Dean Forest Hospice

Great Oaks Dean Forest Hospice

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?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 28 October 2016 and was announced. We gave the registered manager 48 hours' notice of the inspection because we wanted key people to be available.

The service provides a hospice at home service and a day hospice service. For some people 'out-patient' appointments were made for them to attend Great Oaks to see complementary therapists, nutritional therapist, a social worker, a nurse or to attend a clinic with doctors or specialist nurses. Other service providers within the Gloucestershire area provide in-patient services. The service is for people with a life-limiting illness. This includes malignant diseases (cancer) and chronic disease management, such as heart and lung failure and progressive neurological conditions. The service was not bound by strict criteria and people were not excluded from a service if they did not have the right condition. There was also an out-reach service where practical help from a volunteer or referral onto other services may be made and various support groups, including bereavement support.

Great Oaks is a purpose built facility, has a pleasant and relaxing atmosphere and is surrounded by beautifully maintained gardens. The service employs nurses, health care assistants, social care and allied health care professionals, complementary therapists and business managers. A team of committed volunteers support the day hospice, maintenance of the gardens and visit people in their own homes for companionship.

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. Their care was delivered by trained health care assistants or qualified nurses. This number varied from one week to the next. The criteria for receiving a service was the person was living with a life limiting illness. The majority of service provision was delivered overnight in order to provide relief for families. Health and social care professionals referred people to the service for support and whilst a hospice at home service was provided, the district nurses remained the lead health care professional. Hospice at home staff worked in partnership with the district nurses.

A day hospice service was provided on two days a week and people were allocated a place for 12 weeks on a Tuesday and Friday and on other days the premises were used by a variety of support groups. Examples of these groups included carers support, family support, friendship groups, drop-in coffee mornings, a breathe easy group, MS and MND support groups.

People who used the service were safe. Risks to people's health and welfare were well managed. Staff were trained on how to moving and handling equipment and had received safeguarding adults training. 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.

Staffing levels were sufficient and adjusted as and when necessary, to ensure people's needs were met. The hospice at home service had a flexible workforce in order to be able to accommodate demand for their service.

New staff completed an induction training programme and there was a programme of refresher training for the rest of the staff. Staff had the necessary skills and qualities to provide compassionate and caring support to people and their families. Families were assisted with bereavement support by the service where this was needed.

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

People were assisted to eat and drink where they needed this level of support. Those attending the day hospice were served a midday meal and given refreshments throughout the day. People had access to a nutritional therapist if there were concerns about diet and fluid intake. Staff liaised with the district nurses and GPs when needed. Staff worked in partnership with healthcare professionals and families to be supportive and provide an effective service.

Staff and volunteers were kind, compassionate and fully respected the people they were supporting. The hospice at home staff developed good caring, working relationships with the people they were looking after and also supported and cared for their families. People were supported to die in their preferred place because the hospice at home service were able to provide a service promptly. These working relationships could be only for a matter of days, but it was evident from feedback we received that these relationships impacted on the family members left behind. The families had extremely complimentary views of this service. Staff were well supported emotionally by their colleagues and managers.

People were provided with a service from Great Oaks that met their own individual needs. The service was delivered in the day hospice or in people's own homes by the hospice at home team. People were always 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 other health care professionals. Communication between Great Oaks and other professionals ensured significant information was reported and any changes in people's health were reported. This meant people continued to be supported in the way that met their needs.

The service was well led with good leadership and management provided by the registered manager and the other members of the senior management team. The service had a regular programme of audits in place. These ensured the quality and safety of the service was monitored so that adjustments could take place where needed.

The staff were dedicated and compassionate about their jobs and totally committed to getting it right. Where they were looking after people at the end of their life they ensured the person had a good death and their families were supported. Where things did not go as well as expected, they reflected on why this had been and took measures to do things differently next time. There was a continual programme of review to drive forward improvements.

People's views and opinions were gathered using a range of different methods. They were asked how they felt about the service they received and encouraged to make suggestions. The service also received feedback and suggestions from the user group, listened and took action. These measures ensured the service remained appropriate for what was needed.

Great Oaks worked in partnership with other care providers and hospice services in Gloucestershire. This enabled Great Oaks to share good practice with others, to learn from their improvements and improve care for people who were at the end of their lives.

