

St. Gemma's Hospice

St Gemma's Hospice - Leeds

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location

Outstanding 

Are services safe?

Good 

Are services effective?

Outstanding 

Are services caring?

Outstanding 

Are services responsive to people's needs?

Outstanding 

Are services well-led?

Outstanding 

Summary of findings

Overall summary

Our rating of this service stayed the same. We rated it as outstanding because:

- There was a holistic approach to assessing, planning and delivering care and treatment to people who use the services. The safe use of innovative and pioneering approaches to care and how it is delivered were actively encouraged. All staff were actively engaged in activities to monitor and improve quality and outcomes. Teams were committed to working collaboratively and found innovative ways to deliver more joined-up care to people who use services.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers and went above and beyond what would have been expected to meet individual needs and wishes.
- Services were delivered in a way to ensure flexibility, choice and continuity of care and were tailored to meet patients' individual needs and wishes. The service planned and provided care in a way that fully met the needs of local people and the communities served. It also worked proactively with others in the wider system and local organisations to plan care and improve services.
- Leaders ran services well, led innovations and supported staff to develop their skills. Staff understood the vision and values, and how to apply them in their work. Staff were motivated to provide the best care they could for their patients. There was a common focus on improving the quality and sustainability of care and people's experiences. Staff were proud to work at the service and felt respected, supported and valued. Leaders operated effective governance processes and staff at all levels were clear about their roles and accountabilities. The service engaged well with patients, staff and the local community.

We found areas of good practice:

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

Summary of findings

Our judgements about each of the main services

Service

Hospice services for adults

Rating

Outstanding



Summary of each main service

- Our rating of this service stayed the same. We rated it as outstanding. See the summary above for details.

Summary of findings

Contents

Summary of this inspection

Background to St Gemma's Hospice - Leeds

Page

5

Information about St Gemma's Hospice - Leeds

5

Our findings from this inspection

Overview of ratings

7

Our findings by main service

8

Summary of this inspection

Background to St Gemma's Hospice - Leeds

St Gemma's University Teaching Hospice provides palliative and end of life care support to patients living in Leeds with a life limiting or terminal illness. The hospice has 32 inpatient beds, five of which were nurse led beds for patients without complex palliative care needs who wished to die at the hospice. At the time of the inspection the hospice had reduced bed occupancy to allow for social distancing requirements and was caring for up to 16 patients on the inpatient unit.

Facilities include an inpatient unit, community and specialist palliative care services, day and out-patient services. Services include complimentary therapies and emotional, spiritual and bereavement support. The Academic Unit of Palliative Care is managed in partnership with the local university and undertakes research projects and delivers training in a range of specialist palliative care subjects.

The chief nurse was the registered manager.

The service is registered with the CQC to provide:

Treatment of disease, disorder and injury

Diagnostic and screening procedures

How we carried out this inspection

We visited the inpatient unit and observed a clinical nurse specialist home visit. We spoke with staff delivering inpatient, community and bereavement services. We held interviews with service leads, executives and the chair of the board of trustees. We spoke with 35 staff and volunteers including clinical nurse specialists, nurse consultants, registered nurses, health care assistants, doctors, bereavement staff, catering staff, housekeeping and facilities staff, reception and non-clinical staff. We also spoke with three patients and two relatives who had experienced support from hospice staff. We observed care and treatment provided in the inpatient unit, reviewed data about the service and reviewed three patient care records and 12 prescription charts.

We undertook this inspection as part of a random selection of services rated Good and Outstanding to test the reliability of our new monitoring approach.

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

Outstanding practice

We found the following outstanding practice:

- The hospice worked to improve patient outcomes and care within St Gemma's Hospice and beyond, by undertaking research, publishing articles and sharing innovative practice. They benchmarked against other services and worked

Summary of this inspection

collaboratively with the wider palliative and end of life care systems within the community to develop standards and evaluate practice. They had a well-established approach to using outcome measurers and monitored and reported these using monthly dashboards. They used quality improvement activities to demonstrate care in line with published research.

- Staff demonstrated the highest level of compassion. There were examples of where staff had gone the extra mile to support patients and those close to them at the end of life. This included supporting patients to connect with estranged family members at the end of life. They had also expanded their bereavement services during the pandemic, including providing support for young people at risk of losing older relatives. Feedback from patients and those close to them was consistently positive.
- Services were delivered in a way to ensure flexibility, choice and continuity of care and were tailored to meet patients' individual needs and wishes. The service planned and provided care in a way that fully met the needs of local people and the communities served. The hospice had worked to increase the inclusion of underrepresented patient groups as part of their strategy. This showed that the hospice supported a higher proportion of patients from ethnic minority groups. They had also worked to increase access for older patients, those with dementia and patients who were homeless.
- Leaders ran services well, led innovations and supported staff to develop their skills. There was a common focus on improving the quality and sustainability of care and people's experiences, including in the wider community. They shared research, best practice and innovation to influence improvements to palliative and end of life care. In 2020 the hospice was 18th in the Times top 100 not for profit organisations. They had won the Nursing Times team of the year award in 2021, for the work undertaken on widening access for homeless and vulnerably housed people.

Areas for improvement

Action the service **MUST** take is necessary to comply with its legal obligations. Action a trust **SHOULD** take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.











Action the service SHOULD take to improve:

- The service should continue to review the safeguarding training needs of all patient-facing staff and meet the requirements as set out in national guidance.






Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Hospice services for adults	Good	Outstanding 	Outstanding 	Outstanding 	Outstanding 	Outstanding 
Overall	Good	Outstanding 	Outstanding 	Outstanding 	Outstanding 	Outstanding 

Hospice services for adults

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

Are Hospice services for adults safe?

Good 

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

Mandatory training

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

Staff received and kept up to date with their mandatory training. The training compliance rate was 90% which was in line with the hospice target. Training compliance ranged between 85% for information technology security and 100% for fire safety and manual handling. All other mandatory training compliance was over 90%.

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training modules included infection control, information governance, health and safety and equality and diversity.

Managers monitored mandatory training and alerted staff when they needed to update their training. They monitored non-compliance and took action to address shortfalls in completion. Mandatory training rates reports were shared at senior leadership meetings as part of hospice governance processes.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. All staff completed level one awareness training and clinical staff completed level two training. Some senior members of staff and social work staff had completed level three safeguarding training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff demonstrated a good understanding of safeguarding processes and gave examples of when these had been implemented.



