Longfield Hospice Care

Longfield

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Outstanding
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 10 and 11 March 2016 and was announced. We gave the registered manager 48 hours' notice of the inspection because we wanted key people to be available. The Hospice at Home service provided short-term care for people with a rapidly deteriorating condition in the last three months of life. The service supports people in their own homes, or the place where they live and works in conjunction with GPs and community based nurses.

The service also runs a day therapy service, an outpatient service and a counselling service for people who have life limiting or life threatening conditions. These services do not come within the scope of registration with the Care Quality Commission. We have however spoken with some people using the day therapy service in order to gain a broad view of "people's experience of using Longfield". Longfield is a purpose built facility, has a pleasant and relaxing atmosphere and surrounded by beautifully maintained gardens.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the time of the inspection the hospice at home team were supporting seven people. They have at times helped up to 25 people at the same time. The criteria for receiving this service was the person was in the last three months of their life. The average length of time people received support from the hospice at home team was seven days in 2014/15. Health and social care professionals referred people to the service for support and the district nurses were the key workers. Hospice at home staff worked in partnership with the district nurses.

People who used the service were safe. This was because the nurses and healthcare assistants were trained on how to safely use any moving and handling equipment and had received safeguarding adults and children training. Risks to people's health and welfare were well managed. Safe recruitment procedures were followed to ensure that only suitable staff were employed. The appropriate steps were in place to protect people from being harmed.

People were safe because the staffing levels were sufficient. The service offered to support people at the end of their lives only when there was sufficient staff available to meet their needs. The service had a flexible workforce in order to be able to accommodate demand for the service.

All staff completed a programme of essential training to enable them to carry out their roles and responsibilities. New staff completed an induction training programme and there was a programme of refresher training for the rest of the staff. Staff received palliative and end of life training and had the necessary skills and qualities to provide compassionate and caring support to people and their families. Bereavement follow-up is an opt-out service. They automatically follow up all families and carers of people

who have died and been supported by Longfield .

People were supported to make their own choices and decisions where possible. Staff understood the principles of the Mental Capacity Act (2005). Where people lacked the capacity to make decisions because of their condition or were unconscious they worked within assumed consent but checked with healthcare professionals and family members before providing care and support.

Where identified as a care need people were provided with the assistance they needed to eat and drink. Staff liaised with the district nurses and the person's GP when needed. Staff worked in partnership with healthcare professionals and families to be supportive and provide an effective service.

Because of the nature of the work the hospice at home team undertook the staff team developed good working relationships with the people they were looking after and their families. These working relationships were short but intense. Staff were well supported emotionally by their colleagues and managers.

People were provided with a personalised service that met their own individual needs. People were included in decision making about the support they, and their family needed. The hospice at home staff worked in partnership with the district nurses and ensured important records they kept about peoples care was shared between all agencies. Communication between nurses, healthcare assistants and the office ensured that significant information was reported and changes in people's health was reported.

The service was well led with dedicated, compassionate and experienced good leaders and managers. All staff had a passion for providing a quality service and ensuring people had a good death. Where things did not go as well as expected, they looked at the reasons why and made adjustments accordingly. There was a continual programme of review to drive forward improvements.

People's views and opinions were at the heart of the service provision. There was a variety of means of gathering feedback from people who used the service about how they felt about the service. All feedback that the service received was used to drive improvements. The service used a "You said….We did" approach to any critical comments made.

Longfield (the whole hospice service) worked in partnership with other care providers and also helped other care services attain the Gold Standards Framework in End of Life Care. This partnership arrangement enabled the service to share good practice with other care providers and improve standards for people who were at the end of their lives.

The service had a regular programme of audits in place but this was being expanded to align to the fundamental standards, the five key question areas and the key lines of enquiry.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People received care from staff who were trained in safeguarding and would act to protect people from being harmed. Recruitment procedures for new employees were safe and ensured suitable staff were employed.

Any risks to people's health and welfare were well managed. People were not on the whole assisted with medicines but qualified nurses supported them when necessary.

The service had a flexible workforce. There were always sufficient numbers of staff with the required skills and experience to meet people's needs safely.

Is the service effective?