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 hospice at home 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 were aware of the principles of the Mental Capacity Act (2005) and the need to obtain consent before providing care, support and treatment.

People were assisted to eat and drink sufficiently. The staff teams liaised with GPs and other hospital and community based healthcare professionals to ensure people's needs were met.

Is the service caring?

Good

The service was caring.

Feedback from all sources was overwhelmingly of the view that staff and volunteers were kind and compassionate and treated people well.
The staff and volunteers formed good relationships with the people they were looking after and their families. Staff talked respectfully about people and treated them with dignity at all

times.

People were supported at the end of their life and helped to have a dignified and pain free death. The service also looked after all their staff and volunteers and ensured their emotional needs were met.

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. Any complaints would be responded to and the issues used to drive improvements.

Is the service well-led?

Good

The service was well led.

People's voice was at the centre of all decision making. Feedback from all sources was used to make improvements to the service.

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

Great Oaks Dean Forest Hospice

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.

This inspection took place on 28 October 2016 and was announced. We gave the registered manager 48 hours' notice of the inspection because we wanted key people to be available. The inspection was undertaken by one inspector. The previous inspection of Great Oaks was in December 2013. At that time there were no breaches of the legal requirements.

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 health and social care professionals the provider had previously told us knew about their service. We 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 four people attending the day hospice service and five people using the hospice at home service or relatives who had previously been supported by them. We received feedback from three other relatives, either in person or via an email sent in to Care Quality Commission (CQC). We spoke with nine members of staff during our visit and this included the registered manager and two members of the board of directors. We spoke with three nurses by telephone and received email correspondence from other staff and volunteers, telling us about the service.

We looked at the care records for three people who received a hospice at home service. 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 or attending the day hospice were safe. This was because the provider had steps in place to ensure the places where staff worked were safe, any risks identified were well managed. People were supported by suitable staff (including volunteers) and there were sufficient staff to meet their care and support needs. Feedback we received included, "I am very safe when I come here, the staff are all very attentive", "I have no concerns when (named person) attends the day hospice, the staff all know how to move him in his wheelchair". Also, "When people are attending the day hospice they are supervised and not left alone at any time". One person who had used the hospice at home told us, "It was a pleasure having the nurses and care staff in my home. They all treated me well and were always polite and professional".

All staff were provided with a copy of the safeguarding alerter's guide. This advised staff on what to do if they became aware that a person they were supporting was being harmed and advised who to report to. The document needed to be updated as it referred to the previous commission and not the Care Quality Commission. The provider's safeguarding policy had been kept under regular review and was in line with Gloucestershire Council's safeguarding policies and procedures. The hospice social worker had been identified as the lead worker for safeguarding adults and had received additional training from Gloucestershire Council. They were able to deliver training to the rest of the staff team. All staff received safeguarding training every three years with an annual awareness session as part of mandatory updates.

Staff would report any concerns they had if they suspected, witnessed or it was alleged any person had been abused to their line manager or the registered manager. Staff were aware they could report directly to the local authority, the police or the Care Quality Commission.

Staff recruitment records were checked to ensure that safe procedures were followed. The measures the service had in place prevented unsuitable staff being employed and volunteers being used within the service. Each staff file evidenced appropriate pre-employment checks had been completed. This included a disclosure and barring service (DBS) check. A DBS check allows employers to check whether the applicant had any past convictions that may prevent them from working with vulnerable people.

Hospice at home staff were trained to move people safely. One of the nurses was the lead moving and handling assessor and trainer. They ensured staff were competent at using moving and handling equipment before they were able to support people. The district nurses were responsible for arranging the supply of any equipment in people's homes however nurses employed by Great Oaks can refer to the local council for assessment and provision of equipment. There was a supply of moving and handling equipment in the day hospice. The diversional therapist (an experienced occupational therapist) was part of the therapy team based at Great Oaks. All occupational therapy services were provided by a specialist occupational therapist based with the palliative care team at the NHS Trust. The measures in place ensured people were assisted properly and were not harmed by being moved incorrectly.

A full risk assessment of the person's home was completed at the start of the hospice at home or outreach

service. The assessment aimed to identify any risks both outside and inside the home. This ensured the person's home was a safe place for the hospice staff to work. Staff were expected to report any new or emerging health and safety risks to the coordinator so appropriate action could be taken to reduce or eliminate the risk.