Hospice services for adults

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff understood what constituted a safeguarding concern and knew how to escalate concerns internally and externally. External contact numbers were included in the safeguarding protocols for both adults and children.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There were clear flow charts on how to escalate concerns and staff completed standard referral forms which were routinely monitored by managers. There were clear contact details for raising alerts with external authorities and staff knew how to access these.

Staff followed safe procedures for children visiting the ward. They ensured all children were supervised by a parent or guardian.

Cleanliness, infection control and hygiene

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

Ward areas were clean and had suitable furnishings which were clean and well-maintained. We saw that cleaning standards were high, and the environment was tidy.

The service generally performed well for cleanliness. Monthly cleanliness and infection control audits were carried out. These showed performance was at 100% in September 2021. Hand hygiene audits for both wards was also at 100%.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. This included high touch areas such as door handles.

Staff followed infection control principles including the use of personal protective equipment (PPE). The hospice had undertaken a COVID-19 risk assessment and followed national guidance. PPE guidance was visible for each patient, depending on their COVID status and activities undertaken. There were clear PPE donning and doffing areas. Scrubs and uniform bags were provided to all clinical staff to reduce the risk of cross infection. There were arrangements in place to test staff and patients and there were screening processes in place for all visitors. Staff caring for COVID positive patients had received additional training. Rooms had been measured to ensure clear guidance for social distancing, with a maximum number of occupants clearly identified. Leads had been involved in a local outbreak planning group and an internal outbreak plan had been developed.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Clinical equipment was visibly clean, and 'I am clean' stickers were in use to demonstrate this.

Environment and equipment

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

Patients could reach call bells and staff responded quickly when called. Patients told us that staff responded promptly to any requests for help.



Hospice services for adults

The design of the environment followed national guidance. Due to the pandemic all patients were cared for in their own room and shared bays were not in use. As a result, bed availability had reduced from 32 to 20. Isolation arrangements were in place for patients who tested positive. In the event of an outbreak the hospice was to be zoned into COVID positive and negative wards.

Staff carried out daily safety checks of specialist equipment. They ensured that emergency equipment and essential equipment such as syringe pumps (for continuous administration of palliative and end of life care medicines) were routinely monitored, maintained and accessible.

The service had suitable facilities to meet the needs of patients' families. Families could visit in patient rooms during the pandemic and stay overnight when needed. Outside of these restrictions there were family areas accessible for loved ones to stay overnight.

The service had enough suitable equipment to help them to safely care for patients. Staff told us that equipment was readily available and there were no concerns with access.

Staff disposed of clinical waste safely. We observed appropriate segregation of clinical and non-clinical waste. Sharps containers were clean, labelled and not overfilled.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The hospice had implemented a modified early warning score in 2018, to support the identification of deterioration in those patients appropriate for medical intervention. The score was used to prompt appropriate escalation for active treatment interventions. In addition, they identified patients based on their phase of illness through regular monitoring of outcome scales and recognised patients who were in the last days of life.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. Staff knew about and dealt with any specific risk issues. For example, relating to sepsis, falls and pressure ulcers. They used nationally recognised risk assessment tools to identify risks associated with malnutrition, the use of bed rails and manual handling considerations.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. They had internal psychological support services and could refer patients for more specialist mental health support.

Staff shared key information to keep patients safe when handing over their care to others. Handovers included a holistic approach to assess physical, emotional and social needs and staff ensured these aspects of the assessment process bore equal weight in identifying risks to patient wellbeing.

Shift changes and handovers included all necessary key information to keep patients safe. Staff had enough time to share information during shift changeovers.

Nurse staffing



Hospice services for adults

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

The service had enough nursing and support staff to keep patients safe. Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Staffing levels were planned and reviewed so that patients received safe care and treatment. Data up to the end of September 2021 showed five whole time equivalent (WTE) registered nurse vacancies and 2.79 WTE healthcare assistant vacancies on the inpatient unit. Managers were actively recruiting to vacant posts and had appointed new staff. A monthly quality assurance scorecard showed that inpatient unit score was at 77% which was rated red. Managers told us they managed the risk by reducing the bed occupancy on the unit and monitoring dependency. For example, at the time of the inspection 15 of the 20 beds were in use due to the reduction in planned staff numbers and the impact of sickness and self-isolation on staffing.

Community and day hospice staffing was at 87% and rated amber. Allied health professional staffing was at 93%. Family support and spiritual care teams were at 100%.

The managers could adjust staffing levels daily according to the needs of patients. Patient dependency was monitored and there was an escalation procedure. This was utilised if staffing levels fell below planned numbers. Action included using nursing staff from other areas, staff taking on additional hours or the use of bank staff. Staffing levels were reported as an incident if they fell below a ratio of one registered nurse to six patients or in the community if clinical nurse specialist numbers fell below five. Other triggers included if a 'red flag' such as an urgent visit not taking place or a prescribing error in community, or delayed analgesia or missed care on the inpatient unit. Incident data showed that no such incidents had been reported in the year to date. Staffing concerns were escalated to senior staff or on call managers. There was a daily staffing huddle where senior staff reviewed the numbers in each department.

The number of nurses and healthcare assistants matched the planned numbers. Acuity and dependency tools were in use on the inpatient unit to monitor patient dependency and ensure that the planned and actual staffing numbers reflected need. Referrals were reviewed daily to ensure that appropriate staff to patient ratios were in place. Staffing rotas at the time of inspection showed that actual staffing matched planned levels.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service. They had regular bank staff who had received appropriate induction, training and support within the service. Agency staff were used when necessary, primarily to assist with one to one care needs.

Medical staffing

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

The service had enough medical staff to keep patients safe. The medical staff matched the planned number. Medical staffing was at full establishment with 3.2 whole time equivalent consultants and 4.5 non-consultant medical staff.

The service always had a consultant on call during evenings and weekends. The hospice consultants participated in a city-wide specialist palliative care consultant on call rota.



