turnover rates for medical staff. Turnover rates were low for senior staff and as expected for junior doctors who were there on rotational placement or as fellows. Medics told us told that jobs and placements at the hospice were sought after.

The service always had a consultant on call during evenings and weekends. There was an out of hours on call rota with a first and second consultant on call. Nursing and junior medical staff told us the on call consultants always welcomed contact and came in when needed.

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 in-patient unit records were kept as a combination of paper and electronic records to allow risk assessments to be easily updated. Staff were satisfied with this approach and our review of records indicated that there were no inconsistencies. For the outreach team all records were electronic, and our review of records indicated these were comprehensive and up to date. The hospice at home team used paper records that were kept in the patient's home and our examination of records which were being scanned and archived showed them to be suitable and up to date.

The service completed record audits and we noted that the most recent audit scored 94% compliance for the in-patient unit. However, we also noted that the figure for the outreach team was only 64% and this had prompted a review as to the causes and an action plan to address them which was being effectively implemented.

When patients transferred to a new team, there were no delays in staff accessing their records. 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 a paper format, for example the DNACPR form, 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 the clinical portal at the local NHS trust which allowed staff to view outpatient letters, imaging and pathology results when patients received their care in that setting to ensure continuity of care.

On discharge from the service (either as an inpatient of from community services), all patients were provided with a clinical letter for their GP, with copies sent to key clinicians for example their oncologist.

Records were stored securely. On the in-patient unit we observed that paper records were secured in a locked notes trolley in the nursing office and returned promptly by the staff. Computers used to access electronic records used passwords and were noted to be locked when not in use.

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 their administration was recorded in line with the organisation's policies. Staff wore tabards to indicate they should not be disturbed while administering medicines and certain doors had indicator lights to indicate staff should not be disturbed for the same reason. We reviewed five prescription charts and records and no concerns were found.

Medicines, including intravenous fluids were stored securely and kept at the correct temperature including refrigeration as necessary.

Controlled drugs were in use by provider and these legally require additional arrangements to prevent their misuse and abuse. We saw that the correct records were kept, and the necessary checks were in place. There was a controlled drugs accountable officer registered with the CQC and we saw evidence that they worked with the local Controlled Drugs Local Intelligence Network.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Staff followed current national practice to check patients had the correct medicines. The provider employed a pharmacist to work 15 hours a week to provide support in the safe and effective use of medicines. Medicines were supplied by the local NHS trust and they provided a pharmacy technician to manage the stock. Medicines reconciliation was done as part of the patient's admission to the service by medical and nursing staff.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Prescriptions were made using FP10 forms which were kept securely.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Since our last inspection a medicines safety group had been established and we saw from the notes of this meeting that incidents were reviewed and, if necessary, actions and improvements made. Because of the culture of reporting small incidents there was enough information for the provider to identify trends and act to rectify them.

Good

Hospice services for adults

A significant medicines error had recently taken place although no harm was caused. Many staff made reference to it and the changes that had been made to prevent a reoccurrence when talking to us about incidents and medicines. This demonstrated that changes made as a result of incidents were embedded.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. There was oversight of individual patient's medicine regimes through the multi-disciplinary meetings which ensured that medication was necessary and appropriate.

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 trust/provider policy. Staff reported serious incidents clearly and in line with trust policy. The provider used a commercially available incident reporting system. Staff were familiar with the criteria for incident reporting and spoke confidently of how to do it. When we looked at the notes of governance meetings, such as the medicines safety group it was clear that there was a positive culture of reporting incidents.

The service had no never events.

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. Incidents and complaints were reviewed to judge whether they met the criteria for the duty of candour. Staff were familiar with the need for transparent and open when incidents occurred and kept patients and relatives informed.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Managers debriefed and supported staff after any serious incident.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to patient care. Staff told us that they received feedback when they reported incidents and we heard incidents discussed in the handover meeting we attended. From the notes of governance meetings, we saw that external incidents were considered, and lessons learned.

There was evidence that changes had been made as a result of feedback. We saw examples of how incidents had resulted in improvements including systems to ensure staff were not disturbed when preparing or administering medicines.

Are Hospice services for adults well-led?

Good

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

Good

Hospice services for adults

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.

During our inspection we spoke to staff at all levels of the organisation and they exhibited the necessary skills and knowledge to manage the services for which they were responsible. They were knowledgeable about any challenges and issues and spoke confidently, and consistently about proposed solutions.

Leaders were recruited to meet the requirements of the role through robust procedures and against job descriptions and person specifications. Many had been supported to progress through the organisation to senior roles.