All equipment the staff were expected to use was subject to regular maintenance checks and servicing. Records were kept of all fire, water, security and premises checks. The receptionist on duty managed entry in to the day hospice building. For people receiving the hospice at home service risk assessments that had been completed by the district nurses were included as part of the person's plan of care. These were reviewed and amended as often as necessary, when people's care needs changed. 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 their care plan detailed what equipment and the number of staff required.

The hospice at home and day hospice staff teams employed sufficient staff in order to be able to meet people's care and support needs. Some of the hospice at home staff were employed on a bank basis and informed the team of their availability each month. This meant the availability of staff to provide a service was able to expand in response to referrals. People were either supported by health care assistants or qualified nurses; this was dependent upon their specific care and support needs. The hospice at home service was provided during the day and overnight and resources were arranged on an individually assessed basis. The team had two coordinators plus up to 14 other members of staff. The service was expanding in order to meet demand and had recently recruited one new health care assistant.

The day hospice had sufficient numbers of staff and volunteers on duty based upon the numbers of people who were attending and people's specific needs. The team was made up of qualified nurses, art therapists and complementary therapists, allied health care professionals and volunteers. Volunteer's assisted with activities in the day hospice and during the meal time. One person said, "There are always loads of staff about to help you, just sit and chat with you, or help us get to the dining room for lunch". The provider had a volunteer co-ordinator who arranged when volunteers were available to work in the day hospice.

The day hospice staff did not support people with their medicines and no medicines were kept on site. However, some people who attended the day hospice needed to take medicines whilst they were there. The staff obtained written instructions from the person's GP regarding what medicines the person was taking to ensure, that if they had to support them, they did so safely and correctly. Lockable facilities were made available for storage of their medicines. In the community the responsibility for people's medicines remained with the GP, the district nurses or family members. Arrangements for their supply, administration and disposal of medicines did not sit with the hospice at home team. However, nurses who worked for the hospice at home team worked in collaboration with the district nurses. They received syringe driver training in case they needed to attend to a syringe driver and could replenish medicines whilst they were present in the person's home. Healthcare assistants 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

Feedback we received from people using the service, relatives, health care professionals, staff and volunteers was overwhelmingly positive in saying the service was effective. Comments we received included, "I am always asked what I want which means the service I receive meets my needs", "The hospice at home service does what it says on the tin. It allowed my husband to die in his own bed. That was so important to him. I would not have managed that on my own". Staff quotes were, "Great Oaks is very effective as it builds patients confidence, trust and physical and emotional well-being" and "We are a changing service and these changes are based on what people want from us. In recognition that not everybody likes to attend a day hospice we are trying alternatives, for example an outreach service in people's homes".

Hospice at home staff were proud of the job they did and were supported in order to do their job properly. One nurse told us they were able to provide a service quickly when people were in crisis and were "more effective that your standard domiciliary care service". This meant people's wishes to be looked after in their own home or supported to remain there for as long as possible, was achievable. They were referring to those people who had life-limiting progressive neurological conditions, who they supported to remain in their own homes.

All new staff and volunteers had an induction training programme to complete when they started working at Great Oaks. The programme consisted of a corporate induction day and was attended by all staff including volunteers. The day covered confidentiality, palliative and end of life care, staff boundaries and the mandatory training. All staff had to complete this mandatory training and there were annual refresher training days as well. Mandatory training for all staff included health and safety, risk assessments, fire awareness, safeguarding, moving and handling and infection control. Training records were maintained for each staff member. Nurses were supported with their clinical training and the Nursing and Midwifery Council (NMC) revalidation process.

Great Oaks had their own training suite and training was delivered via a range of different methods. There were taught sessions, training forums and e-learning courses. One staff member commented having face to face training sessions were of greater benefit to the staff team because staff were able to share experiences, and this provided a greater understanding or awareness of the subject. Other training sessions that were arranged included information governance, the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and infection control.

The training suite was also used by other external training providers. Examples of other care providers who have used the training suite include the NHS and the ambulance service. Training sessions arranged by Great Oaks were provided to their own hospice staff and to local care providers. One local care home manager wrote to us and told us their staff had attended end of life care training at Great Oaks and this had enabled them to develop their own practice, forge a link with the hospice team and support their residents with end of life care.