Hospice services for adults

Records

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

Patient notes were comprehensive, and all staff could access them easily. Patient notes were held on an electronic patient record system with appropriate access controls. Records were audited and results reported to the quality assurance group. The documentation audit was completed in October 2021, so had not been analysed and presented at the time of the inspection. Thirteen patients were included in the audit and documentations standards were assessed for every patient. Initial results showed that records relating to patient information, care plans and assessment and recorded outcomes measures were appropriately completed. Areas for improvement included consent to use medicines during admission and documentation of concerns about sharing data. Record audits were carried out routinely and leads told us that once the audit report had been completed, an action plan to improve would be implemented, with a re-audit date.

Patient care plans were reviewed as part of the ward monthly audits. Results for September 2021 showed that care plans and assessments were appropriately completed.

Records were stored securely. Electronic records were encrypted, and password protected. Paper records were kept locked when not in use.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The service had non-medical prescribers in addition to doctors. The service had a dedicated pharmacist team who worked at the hospice. Medicines were supplied by a combination from the local Trust, the local community pharmacy and direct from suppliers. The pharmacist was actively engaged in medicines optimisation and provided leadership and advice. A pharmacy technician ensured stock medicines were available and suitable for use. The pharmacist attended MDT meetings and worked with the senior leadership team to ensure the safe use of medicines within the service.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. There was an electronic prescribing system in place and prescribing was clear, safe and appropriate to be able to respond to symptoms that patients may experience during their stay. It was clear to staff which medicines were to be administered for which symptom and in which order. If medicines were not administered, reasons were clearly contained within the electronic record. Staff reviewed patient's medicines regularly and there was evidence of medicines being appropriately titrated to respond to patients' increasing symptoms or to take into account other medical conditions (for example renal or hepatic disease). This included prompt and adequate pain relief. People receiving medicines by syringe pumps (medicines delivered through the skin) were regularly monitored and although these remained on paper records, they were cross referenced within the electronic system to ensure people remained safe. The service allowed single nurse administration of Controlled Drugs to ensure that people received their medicines in a timely manner, and this was closely monitored. At discharge the patients were provided with a list of their medicines and how to take them.

People were able to access non-prescribed medication so there was no delay in getting medicines to treat minor ailments. Emergency medicines were available should they be required.



Hospice services for adults

The service had a medicines policy and staff followed it. Prescription stationery was safely stored and controlled.

Medicines were prescribed off-label and occasionally unlicensed medicines were used within the hospice. This means the use of these medicines is not covered by the manufacturer. This prescribing was guided by standard practice within palliative care and prescribers gave additional information to people if required.

Staff followed current national practice to check patients had the correct medicines, although there was no data available to see if this check (medicine reconciliation) was carried out in a timely manner. Ideally this should be completed within 72 hours to ensure that people's normal medicines are continued appropriately.

There was a procedure in place to allow people to self-administer their own medicines if they wished and facilities were available within people's rooms so they could keep their medicines safely with them.

The service had a system to ensure staff knew about safety alerts and incidents, however the service was unaware of an alert ensuring people who took steroids were adequately informed and carried an alert card. This should have been actioned by May 2021. Senior staff told us that at the time of the alert they were transferring from a paper to an electronic monitoring process. Following the inspection, we were informed that action had been taken to address the specific steroid alert by the pharmacist and that this was scheduled to be reviewed at the pharmacy group meeting the following week.

Staff reported medication incidents and near misses. Incidents were then reviewed at the Pharmacy Group Meeting. There was evidence that actions had been completed, processes revised, and learning shared with hospice staff.

There was active collaboration across the locality with participation in the evidence-based practice group and involvement at the Leeds palliative care network (LPCN) group. This group produced city wide guidance for safe prescribing and participated in cross site audits.

The service conducted audits to assess compliance against the medicines policy including management of Controlled Drugs. There was evidence that issues identified within these audits were addressed and learning shared.

All relevant staff had received medicines training including an annual update.

Incidents

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

Staff knew what incidents to report and how to report them. They reported all incidents such as patient falls, pressure ulcers, medication errors, breaches to personal protective equipment (PPE), information governance issues and near misses. Incident reporting within the hospice had increased as a result of managers encouraging greater reporting. For example, in 2019/20 161 incidents had been reported and in 2020/21 this had increase to 421, of which 53% were pressure ulcers with 70% of these acquired prior to admission.



Hospice services for adults

Staff reported serious incidents clearly and in line with hospice policy. One patient fall was recorded as a serious incident and appropriately reported externally in the year. All incidents were graded according to the level of harm in line with NHS and Hospice UK guidance.

There were no incidents classified as resulting in serious harm and 116 incidents classified as involving moderate levels of harm or risk. Of these, 103 related to pressure ulcers and the others involved infection control incidents due to the pandemic, falls, medicines and information governance.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. They apologised and shared learning outcomes with those involved.

Staff received feedback from investigation of incidents. Staff told us that learning was shared amongst the staff team. Learning from incidents was shared with staff through a quarterly report. Relevant incidents were discussed so that staff were involved in identifying the learning and improvements.

There was evidence that changes had been made as a result of feedback. Managers investigated incidents thoroughly. All clinical incidents were reviewed at a monthly incident review meeting attended by the senior clinical team. All moderate or severe Harm incidents were investigated, and the root cause of the incident was analysed. These were reported through the incident review group. Falls and medicine incidents were discussed at the falls and pharmacy groups respectively. In 2019 analysis of trends identified an increased number of falls at night on the inpatient unit. Staffing numbers at night were increased in response to this.

Are Hospice services for adults effective?



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

Evidence-based care and treatment

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

The hospice consistently identified and implemented evidence-based practices to support the delivery of high-quality care. The hospice had been awarded the status of University Teaching Hospice in partnership with the local university due to the active research and impact of the hospice's academic unit of palliative care and medical research team. The research team routinely undertook studies and published papers in a range of peer reviewed journals, focusing on improving the care of those approaching the end of life. Examples of published research articles included palliative care assessment of dry mouth; implementing person-centred outcome measures in palliative care; and, an analysis of the Electronic Palliative Care Co-ordination Systems (a method of recording individual's care preferences and key details about their end of life care) in primary care, which showed low and late uptake.