Senior staff were often present on site and staff told us that they had no worries about speaking to them if they had concerns.

Following our previous inspection, the organisation had strengthened its management arrangements Governance arrangements were now through a central team to increase quality monitoring, policy development and review and risk management. There were two managers with safeguarding responsibility as well as a designated trustee. In addition, a trustee was assigned to each of the eight sub-committees to provide leadership and oversight.

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.

The service identified its vision as:

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

There was also a clear strategy to, when possible, deliver care closer to home and this was evidenced by recent, and continuing developments to strengthen the provision of outreach and hospice at home services. We saw that a new building had been built from which the outreach and hospice at home staff worked and that this had capacity for further staff to be employed.

These approaches had been developed through engagement with patients, their families, and the wider community where a clear desire had been expressed for improved access to services in patient's own homes. This was supported by the proposed use of a "community bus" to deliver services and clinics across the catchment area of the service, parts of which were rural and geographically isolated.

The vision had also been developed with commissioners and other stakeholders from the local health and social care economy. As a result, the vision was aligned with local health plans and had also responded to health professionals' requests to provide specialist education, advice and support.

Another facet of the vision was to engage with people to understand the service and what could be offered. The new building at Bicton incorporated a well-appointed and pleasant café which was available to, and used by, the public. This, together with the "community bus" was intended to break down barriers such as the fear and misunderstandings of hospice services.

Good

Hospice services for adults

Staff at all levels, to whom we spoke were conversant with and supportive of the vision and our examination of the notes of meetings demonstrated how it was being implemented.

Culture

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.

All staff spoke positively of their individual managers and the senior leadership team. They said that they valued the work they did and in turn felt valued by their colleagues and their managers.

The turnover of staff was very low and while staff described some stresses and frustrations these were largely external to the organisation or as a result of the pandemic. Staff were, without exception, proud and happy to work for Severn Hospice. We were told it was the best job they had ever had, the most satisfying job they had had. Newer members of staff told of their pleasure at securing a post or placement as it was seen as a place to aspire to work with high standards.

Throughout the inspection we saw that staff at all levels and in all disciplines worked well together and had the needs of patients and their relatives at the heart of what they did. This was very clear in, for example, the shift handover meeting. We saw that the needs of the patients and their relatives for the upcoming shift were explicitly described and plans made with empathy for the patients and relative's needs.

Staff were often promoted from within and we noted that this was the case for several very senior managers and executives. Other staff told us that their careers had been progressed through training and with financial support to obtain qualifications.

Staff told us that they were encouraged to raise issues that concerned them without fear of it harming their careers. When we looked at the notes of governance and safety meetings we could see that this was the case as many issues had been raised by staff or patients and appeared to be discussed openly without personal criticism.

Managers valued staff wellbeing in order 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 all staff and volunteers were supported at Severn Hospice. Providing staff support was paramount to ensure the well-being of staff was valued within the Hospice and staff were supported to provide high quality of care. The hospice provided up to six hospice counselling sessions for each staff member annually, mental health first aiders, clinical supervision and peer support.

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.

Following our last inspection, the service had identified the need for more robust governance arrangements. Governance arrangements were now through a central team to increase quality monitoring, policy development and review and risk management. This 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 systems had been introduced to review policies and procedures to ensure they met best practice, new legislation, national standards or latest guidance and ensure they were updated. Information provided by the service following the inspection confirmed all policies had been reviewed and updated.

The board of trustees and the clinical governance group met quarterly to review the quality and safety of the service. The clinical group reported to the board of trustees. The service had separate committees and groups which met more frequently and fed into the clinical governance committee and leadership meetings. For example, there were medicines management, infection prevention and control, health and safety and audit and risk groups. The latter 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 the 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, July and October 2021. Each meeting had standing agenda items which included but were not limited to activity monitoring and audit, risk management, and reported incidents, including those involving medicines, 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. They were formal meetings and minutes were taken and circulated. 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 with 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.

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 improved governance arrangements provided greater assurance for identifying, recording and managing risks, issues and implementing mitigation. 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 and operational risks. Some of the reports received included medicine errors and service reviews. 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. Staff told us confirmed they received feedback from audits.

Staff told us 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. The information systems were secure. Data or notifications were consistently submitted to external organisations as required.

Performance data to measure the performance of the service was being collected, monitored and reviewed. 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 including tThe Care Quality Commission.

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 organisations and with service users.

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

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

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 at 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.

Good

Hospice services for adults

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 improve the service provided. The community bus would 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. The community bus was planned to commence in the summer of 2022.

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.