End of life care support forums were held on a monthly basis. Examples of some of the forums that had taken place in 2016 included skin care with radiotherapy, discussing difficult issues, oral care, living with motor neurone disease and supporting children when a parent is dying. Great Oaks was involved with a countywide palliative and end of life care training programme, working in collaboration with two other Gloucestershire hospice services. Examples of the training provided included syringe driver training, supporting bereaved adults, supporting the use of the best interest planning tool for people lacking capacity and shared care records. Feedback we received from staff included, "The manager is very supportive, the training opportunities are excellent" and "We use the internet to find out information if we are faced with new experiences and share information with the rest of the team". This meant the staff who worked for Great Oaks and the staff from other care providers, were well trained and able to provide good end of life care.

The provider supported the staff team well to do their jobs effectively. Individual performance appraisals were completed on an annual basis and objectives were set for the following year. These objectives included identifying performance and improvement plans so the staff member could be more effective, or specific training. Individual line management supervision sessions were also arranged in order that the aims of Great Oaks "to provide great care" were met by all staff. Staff told us they felt valued by the management team and encouraged to expand their skills and roles. Staff meetings were held on a regular basis and they were given plenty of support and opportunities to talk about their feelings after a death, particularly where things had not gone as well as they could have done.
Each person supported by the hospice at home service and day hospice was assessed to determine their mental capacity to make decisions for themselves. Mental Capacity Act 2005 (MCA) legislation provides a legal framework for acting and making decisions on behalf of adults who lacked the capacity to make decisions for themselves. A nurse from the foundation trust for Gloucestershire NHS had delivered (MCA) and Deprivation of Liberty Safeguards training (DoLS) to key members of staff earlier in the year. Those staff we spoke with knew the importance of gaining consent before they provided care or support. The registered manager and coordinator talked about when consent for a service had been given at the start of the service, if that person then became unconscious or was at the very end of their live, assumed consent was still in place. For those people who lacked the capacity to give consent, at the start of the service, the staff followed a best interest decision making process involving family and healthcare professionals. They did say this was not likely to happen.

The registered manager and both coordinators were familiar with the principles of the DoLS legislation however this was not relevant to the service they were providing. This was because people were being looked after in their own homes or were voluntarily attending the day hospice. DoLS is a framework to approve the deprivation of liberty for a person when they lacked the capacity to consent to treatment or care.

Those people attending the day hospice were served with a midday meal and refreshments throughout their day's attendance. Their nutritional needs were identified as part of the assessment process and if necessary, they were able to have a discussion with the nutritional therapist. One person said, "The soups are always superb". On the day of our inspection people were served with chicken, vegetables and mashed potatoes, followed by apple pie and custard. One person said the food was always well cooked and nicely served and added, "I don't eat very well on my own at home, so it is nice to come here and have such a lovely meal".

People who were supported by the hospice at home team were assisted to have drinks and food but the staff did not prepare meals. Any preferences and choices people had in respect of food and drink were taken in to account. Where people were unable to eat and drink, the nurses and health care assistants would offer mouth care and oral hygiene in order to keep people comfortable.

The staff from the hospice worked collaboratively with people's hospital consultants and oncologists, GPs, district nurses and other relevant health and social care professionals in order to ensure that their health care needs were met. For the people using the hospice at home service, the district nurses were the lead professionals for their care. Staff communicated with them after every visit to update them on the person's health status. Healthcare professional feedback was wholly positive about the services provided by Great Oaks. One healthcare professional said, "I have always found the service to be very easy to communicate with". Other comments included, "They provide a wonderful day hospice service", "The overnight care service is highly valued by patients and their families" and "The staff are professional and trained in the field they deliver (day hospice or hospice at home)".

Good

Is the service caring?

Our findings

People received a caring service from the staff at Great Oaks. People said, "As you make your way down the tarmac drive, you know you will be greeted with a warm welcome", "The staff and volunteers are so dedicated and always ready to listen" and "All of those who work for the hospice have people's very best interests at heart".