We saw evidence that the research contributed to improving the care of patients at St Gemma's. For example, we saw that internal audits had been implemented around mouth care and that the hospice had implemented comprehensive patient outcome measures to monitor care improvements over time. Hospice and academic unit leads used the results



Hospice services for adults

from studies as a basis for securing longer term research funding for ongoing research and further development of evidence-based practice. In addition, the hospice's academic unit were invited to submit evidence from all their research to the All Party Parliamentary Group on End of Life Care which made recommendations to the Department of Health, therefore influencing national policy and guidance with a view to improving care for patients both within and outside of the hospice.

We saw anticipatory medicines for pain management, breathlessness, nausea, distress and agitation were prescribed. These were given in line with the National Institute of Health and Care Excellence (NICE) guidelines for care of the dying adult in the last days of life and palliative care for adults. The hospice audited the use of these anticipatory medicines to ensure patients were benefitting from them. Additional audit had been carried out to understand the benefit of end of life care medicines for the treatment and symptom management of patients with COVID-19 in order to better understand symptoms and how to manage these for patients at the end of life.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. A monthly evidence-based practice group met to ensure that clinicians were supported to integrate latest evidence alongside clinical expertise. There was multidisciplinary membership of the group and it aimed to promote a culture of questioning and challenge. The group updated clinical guidelines and oversaw the clinical audit programme. Examples of policies updated in the last year included constipation in palliative care in line with NICE clinical knowledge summaries.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff had a good understanding of the act and described how they would take action to support patient's rights.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Bereavement and psychological support staff were available on the unit and involved in handovers and multidisciplinary meetings.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, particularly those with specialist nutrition and hydration needs. Patients and those close to them told us there was a wide choice of foods available and that catering staff went out of their way to provide foods of choice and preference. The chef spoke with patients individually to identify specific needs and ensured patients preferences were met.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. They could access specialist support for patients requiring additional interventions regarding nutrition and hydration. This included enteral feeding specialist at the local acute NHS Trust. Specialist support from staff such as dietitians and speech and language therapists were also available.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. In addition, the records we reviewed showed appropriate mouth care assessments had been carried out. Leaders told us they had implemented changes to mouth care assessments as the result of an audit that showed improvements in assessments were required.



Hospice services for adults

Changes included adding assessment prompts to the electronic patient record system, revising documentation to ensure a standardised approach and providing education. This included the development of November as a 'mouth care month' where regular training sessions were held to cover oral problems, care of the mouth and documentation in line with guidelines. A re-audit was planned once the training had completed.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. There was an individual approach to pain relief and patients were supported in assessment approaches to ensure that their needs were met. Assessment tools included approaches based on patient's individual needs. For example, for patients with dementia and those unable to express their pain verbally.

Patients received pain relief soon after requesting it. We reviewed drug charts and found them to be completed in full and demonstrated that patients received the correct medication at the right time.

Staff prescribed, administered and recorded pain relief accurately. The effectiveness of pain management approaches was assessed on an individual patient basis and outcome measures were collated to provide assurance. September 2021 monthly dashboard data showed that the inpatient unit scored 89% for the control of pain and 94% for the control of other symptoms. Staff told us that where patients were admitted for support to manage their symptoms, pain relief was titrated over time to ensure a balance between managing pain and managing side effects such as drowsiness. They told us that some patients preferred to manage their pain with complementary therapies alongside pharmaceutical interventions to maintain quality of life. Staff supported them to do so.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits. In 2019 the senior leadership team adapted the National Care of the Dying audit for the hospice setting to measure performance against recognised national standards. An audit took place in 2020 with high levels of attainment in several areas. For example, 100% of patients had a record of the recognition that they were dying and that the needs of families and loved ones had been explored. Most audit indicators scored above 90%. Areas for improvement included a need for better recording of verification of expected death, and mental capacity assessments.

Information from the national audit was used to improve care, treatment and standards. For example, a focused audit of verification of expected death was carried out to understand where performance fell below expected standards. Additional training was implemented for staff and a re-audit was planned for 2022. Interim monitoring showed evidence of improvement as a result.

Outcomes for patients were positive, consistent and met expectations, such as national standards. The use of four of the Outcome Assessment and Complexity (OACC) measures was well-established on the In-Patient Unit. These included the Australian Karnofsky Performance Score (AKPS) and Barthel Index, providing a clinical picture of a patient's health,



Hospice services for adults

phase of illness and activities of daily living. The Integrated Palliative Outcome Scale (IPOS) was used to measure the physical, psychosocial, social and spiritual impact of illness, including self-reported patient outcomes. Outcome measures were collected on admission and then weekly during an in-patient stay. This data was viewed and discussed at the first consultant ward round of the week for each ward. Barthel and AKPS were used as part of the wider clinical assessment picture to guide on deterioration and prognosis. IPOS scores and the symptoms the patient lists as most important to them on the questionnaire were then used to guide discussion with the patient.

Outcomes relating to control of pain and other symptoms was captured within the inpatient unit monthly dashboard. In September 2021 pain control was recorded as 89% and other symptoms as 94%.

Within the community service IPOS, Phase of Illness and AKPS were evaluated on initial assessment and monitored throughout community contact. It was used in multidisciplinary discussions and to support the evaluation of the community caseload.

Managers and staff used the results to improve patients' outcomes. An evaluation of patient outcomes was reported monthly to the senior leadership team and quarterly to commissioners.

Achievement of preferred place of death (PPD) was monitored and reported monthly through Clinical key performance indicators. Preferred place of death was recorded in 95% of patient records. In September 2021 PPD was 83%. Service leads told us where this fell below 85% individual cases and patterns of decision making were reviewed. For example, a high number of hospital deaths was noted and investigated and found that various referrals to hospital had been unrelated to the primary diagnosis. This included hospital admissions for patients in the community for other acute illnesses, complications following routine investigations and falls at home.

Senior leaders had identified that ongoing monitoring was not as consistent as it could be, and the use of OACC had been identified as an area of Quality Improvement. They had engaged with the NHS Improvement Academy and were exploring a partnership with them to further consider this area of work. Caseload reviews were undertaken by senior clinicians, to check that management plans reflected the initial IPOS scores and that symptoms were improving or were being actively addressed.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Oversight of this was provided by the hospice's evidence-based practice group. Inpatient unit audits included a monthly check of patient records, safety, infection control and repeat audits included anticipatory prescribing on the inpatient unit and remote prescribing by the community team. Additional audits we reviewed included mouthcare, verification of expected death and the use of blood transfusions in palliative care.