Good

The service was effective.

People were looked after by staff who were well trained and well supported to carry out their jobs. Staff had the qualities and skills to provide compassionate care and support

Staff understood the importance of obtaining consent from people before helping them. The service was aware of the principles of the Mental Capacity Act (2005).

People were provided with support to eat and drink where this was needed and supported to see their GP and other healthcare professionals as required.

Is the service caring?

Outstanding

The service was caring.

People were treated with respect and kindness and were at ease with the staff who were looking after them. The staff not only cared for the 'service user' but also other family members who were affected by the imminent death of a loved one.

The staff team had good relationships with people and talked

respectfully about the people they looked after. They were compassionate about their role and getting the care and support right for the person and their families.

Is the service responsive?

Good

The service was responsive.

People and their families received the care and support that met their specific needs. The service was adjusted to take account of any changes in people's needs.

People were listened too and staff supported them if they had any concerns or were unhappy.

Is the service well-led?

Good

The service was well led.

Feedback from people who used the service and their families was regularly gathered and used to make improvements to make the service better.

There was a good management structure in place. Staff were provided with good leadership and supported to provide the best quality care.

There was a programme of checks and audits in place to ensure that the quality of the service was measured. Any accidents, incidents or complaints were analysed to see if there was any lessons to be learnt.

Longfield

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was announced and was undertaken by two inspectors and an expert by experience. An expert by experience is a person who has used this type of service in the past. The previous inspection of Longfields was in December 2013. There were no breaches of the legal requirements at that time.

Prior to the inspection we looked at the information we had about the service. This included notifications that had been submitted by the service. Notifications are information about specific important events the service is legally required to report to us. We reviewed the Provider Information Record (PIR). The PIR was information given to us by the provider. This is a form that asks the provider to give some key information about the service, tells us what the service does well and the improvements they plan to make.

We contacted four health or social care professionals and asked them to tell us about their views of the service. Their comments have been included in the body of the report.

During our inspection we spoke with 17 people who were using the day therapy service and five relatives who had previously been supported by the Hospice at Home team. We spoke with 18 members of staff plus the registered manager and the Chief Executive.

We looked at four people's electronic care records. We looked at six staff employment records, training records, policies and procedures, audits, quality assurance reports and minutes of meetings.

Good

Is the service safe?

Our findings

People using the Hospice at Home service, day services and the drop-in service said they felt safe because "they were surrounded by staff who understood their needs and knew how to support them physically, mentally and emotionally". Comments from people and relatives included, "Very confident that (person's name) was safe in the hands of caring experienced staff", "I was happy to leave my wife with the staff knowing that she was safe and being well looked after" and "Safe beyond doubt. I cannot speak too highly of the safe care that he was given".

The service had a safeguarding policy and procedure in place. Information about this was on display in the staff room and staff we spoke with referred to its location. The policy was reviewed regularly to ensure it linked with and reflected countywide policies and procedures. A senior manager had been identified as safeguarding lead and had received accredited training from Gloucestershire County Council. They were able to deliver training to the rest of the staff team. All staff received safeguarding training and were aware of their responsibility to keep people safe. Staff also completed child protection training because some people supported may have visitors to their homes who are children.

Staff knew about the different types of abuse and what action to take if abuse was suspected, witnessed or alleged. They said they would report any concerns they had to the clinical coordinators, the hospice at home manager or the registered manager. Staff were aware they could report directly to the local authority, the Police or the Care Quality Commission.

Staff files were checked to ensure safe recruitment procedures were followed. The measures in place prevented unsuitable staff being employed. Each file evidenced appropriate pre-employment checks had been completed. Disclosure and Barring Service (DBS) checks had been carried out for all staff. A DBS check allows employers to check whether the applicant had any past convictions that may prevent them from working with vulnerable people.

Staff were trained to safely use any moving and handling equipment including hoists. The service had six members of staff who were moving and handling trainers and all staff were trained with any equipment before they were able to use it. This ensured people were assisted properly and were not harmed by being moved incorrectly.