We spoke to one person who had previously used the day hospice service. They said, "I was so wrapped up in my own illness and failing health before I attended the day hospice. They helped me focus on 'Me' and get some purpose back in to my life". Another person who was attending the day hospice on the day of the inspection told us, "I am blown away by the kindness of everybody particularly the volunteers. They don't get paid to look after me, but they are so kind and caring". One relative told us their husband's attendance at the day hospice and the hospice at home service they received made all the difference to being able to manage.

One of the senior managers who had worked at Great Oaks for 12 years told us about the many positive differences the service had made to people's lives during a difficult period of time. They talked about one example where a married couple were enabled to carry on with their lives, in their own home, to attend a family wedding and go on a last holiday before one of them passed away. Post bereavement, the carer had been supported until such time as they felt able to carry on with their own life.

One volunteer told us the nursing staff were, "caring and thoughtful and showed empathy to the whole family". Staff from the hospice at home team were passionate about getting end of life care right. Those in the day hospice were passionate about enabling people to live a full a life as possible whilst living with their life limiting condition. It was evident from all the staff we spoke with and those who emailed us that they were proud to work for Great Oaks and felt their (staff) welfare was also of importance. One nurse said they had been "worn down" working for the NHS but at Great Oaks they were supported to do their job properly. They added, "We can really care about people, we have the time and the whole team, nurses and care assistants have the right qualities and skills for this work".

We made a note of some of the accolades made in complimentary letters and cards the hospice had received since the beginning of the year. Comments included, "Grateful thanks for the kindness and care", "you made my (person's name) dying wish achievable", "thank you for creating such a happy place (day hospice)", "a place that changes lives. I have the energy to carry on living and am getting the most out of my life now" and "I will never forget the kindness shown to me. You helped me get back on my feet".

One healthcare professional told us about a younger person they had on their caseload who had lost purpose and meaning to their life. They had attended the day hospice and Great Oaks staff had helped them renew a hobby. The person had previously played the guitar but could no longer hold the instrument, so they were introduced to the Ukulele. They now had enjoyment in their life, had joined a band and played gigs in local pubs. One of the therapists we spoke with told us about this person had been responsible for introducing the Ukulele to them.

The atmosphere in the day hospice was relaxed and welcoming. There was a lot of activity going on including an exercise and relaxation activity, an art class, a singing session and the midday meal. The staff and volunteers were caring and attentive towards the people who were there. They spent time with them and during the musical session, sat with those who could not participate and shared the song sheet with them. People did not have to wait for assistance as the staff and volunteers were able to predict people's care and support needs in advance. It was evident that staff knew people well.

We saw plenty of positive interactions between the staff and those people in the day hospice. It was evident the staff and volunteers knew about people's 'whole life'. One nurse said, "Great Oaks has a holistic approach to patient care which includes the patient's family". Staff asked about people's family, their pets and how things had gone in the last week. One person said, "They are always interested to know how I am and what has happened in the last week since I was here. Not my illness, but the things I have done". There was a great sense of community spirit amongst the staff. A volunteer told us they had been the carer for their partner before they had died and now wanted to "give something back to the service that had been so important during a difficult time". All staff spoke about the people they were looking after or supporting with respect and in a dignified manner.

Post bereavement support was offered to the family after the person had died. The level of support would depend on what the family needed. A family support and bereavement service was led by the social worker. The social worker contacted bereaved families six or eight weeks after the death and a card was then sent on the anniversary of the person's death. The families of people who passed away may be supported for a short period of time after, by the hospice at home service. If staff attended the person's funeral they went in their own time and were not representing the hospice. The coordinator from the hospice at home team explained that staff were not always able to attend every funeral therefore did not want families to feel "left out" if a representative from Great Oaks had not attended. This showed great compassion for families feelings.

An evening of remembrance was held each December and this year this will be held for the ninth time. The families were given the option to attend and to hear their relatives name read out. This was not a church service but a social function. If families were not able to attend they were given a bauble with a message inscribed on it to hang on their Christmas tree.

The coordinators for the hospice at home service were generally able to match their nurses and healthcare assistants to the person being supported in order to achieve the best possible working relationships. Where the team were supporting a person who was right at the end of their life, the staff formed intense and close working relationships with the person and their family. In all the feedback we received during this inspection, it was expressed how important these relationships were valued by the family left behind. Great Oaks looked after its staff as well as those people who used the service and provided them with emotional support during and after people died.

Good

Is the service responsive?