Managers used information from the audits to improve care and treatment. Audits led to changes in practice which were re-audited to measure successful implementation. An audit of blood transfusions was undertaken following a study that found that limited use of blood transfusions in palliative care were as effective and limited risk associated with transfusions. The hospice implemented a restrictive approach in line with the guidance from the study, administering one unit of blood then reviewing the patient. The audit undertaken by the hospice included participation from other hospices in order to benchmark. Results showed that 72% of patients requiring a transfusion had one unit, compared with 16% of patients within other hospices. Audit leads shared findings through a published paper and presentation at the Association for Palliative Medicine conference.



Hospice services for adults

Managers shared and made sure staff understood information from the audits. There were a variety of mechanisms to inform staff of changes. This included training, meetings and regular email updates. The evidence-based practice group provided regular training for staff in practice enquiry to support the ambitions of the group and a culture of enquiry within the clinical teams.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff completed training appropriate to their role in relation to end of life care. This included recognition of dying and advanced communication skills tailored to individual roles within the team.

Managers gave all new staff a full induction tailored to their role before they started work. There was a rolling induction programme in place where new staff attended training to help them in their role. Clinical induction included symptom management, Mental Capacity Act, advance care planning, bereavement and spiritual care and other mandatory training. Staff new to their roles had individual induction plans with appropriate shadowing, mentoring and probationary review. A band five nurse who had started at the hospice in the last year told us they had not been included in the nursing numbers for the first six weeks, ensuring the focus of their time was on learning.

Managers supported staff to develop through yearly, constructive appraisals of their work, however achievement had been impacted by the pandemic and some long-term staff absences. We saw that 91% of staff had received an appraisal in the last 12 – 18 months. Staff we spoke with told us they had regular appraisals. Staff told us they had informal discussions about development with line managers and mentors and there was a range of learning opportunities available to them.

Managers supported staff to develop through regular, constructive clinical supervision of their work. There were trained supervisors within the hospice. Staff had access to group and individual supervision, and this was monitored as part of the monthly clinical dashboard. In September 2021 99% of clinical staff had been offered clinical supervision.

The clinical educators supported the learning and development needs of staff. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. We saw that staff had access to a range of training opportunities through the clinical education programme. Qualified staff completed a European certificate in essential palliative care run by the hospice. We saw that staff had opportunities to study at masters or advanced practice levels. Healthcare assistants were given opportunities to undertake nursing and healthcare support worker apprenticeships.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Additional communication was shared through regular email updates so that staff kept up to date with changes.

Managers identified poor staff performance promptly and supported staff to improve. The hospice had a performance management framework that provided support to managers and staff to increase formal reviews and set timely goals to meet performance requirements.

Managers recruited, trained and supported volunteers to support patients in the service. There was a volunteer coordinator and specific induction and training for volunteer's dependent on their role.



Hospice services for adults

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. These were held weekly on the inpatient unit and involved medical, nursing, allied health professionals and psychological support staff. Individual patients and their ongoing care needs were discussed in detail. Handovers and safety huddles had input from the multidisciplinary team including physiotherapist support in areas such as falls prevention. A daily referral meeting included consultants, clinical nurse specialists and senior nurses. This ensured a multidisciplinary approach to decision making on admissions and prioritising these based on need and included representation from other services across the city.

Pathway specific multidisciplinary meetings were also held. For example, a heart failure MDT was created in 2017 and held monthly since. Hospice staff actively participated in the meetings and provided training to generalist staff. For example, in relation to advance care planning.

The hospice had undertaken a pilot to introduce a mental health practitioner into the multidisciplinary team. This had been evaluated and results were positive.

Staff worked across health care disciplines and with other agencies when required to care for patients. Inpatient unit staff had a good understanding of the support available from other agencies and there were referral processes in place. Community staff worked in partnership with other health and care providers to meet the needs of patients. There were open discussions between professionals to support patients transitioning between services.

As part of the homeless project to support patients to access palliative and end of life care, the hospice staff worked with a local GP practice to set up a dedicated multi-disciplinary meeting to ensure that patients had a collaborative approach to meeting their care needs. Specific actions included setting up an electronic palliative care register that was shared with relevant services to ensure a more joined up approach to care.

Seven-day services

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

Consultants led twice weekly ward rounds, and patients received access to medical review seven days a week. There was medical and senior nurse support for the inpatient unit 24 hours a day through the on-call system.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Health promotion

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

The service had relevant information promoting health and wellbeing. This included advice and support on nutrition, pain control, emotional and spiritual needs. Staff cared for patients with a holistic approach and regularly monitored patients' wellbeing.



Hospice services for adults

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff had received training in assessing patient's capacity and compliance for this was above the target at 95%.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Nursing staff we spoke with had a good understanding of requirements and understood the process for gaining consent and how to raise concerns if they identified barriers to this.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff supported patients to make advance care plans so that information about their wishes was available should they no longer be able to be actively involved. Where patients were unable to be involved in discussions or decisions staff involved those close to them. A 2020 care of the dying audit showed that 96% of family members were involved in discussing ceilings of treatment and care and 98% of family members had been involved in the care planning process.

Staff made sure patients consented to treatment based on all the information available. They ensured that informed decisions were made by providing information, support and written information where appropriate.

Staff clearly recorded consent in the patients' records. This included consent to share patient information. An audit from the period April to September 2021 showed 100% compliance with records of communication and consent to share information.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Relevant policies were up to date and included clear guidance and escalation processes.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. These were recorded on the inpatient unit monthly dashboard. Staff demonstrated a good understanding of processes and knew when to act.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. A 2020 national care of the dying audit showed that of those records reviewed, 82% had a relevant recorded mental capacity assessment. As a result, the hospice had provided additional training for staff and had amended processes to make assessments easier to record. A re-audit was planned for early in 2022.

Are Hospice services for adults caring?



Our rating of caring stayed the same. We rated it as outstanding.



Hospice services for adults

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff interacting with patients in a way that allowed them time to ask questions, gain clarity and an understanding of treatment and care. Patients said staff treated them well and with kindness.