Risk assessment and health and safety systems were in place and were subject to regular review. A designated senior manager had responsibility for health and safety and attended health and safety meetings. This enabled them to share information with other areas the service provides. Risk assessments were included as part of people's assessments and care records. These were reviewed and amended whenever there was any changes or developments in the person's care and support needs. Risk assessments were completed in respect of moving and handling, the likelihood of pressure damage to skin, falls and nutrition. Where people needed to be assisted to transfer or move from one place to another a plan was written detailing equipment and the number of staff required.

Because staff supported people in their own homes an environmental risk assessment was undertaken. These covered both the external and internal aspects of the home. We discussed with the clinical coordinators an expansion of these assessments since staff worked alone with people, particularly at night. These assessments could record the location of water stop cocks and the fuse box, in case of emergencies.

The service had a disaster recovery plan and a major incident plan. This covered IT failure and an adverse weather policy. The service has a group text system in place where there were able to message all staff and inform them of any changes. This meant the service would still aim to deliver what was expected of it during difficult circumstances.

The hospice at home staff team consisted of a hospice at home manager, three clinical coordinators, nurses and health care assistants. The team was made up of 21 permanent staff and 13 bank staff who informed the team of their availability each month. The aim for those staff who had contracted hours was to work on a four days on, four days off basis. This meant people would be supported by the same staff. By having a flexible workforce, the service was able to respond to demand for assistance from this team. People receiving support were generally allocated two, three or four visits per day dependent upon their needs. During the day all calls were covered by two staff members – this could be a mix of clinical coordinator, nurse or healthcare assistant. There were two clinical coordinators available each day, one working with the team in the community and the other office based or out visiting people and completing assessments. Night cover was provided either by nurses of healthcare assistants. Overall, there were always enough staff with the required experiences and skills to enable them to support people safely.

Longfield staff supported and enabled people to manage their own medicines. This remained the responsibility of the district nurses or family members who arranged for their supply, administration and disposal. However nurses who worked for the hospice at home team received syringe driver training in case they needed to attend to a syringe driver or replenish medicines. Healthcare assistant did not provide any support with medicines. All documentation to do with medicines belonged to the district nursing service.

Good

Is the service effective?

Our findings

People told us they had been involved in making decisions about their care and support. They said this had been a two way process and that their decisions were respected. Much of the feedback we received regarding the hospice at home service was from relatives whose loved one had already died. They said, "On the first morning looking after my wife there were two nurses. She needed expert nursing. The carers and the district nurses were all very good, very skilled and knew exactly what to do", "'Care and support was fully discussed with (person's name) throughout", "It was a struggle to nurse (person's name) so when he came out of hospital the Hospice stepped in to help me. I let them take over the night care. Could not speak highly enough of them", "When care at home was discussed we were fully involved. When anything changed we were consulted and things were agreed. We felt part of it" and "In terms of care and support they treated the whole family as one entity".

Other positive comments we gathered prior to the inspection included, "The professional care provided by Longfield was excellent and positively impacted on the life of the whole family", "People are supported by staff who are well trained and have the necessary skills to care for them" and "The quality of care and compassion is top notch".

Comments from health and social care professionals were, "Longfield provide a fantastic service with amazing facilities and a keenness to expand in to non-cancer services. Also to ensure areas which are geographically isolated are included", "When I have had a patient deteriorate quickly and have needed to arrange funding for care, Longfield will commence the service prior to funding being agreed. This is important when dealing with end of life care" and "The feedback we get from families whose loved one has died is always positive. People are supported to have a good death".

Staff told us, "I know that the job I do makes a real difference to a person's last days and to the families they leave behind", "Working for Longfield gives me tremendous job satisfaction which means I can provide a much better service" and "We enable people to die in their own homes and this is very important to them".

All staff had a programme of mandatory training to complete. Training records were kept for each staff member and the service was in the process of implementing a learning management system that would help in identifying when refresher training was due. Newly recruited members of staff had induction training at the start of their employment. Their training was aligned to the new Care Certificate that was introduced in April 2015. The Care Certificate covered a set of standards that social care and health workers must work to in their daily working life.