Our findings

People and their families said the service was responsive. They received the care and support that met their needs. The families we spoke with were very positive about the service they received or were still receiving. It was evident people received the level of service that had been agreed, no calls were missed (hospice at home), any necessary changes were well communicated and the service was adapted whenever any changes in people's needed were apparent.

As much as the hospice services hoped to meet every referral request, at times they were unable to do so. They told us they may signpost referrers to other hospice or care services. One of the coordinators told us there had been occasions when they had shared the care for one person. On occasions like this they would work collaboratively with the other care provider.

Each person's care and support needs were fully assessed by either the day therapy staff or the hospice at home team. The service provided was then based upon the person's specific needs and the support required by the family. People and their families told us the nursing staff always discussed treatment options with them. People were involved in making decisions about their treatment plans. They said they were able to ask questions about how the service could best help them. The therapy team were mainly complementary therapists. Occupational therapy and physiotherapy services were accessed from the NHS or social services. The diversional therapists used creative arts as therapy to help people and their families relax and relieve anxiety.

Prior to the hospice at home nurses and health care assistants attending to a new person, they were provided with a full history of the person and the details of the person's care plan. If people had not completed their advanced care plan, the nurses would broach the subject with them.

The day hospice provided care and support from the clinical team of nurses, social worker, complementary nutritional, and diversional therapists, and volunteers. Each person had their own individual plan of care. Assessments for the day hospice would be undertaken in the person's own home or during the first visit to Great Oaks. People attended the day hospice for a minimum of 12 weeks. Their care and support needs were reviewed every 12 weeks. The average length of attendance is from six months up to a year. Transfer to other hospice services for on-going support was common.

Those people who were supported by the hospice at home team had their care and support needs reviewed at each visit. The member of staff would complete a record of care after each visit but were expected to report any major changes to the person's by telephone to the office and the district nurses. The district nurses confirmed there was good communication with the hospice service. This ensured that service provision always remained appropriate and remained responsive to people's changing needs. One nurse told us they continually monitored, assessed and reviewed people whilst working in conjunction with families and other care services.

Each week there was 'whole hospice' meeting. Weekly evaluations were discussed for each person who

attended the day hospice and received support from the hospice at home team. There were discussions regarding any referrals to Great Oaks. When some referrals to the day hospice were not appropriate because the person was too poorly, the hospice staff would explore other ways they could support the person.

People and their families were provided with information leaflets telling them what they could do if they were unhappy about the service they received. The leaflet stated that Great Oaks valued any comments and idea's people wanted to share and used the feedback to develop the service to benefit others. For those people who visited the Great Oaks building there was a suggestion box in the main reception area where people could post their comments. No one we spoke with had any reason to raise concern or to make a formal complaint. They did make reference to the fact they would speak to a coordinator or a manager if they were not satisfied or had a suggestion to make. People and their families felt staff would listen to them if they did raise an issue and something would be done.

Their complaints policy stated any complaints would be acknowledged within two working days and a written response would be provided within 28 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 year Great Oaks had received three complaints – only one of these had been a formal complaint. However the registered manager had taken the opportunity to look at whether there were any lessons to learn from the issues raised for the other two. One of these had been in respect of attendance at the day hospice ending after the 12 weeks period. Action taken by the service was to ensure that people and families were made aware of these criteria at the start of the service. These criteria had also been shared with the district nurses and the GPs. The second complaint had been in regards of miscommunication about a person's mobility. The registered manager told us the member of staff had completed a reflective practice exercise in order that the mistakes were not made again. The third formal complaint had been raised by health care professionals after a family had raised the complaint with them. The registered manager had investigated the issues and submitted a report to the clinical commissioning group and was awaiting a final outcome. Records evidenced the actions taken. The registered manager used information gained from any complaints to drive improvements.

People were able to feedback about the service they received during their care plan reviews, by raising concerns or complaints and by making suggestions. The questionnaire survey asked about what worked well at Great Oaks, what didn't work so well and one thing the person thought would help Great Oaks grow and improve. Great Oaks gathered the views of people, their carers and families, staff and volunteers and other stakeholders on a regular basis. All the feedback was highly positive – "you offer a wonderful service, just keep going", "Nothing to change, it all worked well for me" and "Maybe a café where we could meet others in a similar position". A friendship group and coffee mornings are held each month. A whole review of service provision was completed on a yearly basis. A report of the findings was then presented to the board of directors. The team leader structure in the hospice at home service was being revised and additional day services were being introduced. This meant the board were aware of what changes could be made to their service in order to improve and enabled the service to be responsive and make changes based upon how people felt and the service they said they wanted.