Feedback from patients and their families was continually positive about the way staff treated them. For example, one patient told us that staff always made time for them, that they were consistently compassionate and kind. Another patient said that staff were 'very attentive' and 'nothing is too much trouble'. Relatives consistently described staff in positive terms. This included one relative who said that staff were 'kind, special people', that the care they provided had a 'major impact' on the quality of life of their loved one and how they couldn't ask for better care. Another relative talked of the 'lovely bedside manner' from doctors and talked of the consistent care and support provided by all staff within the hospice, irrespective of their role.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude, including when caring for or discussing patients with mental health needs. Feedback from a friend of a patient who had been cared for in the hospice described how staff were always compassionate, understanding and accepting of the patient's behaviour that was at times challenging.

Staff consistently worked together to provide compassionate care tailored to individual needs. They went above and beyond to find ways to comply with patient's wishes in the last days of life. For example, one patient had a last wish to visit a wildlife centre. The hospice, organised, paid for and facilitated a bespoke visit for the patient. Another patient had a long-standing wish to switch on Christmas lights so staff put lights on all the trees surrounding the hospice and put up two 20-foot Christmas trees. The patient was then supported to switch on the lights in the hospice grounds to fulfil their wish. A patient who wanted to go to a restaurant for a final meal out with their family was too unwell to do this. Staff set up a 'restaurant' on the balcony outside the patient's room. They provided table service, menus and drinks for the patient and their family.

Staff demonstrated the highest level of compassion to patients and those close to them. Feedback from a patient's mother was positive about the support received from staff, saying that support from hospice staff did not stop when the patient left their care as staff continued to phone and provide support.

Staff recognised and respected the totality of people's needs. Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Social and spiritual support services were available, and staff could access staff and volunteers who could support this work.

The hospice understood the importance of patient stories in demonstrating the care they provided. Patient stories were used to share information with the board of trustees and when delivering training and sharing good practice with other services.

A light up a life memorial service was held annually where people could remember and celebrate the lives of loved ones who had died. This in-person event was unable to be held during the pandemic so had been delivered virtually in 2020 with a further online event planned for 2021.



Hospice services for adults

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. They assessed the needs of patients and those close to them. They provided emotional support and bereavement services. The family support service had social workers and counsellors. They worked with patients, carers, families and friends and offered practical and emotional support.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. A range of communication skills training was provided to staff of all roles and adapted to the level of their needs.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff understood the impact of the pandemic on the local community. As a result, they had widened their bereavement support service, including for children and young people due to the increasing risk of losing older relatives. The service provided individual or group support when someone close to them was ill, or after someone had died.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. We observed staff communicating with patients to explain treatment and care to them. This was done with kindness and compassion and staff took time to listen and understand patient views. Feedback from a community service survey showed that in the current year 96% of patients said that nurses explained their condition and plan of care. This was an improvement on the 2020 survey where results were 88%.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The hospice had a range of feedback resources to capture patient's experience. For example, through routine patient experience surveys that were reported on a quarterly basis. Results from 2020/21 and current year to date showed 100% of patients felt that staff treated them with dignity and respect and listened to them. Results showed 100% positive feedback in relation to patients' overall feedback. Results from a 2020 city wide Healthwatch bereaved carers survey showed that relatives were consistently satisfied with the care provided. As a result, there were no recommendations for improvement.

Staff supported patients to make advance decisions about their care. The hospice worked with patients to develop advance care plans to ensure their wishes were documented for future care needs. An advance care plan is a plan that patients make that sets out their decisions for future treatment, should they later be unable to be involved. Staff supported patients and their relatives to create advance care plans as early as possible in their care.

As part of a homeless project where staff supported homeless patients plan for and access care at the end of life, advance care planning was incorporated. This included support for patients to achieve their preferred place of death. Staff went over and above to ensure that patients were supported in their decisions and choices. For example, a homeless patient at the end of life was supported to make contact with their family after several years. Hospice staff



Hospice services for adults

made contact with the family and supported the patient to re-engage with them, eventually arranging to transfer the patient's care back to their hometown so they could die at home with their family around them. Another homeless patient had been separated from their dog after admission to the hospice. The husband of a member of staff created a collage of photos and staff arranged visits from the dog, to support an ongoing connection for the patient.

Patients gave positive feedback about the service. For example, one relative described it as 'by far the nicest place for care'. Other patients and relatives said that staff were very attentive, that nothing was too much trouble and that support for family was 'superb'.

Are Hospice services for adults responsive?

Outstanding



Our rating of responsive stayed the same. We rated it as outstanding.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. The hospice hosted the Leeds Palliative Care Network which they led in partnership with leads from the local NHS trust. They worked collaboratively across the network to understand the palliative and end of life care needs of the local population and used information such as local health needs data for the population, to understand needs and prioritise action. They had developed a collaborative strategy (2021 – 2026) with an aim for people to die well in their preferred place of care. There were clearly defined outcomes that included increasing access to advance care planning and involvement in decisions, support to live well for as long as possible and to have needs and conditions recognized quickly to be given fair access to services irrespective of background or characteristics.

The hospice had undertaken research in referral patterns to specialist palliative care. This highlighted that patients with advanced disease received referrals to hospice specialist palliative care late in their illness trajectory, with clear inequities relating to older age and non-cancer diagnoses. The hospice had taken action, in collaboration with partners to improve access. For example, they had introduced an embedded emergency care pathway where patients seen in the hospital emergency department could be referred directly to the hospice rather than admitted to hospital. They had also worked with the local ambulance service to provide training in recognising patients who were dying and took referrals directly from the service. This included direct referrals outside of normal working hours.

Other services that had been developed collaboratively were a widening access to palliative care service for homeless people in Leeds. The hospice also had nurse led beds to help support the needs of patients without complex palliative care needs but who wished to receive care in the hospice.

The hospice had taken action to address inequalities and meet the needs of the diverse population. They had a hospice Involve group and routinely reported the ethnicity of the patient population. They had created and maintained a community engagement group and worked with them to act as ambassadors for the hospice in their own communities. Specific internal actions included making the hospice website translatable into multiple languages and incorporating world faith symbols at hospice entrances. They had a diversity and inclusivity champion at board level and had held



Hospice services for adults

myth busting events to showcase hospice care and explore expectations at end of life with different community groups. They had recognised that the ethnic mix of patients was greater in the community, than was accessing services at the hospice. This work identified under- represented groups and leads worked with the hospice community engagement group to break down barriers to accessibility. The 2019/2020 quality account showed that the ethnic diversity of people accessing the services at St Gemma's had increased to 37% as a result of this work.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. At the time of the inspection and because of the pandemic, patients were cared for in individual rooms or adapted bays to reduce the risk of infection. Ordinarily staff managed referrals into the service to ensure that patients were not cared for in mixed bays.