Training was delivered by a mixture of face to face 'taught' training, self-directed training and computer based training programmes. This included moving and handling, equality and diversity, health and safety, information handling, safeguarding adults and children, the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and infection control. There were staff champions or designated lead roles in infection prevention, moving and handling and safeguarding with the aim of embedding responsibility and compliance across the team. Staff were released to attend training and conferences, in order to maintain

knowledge and skills. Their learning was then shared and cascaded across the team and the other areas of the service.

All staff completed end of life training and grief and bereavement training. Their knowledge was then checked against a set of palliative care competencies. Qualified nurses were being supported to comply with the Nurses & Midwifery Council revalidation process being implemented from April 2016 onwards.

There were a range of measures in place to support the staff team to do their jobs effectively. Individual staff appraisals were undertaken on a yearly basis and included objective setting, feedback on performance and encouragement for continued professional development. Identified staff had completed appraisal training during 2015 to increase their knowledge and understanding of the role and importance of appraisal. Also during 2015 a new practice support policy was introduced (clinical supervision) and this was used to promote a culture of continuous learning. There had been a review of the practice support in December 2015 and where shortfalls in the process had been identified, adjustments were made. A further review will take place in 2016. Staff were also able to access group supervision on a regular basis. Staff told us they were well supported, were given plenty of opportunities to 'de-brief' after a difficult death, and therefore were prepared to then go and look after the next person who needed support.

Each person was assessed as to whether they had the mental capacity to make decisions for themselves as part of the process of setting up a service. Staff received training on the Mental Capacity Act 2005 (MCA) and knew the importance of gaining consent before they provided any care, support and treatment. MCA legislation provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions for themselves. Staff talked about assumed consent when supporting people who were unconscious and at the very end of their live.

The registered manager and the clinical coordinators that we spoke with were familiar with the DoLS legislation. DoLS is a framework to approve the deprivation of liberty for a person when they lacked the capacity to consent to treatment or care. People were being looked after in their own homes or a place where they had lived prior to entering the end stages of their life. Hospice at home staff were familiar with DoLS and aware that people's safety was paramount when they could not consent to care and support.

People were assisted to eat and drink where required. Nutritional needs were identified as part of the assessment process. These were recorded on people's care plans and included their preferences and choices. Where people were unable to eat and drink, mouth care and oral hygiene were provided in order to keep people comfortable.

The staff from the Hospice at Home team worked collaboratively with the person's GP, district nurses and other relevant health and social care professionals. The district nurses tended to be the lead professional. A Hospice at Home service was not only provided to people in their own home. They could deliver their service into other care service to help the person remain where they have been looked after and knew as their home. Where people had learning disabilities, the staff worked collaboratively with community learning disability nurses.

Healthcare professional feedback was mixed in respect of communication between the different agencies. Community nurses felt there was constant communication between the Hospice at Home team and themselves, "We are always informed of any changes in people's condition". They referred to shared care records. Others felt that some improvements were needed with communication to ensure there was a joined up approach. They referred to clinical documentation and not having access to each other's documentation. The registered manager talked about the electronic patient record system and the work

with the clinical commissioning group to "join up relevant records". Information provided by the registered manager prior to the inspection referred to the new shared care records. Longfield staff had worked as part of the Gloucestershire education partnership in promoting and supporting staff to use the new document.

Outstanding ☆

Is the service caring?

Our findings

People spoke highly about the care Longfield provided, using such words as exceptional, brilliant and astonishing. They told us they were well cared for by staff who knew them well and who supported them in a caring and dignified way. People felt they were listened to and were involved in the process of organising their care.

Relatives made the following comments, "Our relationship with the carers was astonishing. Because of them it became a joyful experience", "I can't praise the carers enough. Their actions made her comfortable. Even when she was very ill and nearing the end of her life they still made her smile", "The carers were all very nice. I look back with affection for what they did. The carers went that extra bit and stayed with us during his last few hours" and "The carers and nurses were all so happy and it didn't seem as if he was being nursed, rather as if people were coming to visit him".