Good

Is the service well-led?

Our findings

The feedback we received from people and families using the services provided by Great Oaks, the staff and health care professionals was that the service was a well led service. Comments made included, "The staff are extremely helpful and professional", "They provide the exact service they said they would", "We are always informed which nurse is going to visit us and they always telephone if they are going to be a little late" and "All the staff have the right qualities and skills and are totally committed to providing people with the best service possible".

The aim of the care provided by Great Oaks was to ensure the maximum quality of life possible during the person's stages of their illness in order that death could be achieved (when it came) with dignity and in their preferred place. This was a vision shared by all the staff and volunteers we spoke with and who emailed us and told us about their role in the service.

Great Oaks was committed to providing a service for people with life limiting illnesses who lived in the local Forest of Dean community. They had identified that the needs of people being referred to the hospice had changed over the years and that standard day care was no longer what people wanted. They had therefore taken steps to adapt their services to make sure people's needs continued to be met. In 2015, they had been contacted by five separate women, who had recently been diagnosed with cancer. They were each asking for help and support. As a result the hospice set up a support group for people with a newly diagnosed cancer. This support group provided a six week course helping people to prepare for treatment and gave them advice on relaxation, nutrition and healthy exercise.

Examples of other support groups the service have developed or hosted include post cancer treatment courses, sound relaxation sessions, a friendship group, mindfulness groups and a cancer rehab exercise group.

Great Oaks had a user group to ensure the voice of people and their families was heard when decisions were being made about the service and new initiatives. The group was called Butty's – this is a forest of dean term of endearment for a friend. During the last year the Butty advisory group had been involved in a compassionate community project, (involving the hospice service in activities within the community to raise their profile). For example, the Hello, my name is….campaign, communication strategies (removing jargon from information leaflets) and the formation of new support groups. The registered manager told us that those involved in this group were ex users of the service, and were enthusiastic and committed. She described them as "critical friends".

The chairman of the board of trustees ensured there was robust corporate governance in place. Corporate governance meetings were held on a quarterly basis and there was a standard agenda. The agenda was based on the CQC five key questions. Is the service safe? effective? caring? responsive? and well-led? The chairman also met regularly with the registered manager (clinical nurse manager), members of the senior management team, staff and volunteers to listen, advise and support as and when necessary. These steps ensured they were fully aware of how the service was functioning and how people using the services felt

about Great Oaks.

There was a management structure in place. The registered manager was responsible for the hospice at home and the day hospice but there were line managers in post for each of those services. The hospice at home team had two coordinators who organised the work of the nurses and health care assistants. The coordinators were qualified nurses and provided a 24 hour on-call support network for the team. Staff and volunteers were all positive about the registered manager and the senior management team.

The service was signed up with Hospice UK and staff attended conferences and meetings with the South West branch. These meetings enabled the service to share, and learn about, good practices with other hospice services. Great Oaks also worked in partnership with other Gloucestershire based hospice services, met on a bi-monthly basis and provided training sessions for the hospice services and other care providers. This work enhanced the ability of other care services to provide good end of life care for people.

There was a programme of audits in place to check on the quality and safety of the service. The outcomes of these audits resulted in actions plans being devised where improvements were identified. The audit programme enabled the registered manager and the board of directors to check the service remained safe, effective, caring, responsive and well led.

Any accidents, incidents and near misses were reported in line with Great Oaks reporting procedures. Any events were reported to the registered manager and follow up action was recorded. An analysis of the events took place on a monthly basis in order to identify any trends so that further occurrences could be prevented or reduced. The registered manager also managed any complaints or comments in the same way and reported monthly. A copy of the compliments, concerns and complaints procedure was given to each person and their family, whether they were using the hospice at home service or attending the day hospice. The registered manager used learning from any comments made about the service as an opportunity to change the way they do things for the better.

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 they only needed to complete a notification if a person died whilst staff were in attendance and providing a service.