Facilities and premises were appropriate for the services being delivered. At the time of the inspection bed occupancy had been reduced so that shared facilities were not in use and all patients were cared for in their own room.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with a mental health condition, learning disabilities and dementia, received the necessary care to meet all their needs. Staff had received training to support patients with additional needs. Staff supported patients living with dementia and learning disabilities by using 'understanding me' documents and patient passports. The hospice had developed a dementia strategy that included supporting patients living with dementia and other forms of cognitive impairment. The strategy incorporated the needs of members of the public accessing hospice shops and events, as well as patients and visitors to the hospice. They had incorporated dementia training into the hospice induction programme and provided a train the trainer programme for other providers to facilitate their own in-house training programmes.

Wards were designed to meet the needs of patients living with dementia. The hospice had made environmental changes to meet the needs of patients with cognitive impairment, including improved signage to help patients better navigate their environment.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. They had access to a hearing loop and used picture prompts to enhance communication.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. They had access to telephone and face to face interpreters when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Catering staff liaised with patients and family members and planned individual menus to meet their needs.

There was a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that met these needs, which was accessible and promoted equality for people living in vulnerable circumstances and with complex needs. A homeless project had been set up in 2020 to improve access to palliative and end of life care for this group of patients. The project was established in recognition of traditional palliative care services not being appropriate to meet the needs of this group. This included patients who, to date, had



Hospice services for adults

been unable to access traditional healthcare services due to their complex needs. For example, a patient who was unwell and living in a hostel who declined hospital treatment because they didn't know how long it would take and were fearful of losing their place at the hostel. This led to hostel staff feeling 'helpless' and 'out of their depth' to support them, having been told by secondary care services that the patient had the mental capacity to refuse treatment. Support from the homeless inclusion palliative care service enabled specialist support to both the patient and the staff at the hostel. Staff recognised that a strength of the service was the ability to bring care to the patient in their usual place of residence. They facilitated regular medical care at the hostel and co-ordinated practical support in line with the patient's wishes. Feedback from hostel staff included that the support to the patient was pivotal in providing them with care at the end of life that they would otherwise have been unable to access. Hostel staff said they felt listened to and supported with ethical decision making to meet patient's individual needs.

Outcomes included a 2000% increase in homeless people accessing hospice services, from five between 2015 and 2019 to 23 in 2020 alone. Hostel staff had gained confidence to support patients in hostels at the end of life. A multi-agency group had been set up and met regularly to review the needs of patients. Resources had been developed to provide learning and information across the health and support teams in Leeds to raise awareness of the end of life care needs of patients who were homeless. Hospital admissions, where hostel and support staff felt unable to care for patients, had been avoided. Service case studies demonstrated that the service provided an alternative to inadequate care in inappropriate facilities and models, instead providing a more flexible, patient-centred approach.

The hospice worked closely with the acute trust specialist palliative care service to meet the needs of patients at the end of life, including those with complex needs. For example, in recent months they had organised for patients who were ventilated in hospital but wished to die at the hospice to be transferred. This involved the patients arriving with hospital clinicians to have their ventilator disconnected so they could be cared for in the hospice in the last hours and moments of life. Staff set up rooms with appropriate equipment and moved patient beds to a position where they could see outside and have their loved ones around them.

The day service team had formed into the support, therapy and resources team (STAR team) at the beginning of the pandemic. The aim was to support patients and their families with advanced disease. This service was developed in recognition of patients shielding and unable to access their normal treatment and support during the early stages of the pandemic. Support was offered by telephone, face to face home visits, virtual groups and outpatient services.

Access and flow

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

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Waiting times for services were monitored as part of the monthly service dashboard. Results showed that 89% of patients were admitted to the inpatient unit within 24 hours.

The community service had identified a tiered approach to prioritising community services. Referrals were triaged within the framework of the identified tiers. Tier one was where patients were clinically unstable, dying or where there were extra ordinary psychosocial needs. These patients were assessed within two days and had routine follow up including face to face and telephone contact. Other tiers included patients who were deteriorating but where symptoms were managed and those where patients were stable with slight symptoms, or where support for advance care planning was required. Assessment was between three and 14 days, depending on need, for those in tier three with minimum



Hospice services for adults

need for specialist palliative care, there was collaborative working with community registered nurses to support care. September 2021 data showed that on average patients in tier one were assessed within 24 hours, those in tier two within three days and those within tier three within six days. These were all within the time frame identified in the hospice key performance indicators.

Managers and staff worked to make sure that they started discharge planning as early as possible. This was started on admission, identifying psychosocial as well as physical issues that may impact a patient's ability to go home. Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. They had a discharge support worker and involved members of the inpatient unit, therapy team and community nursing team as appropriate. Discharge planning meetings were held with involvement from the patient and their family.

Staff supported patients when they were referred or transferred between services. They had admission pathways in place from emergency care, including from the local ambulance service and emergency department. This enabled admissions direct from emergency care for patients identified as at the end of life or having an irreversible condition, where admission to hospital was not appropriate but where care at home was insufficient.

Nurse led beds were available for patients with reduced complexity who wanted to receive care at the hospice at the end of life.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. There were various sources for patients and those close to them to provide feedback. Formal and informal complaints were encouraged by the hospice so that issues could be resolved quickly.

The service clearly displayed information about how to raise a concern in patient areas. Information on how to complain was available inpatient literature and patients and those close to them were encouraged to raise concerns directly with staff.

Staff understood the policy on complaints and knew how to handle them. Staff told us that where concerns could not be resolved by frontline staff, these were escalated to managers.

Managers investigated complaints and identified themes. They reviewed records and information held, to identify areas for improvement. Issues were captured as feedback and collated to share with relevant staff and as feedback to the board to ensure oversight. An annual complaints report was produced with analysis of contributing factors and circumstances leading to the complaint. There were no themes apparent in the complaints we reviewed.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Five complaints had been received by the hospice in 2021. One was a formal complaint, the others were from a range of feedback sources, including surveys and verbal feedback. The complaints we reviewed had been responded to and resolved quickly, usually within one week.