We were shown the folder containing complimentary letters and cards that had been received by the service. We noted a few of the hand written comments: "I wish to write my heartfelt thanks to the hospice for the support you gave my mum. It gave my mum security and company. It gave us restful nights. Thanks once again", "On behalf of the whole family I would like to thank you all most sincerely for all the excellent care you gave to my husband. Your team of helpers gave us invaluable help during his last days and helped us immensely to ensure he passed away with serenity and dignity in his home with the family he loved" and "We were very impressed with the standard of care, cheery but dignified disposition of the staff and dedicated care that we received. Your help was invaluable especially at such a difficult time. You do a marvellous job and we admire your commitment".

Staff we spoke with were passionate about getting end of life care right as "We only have one go at this". One staff member came to Longfield specifically to see the inspection team because they wanted to tell us, "As a team we are so committed to getting the care and support right. All the staff are hand- picked and have compassionate and caring qualities". Another member of staff said, "I love my job at Longfield, it can be emotional but I am fully supported by my clinical coordinator". Staff spoke about the people they had supported and those they were currently looking after in a respectful manner and several of them said they would recommend the service to others.

Healthcare professionals said, "They offer continuity of care to the patients and their families and we often have feedback from families about how this made caring for their relative a good experience" and "Families felt well supported and developed good working relationships with the staff who often went the extra mile to ensure quality care was provided".

We saw plenty of positive interactions between the staff and those people using the day therapy service. We sat in on a meeting at the start of a day therapy session where the staff were discussing the people who were attending that day. Staff were knowledgeable about the people they were going to be supporting and spoke about them with respect and in a dignified manner. One of the people had requested their information not be discussed when CQC inspectors were present and this was respected by all the staff. Although these

people were not using the hospice at home service, it demonstrated how the staff who worked for Longfield interacted and cared for people.

The families of people who have died were offered bereavement support after death. This may be just a bereavement follow up telephone conversation, the level of support would depend on what the family wanted. Where children had lost a parent, the service introduced specialist children counselling services. Another example of how the service supported the family of people who were at the end of life was the provision of a respite service. This would enable the caring relative to attend counselling sessions at Longfield (pre-bereavement counselling). Counselling can be on a one to one basis or as a bereavement support group. One relative told us they had been offered the service and were going to take up the offer. They added, "All the staff have had a huge input our lives for the last couple of months because of (person' name) whereas this is about supporting me. They care about me too".

Because of the intense and close working relationship that staff formed with the people they were looking after and their families, it was emotional and sad when that person died. Whilst the staff team recognised the importance of post-death support, there were clear boundaries in place to work towards ending that relationship. The team told us how they had recently looked after and cared for, the body of a person who had died during the night when they were not there. They did this to prepare the body for young children to see, so they could say their goodbyes. Officially the 'service user' had died and no longer required a service however out of respect for the whole family, the staff had provided this support. The hospice at home team would provide this support as and when appropriate The registered manager spoke about the boundaries and talked about the work in progress to ensure staff were emotionally supported and not overwhelmed by the families left behind. The team were more often than not invited to attend the funeral to pay their respects. Staff told us "they would if they were able" but acknowledged they were unable to attend all funerals. One of them added, "We have to be available to support the next person and family who need our care and support".

Good

Is the service responsive?

Our findings

People told us they received the care and support that was meeting their needs. Relatives of people who had previously used the service made the following comments: "A brilliant arrangement of care from the beginning. Expert nursing based on what was needed", "When things changed, they bent over backwards to provide whatever we wanted" and "The experts arrived with all the equipment they needed and provided the care she needed". The families said that symptom control and nursing care had been good and they had been able to access counselling services and psychological support.

People told us they were aware of who to speak to and how to raise a concern if they needed to. No one we spoke with had ever had any concerns or needed to complain. People felt that the staff would listen to them if they did and that issues would be addressed.

Each person's care and support needs were fully assessed by one of the clinical coordinators prior to the commencement of care. The service provided was based upon the person's specific needs and the support required by the family. The aim of the service was to look after the person, enable the family to take a break and have a rest, and to support their wish to die at home. Visits by hospice at home staff were provided during the day or overnight if needed which enabled people to be cared for and die at home.

People had their care and treatment needs reviewed at each visit. The healthcare assistants and clinical co-ordinators discussed with people their health needs and had positive communication with the district nurses. People were encouraged to have input into their own care plans and clinical co-ordinators were able to discuss this whilst out on home visits. Staff said they had sufficient time allocated to spend with people. Their visit times ranged from 35 to 60 minutes, depending upon the person's care and support needs. The care visit to each person being supported would be made by one of the clinical coordinators at least once a week. This ensured that the service provision always remained appropriate and remained responsive to people's changing needs.

Where there were changes in people's condition, staff used a secure email and text messaging service in order to keep in contact with the clinical coordinators and the hospice at home manager. After people had been cared for overnight by a healthcare assistant, they reported back to the clinical coordinators to ensure that information of significant changes were communicated to the next members of staff who visited. This meant that service was able to adapt to any sudden changes because the clinical coordinators were able to instigate changes to service delivery promptly.

Multi-disciplinary team (MDT) meetings were held on a two weekly basis and covered all of the hospice services. The outcomes were recorded in the person's electronic care notes. The meeting was chaired by the hospice at home manager and cases were presented by the person's keyworker. GPs, district nurses and clinical nurses specialists could be involved in these meetings. However referrals to the Hospice at Home service were managed on a daily basis in order to remain responsive. Some of the referrals did not meet the criteria for the service and those people would be redirected to other care providers. One healthcare professional who provided us with pre-inspection feedback told us they were unclear why some people they

referred to the service were passed to other providers. This may because of geographical location or capacity. Not only did these meetings discuss those people who were currently being supported but also people the service had recently supported – post-death analysis. The MDT was used as a learning and reflective opportunity for teams - the process allowed team to look at how things had gone and identify where things could have been done differently or better.

People we spoke with felt able to raise any concerns or complaints they had with the staff and were listened to. They were given leaflets that explained what to do if they had concerns or a complaint about the service they were provided with. Their complaints policy stated any complaints would be acknowledged within two working days and a written response would be provided within 20 working days. If any investigation was going to take longer the complainant would be updated and given an indication of how long it would take for the issue to be resolved.

In the last 12 months, Longfield had only received one formal complaint that could be attributed to the hospice at home team. The complaint had not been about the care and support provided by the staff team, rather an administrative issue that had caused confusion. The family of a person who had previously used the service was sent a follow-up letter one year on from the death of their loved one. The letter had been an acknowledgement of the one year anniversary of the family members passing. The letter had been sent by Longfield however the family were supported by Cotswold Care Hospice (the service changed its name to Longfield in 2015). Because this complaint had been logged we were able to track how that complaint had been handled and measures they were taking to ensure they did not upset another family. The registered manager used information gained from any complaints to drive improvements.

People, and their families, were asked to share their views or make comments during their care visits and reviews. This enabled the service to be responsive and make changes based upon how people felt and the service they said they wanted.

Longfield had a feedback questionnaire which was used regularly. This provided them with the opportunity to listen to any recommendations from people who used the service and their families. This enabled them to do things better and be responsive to what people wanted. An example of "You said….We did" the registered manager shared with us was about the use of language. People had commented that the use of goals and achievements in correspondence had meant they felt too much was expected of them. The service now referred to 'areas that you would like to focus on, or priorities' instead.

Good

Is the service well-led?

Our findings

Peoples and their relatives felt that Longfield was a well led service. They said it was easy to contact the management who were genuinely concerned about them and who were keen on establishing good lines of communications. They said the service was well organised and was focused on meeting peoples' needs. They said staff were kind, genuinely passionate about providing a good service and listened to what they had to say. People said they had been asked to provide feedback on the hospice at home service.

Comments they made included the following: "Must be well led because the service they deliver is excellent, and all the staff are happy and seem very settled", "'The place runs like clockwork" and "We have never once been let down by nurses or care staff".

The visions and values of the service were to ensure that each person received a service where they were placed at the centre. Assessment and regular reassessment ensured that support remained appropriate and took account of changing needs. The service planned to review their mission statement and their vision and values in order to reflect the ethos of all parts of the organisation. This work will be led by the staff forum. People's voice will be embedded in this review to influence the work of the hospice. The service was in the process of reviewing their current service user feedback form as they felt this was generally completed by the family and not the person they supported.

One healthcare professional commented about the educational sessions that were arranged by Longfield, and said there was a wide scope of subject matter. Specialists from the service in palliative and end of life care supported community based nursing teams to develop their knowledge and skills. This benefitted people receiving the service by ensuring they received the best possible care.

The registered manager was responsible for the hospice at home and the day therapy services. They were the line manager for the hospice at home manager. The hospice at home team consisted of three clinical coordinators (and one bank coordinator). These staff were qualified nurses and they provided a 24 hour on-call support network for the team. There was a team of 35 bank and contracted, nurses and healthcare assistants.

The registered manager was supported by a team of directors, heads of departments, the chief executive officer and a board of trustees in delivering a well led service. The registered manager shared with us the report of the annual visit by the trustee's dated March 2015. The trustee's had looked at service delivery, referrals to the service, care assessment, working relationships with district nursing services and the professional development of the staff team. There was no evidence of the trustee's having met with people using the hospice at home service. The registered manager was aware of the need for these trustee visits to the service to be aligned to the fundamental standards, the five key questions and the key lines of enquiry. Work was already in progress to address this.

The registered manager ensured that learning and messages were given to all staff. Members of staff were encouraged to raise concerns and challenge practice where they felt this was appropriate. Longfield had

developed a staff forum and representatives from the hospice at home team attended. The idea of the forum was to promote effective communication, by facilitating two-way conversations, organisational wide engagement and observations made. There were opportunities for discussions around staffing, welfare, health and safety and plans for the service. Staff told us they were listened to and their views were valued. We were given an example of a recent issue that had been raised in the staff forum. The hospice at home staff felt they needed to have 'company' mobile phones when they were working. Measures had already been taken to get this organised for the staff.

Staff we spoke with said their manager (they referred to the hospice at home manager and the director of care services – the registered manager) was approachable and felt they could take their concerns to them and be listened to. One staff member described the registered manager as approachable and measured. A staff survey was planned to take place in the summer of 2016 however all staff said they had plenty of opportunities to feedback about their job and the service they provided. The survey that will be used will compare the results of the Longfield survey against other hospice care providers. Staff said they were valued by the management team and "seen as an important part of the service ". Hospice at home staff had a monthly meeting with their manager and there were also weekly 'case load review' meetings.

The service was linked with Hospice UK. Senior clinical managers attend quarterly meetings within the South West who are affiliated to Hospice UK. The registered manager said this enabled the service to share, and learn about, good practices with other hospice service, use national documentation and look at effective governance measures. Longfield had contributed and supported the work to develop a countywide palliative and end of life strategy which will be published in early 2016. Longfield staff were involved with the Gloucestershire hospices education partnership and is a Gold Standards Framework regional centre, delivering nationally accredited training to other care providers. This work enhanced the ability of other care services to provide good end of life care. The hospice at home team was shortlisted for Team of the Year in May 2015 by the Gloucestershire Care Providers.

The registered manager was supported by a quality improvement lead and there was a programme of audits in place to check on the quality and safety of the service. The programme was in the process of being expanded and being aligned to the five key questions (Is the service Safe?, Effective? Caring? Responsive? and Well Led?). All the policies and procedures were kept under continual review. All new policies were circulated to the staff team and available as an electronic record.

Any accidents, incidents and near misses were reported in line with incident reporting procedures. Any events were reported to the hospice at home manager and follow up action was recorded. All reports required signing off by the health and safety lead person. In the three month period October to December 2015 there had been three accidents/incidents recorded. The health and safety lead had analysed the events. This was in order to identify any trends so that further occurrences could be prevented or reduced.

A copy of the complaints procedure was given to people and their families. Learning from any complaints was seen as a tool for driving improvements. There had only been one complaint in respect of the hospice at home team however all other complaints that the organisation as a whole had received, had been handled according to the complaint procedure.

The registered manager was aware when notifications of events had to be submitted to CQC. A notification is information about important events that have happened in the service and which the service is required by law to tell us about. This meant we were able to monitor how the service managed these events and would be able to take any action where necessary. The registered manager and hospice at home team were aware a notification regarding the death of a service user only had to submitted when the person died

whilst staff were in attendance and providing a service.