Hospice services for adults

Managers shared feedback from complaints with staff and learning was used to improve the service. Feedback was given to staff working in the department where the complaint originated. Records showed that relevant staff were involved in reviews and information from this was shared with the wider team to ensure learning.

Are Hospice services for adults well-led?

Outstanding



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

Leadership

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

Leaders demonstrated high levels of experience, capacity and capability. They understood the challenges and priorities of the service and proactively sought to address them. They worked collaboratively with partner organisations, stakeholders and other services to deliver high-quality and patient centred services.

There was a clear management structure with defined lines of accountability. The day to day management of the service was the responsibility of the hospice leadership team. This included the chief executive officer, chief nurse, chief medical officer, chief operating officer, director of transformation and culture and director of income generation. They were supported by a senior leadership team that included department leads and senior clinical staff. The hospice leadership team was accountable to board of trustees.

Trustees were kept well informed of what was happening within the hospice. The hospice committee structure ensured that information was appropriately shared and cascaded, with clear lines of accountability.

Staff we spoke with told us that leaders were visible, approachable and supportive. There were development opportunities for staff to enhance their skills. Staff had the opportunity to attend additional training to improve their competence and develop skills to take on senior roles and responsibilities. Staff told us there were good training courses available and that the senior leaders supported them to achieve their aspirations.

Vision and Strategy

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

The hospice had a vision to meet the needs of people with a terminal illness and those close to them with care, compassion and skill. Hospice values focused on treating people with kindness, empathy, compassion and respect while aspiring to learn and striving for excellence and delivering high standards of care.



Hospice services for adults

They had developed a 10-year strategy that focused on improving care through research, education and practice, working in partnership and developing services to meet the needs of more people in the future. The hospice strategy was aligned with local plans, including the Leeds Adult Palliative and End of Life Care strategy that they had developed in line with other local services through the Leeds Palliative Care Network.

The strategy had been designed in collaboration with stakeholders including staff, patients, commissioners and other local providers. Progress against the delivery of the strategy was monitored by the board of trustees and the hospice leadership team. The annual quality account included priorities for improvement and an evaluation of achievements to date.

Culture

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

The hospice had an inpatient unit culture project led by the director of transformation and culture as part of a culture improvement programme. This was in response to cultural issues previously identified. The aim of the role was to focus on building confidence within the team and minimising isolation felt by staff as a result of the pandemic. Staff received additional training in communication and a communication strategy was implemented. Specific actions included the development of safety huddles, team away days, reorganisation of teams, improving recruitment and retention of staff and reflecting on the hospice values. External coaching was provided with a focus on performance management and improving the overall culture of the service.

Since the beginning of the pandemic leaders had focused on staff wellbeing. This included the development of a wellbeing hub, daily debrief, an employee assist programme and activities to promote wellbeing. For example, during 2021 wellbeing week activities provided included stress management, health checks for staff and mental health in the workplace. Other activities facilitated by the hospice included a mobile pizza van, afternoon tea for retail staff, flower arranging, quizzes, fine art, yoga, Zumba and a lunchtime walk. In addition, in recognition of the work staff had done during the pandemic, staff had been given an additional 'wellbeing' day off.

Equality and diversity were promoted within the hospice. The hospice had worked to identify gaps and improve access to hospice services for patients across the city. However, they identified that this was not reflected in the workforce. For example, 19% of people living in the city were from black, Asian and minority ethnic (BAME) groups, whereas staff from these groups made up just 7.5% of the hospice workforce. In 2020 they set up a multicultural network, inviting all staff from a minority ethnic background working across all hospice services to attend. The network aims included sharing experiences, raising the profile of the contribution of minority ethnic staff, developing and maintaining a representative workforce, influencing strategy and development and ensuring all staff reached their potential.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.



Hospice services for adults

There were effective governance structures, processes and systems of accountability and a clear governance framework to support the delivery of the hospice strategy. The hospice leadership team were accountable to the board of trustees through various sub-committees. For example, a clinical and academic governance committee, finance and business and corporate governance committees. Senior leaders reported back to the board, providing summaries, meeting outcomes and action points.

Quality assurance, clinical leadership, senior leadership and hospice leadership meetings were regularly held. A range of monitoring and quality performance data including quality improvement and assurance audits, safety incidents and risks, training compliance, staffing, complaints and patient experience feedback were reviewed at these meetings.

Staff were clear about their roles and accountabilities and who to report to. Staff were committed to improving the quality of service and maintaining high standards of care. They were involved in discussions about the performance of the service and were encouraged to report issues and work together to learn and develop the service.

There are arrangements in place to manage and monitor contracts and service level agreements with partners and third-party providers. Contract reviews were informed using quality indicators and feedback.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

There were clear processes for identifying and mitigating risks. There were clinical, operational and board assurance risk registers. Environmental risks such as fire safety and equipment use had been mitigated using regular assurance checks in line with guidance.

Individual risk assessments were carried out for each patient on admission and reviewed regularly during admission. Risks from falls and pressure ulcers were mitigated with appropriate measures such as the use of safety and pressure relieving equipment.

Environmental risk assessments were undertaken by internal facilities staff and external contractors. There were effective arrangements in place to mitigate the risks from fire, legionella and slips, trips and falls.

Current and future performance was monitored through a range of information and we saw evidence of this in quality and performance reports. Information included safety measures, feedback and performance against key performance indicators. This information was shared with commissioners as part of ongoing performance monitoring. The hospice benchmarked themselves against another local hospice as part of quality assurance processes.

The hospice reviewed services and took action to make changes where risks to sustainability were identified. For example, in 2019 they had introduced a triage model to the community nursing teams. This saw the implementation of a three-tiered approach to clinical nurse specialist referrals due to an increase in complexity of patients' needs. As a result, they had developed a clear referral, assessment criteria with guidance on the regularity of contacts based on the complexity of needs for each individual patient.

Information Management



Hospice services for adults

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

There was a holistic understanding of performance and this was integrated with patient and family views and information on quality. Integrated management information systems were used to support informed decision making. Clear performance measures were evaluated and reported on. Staff had access to integrated quality and performance data. This included incidents, staffing, patient and family feedback, complaints and service activity performance. Service performance was tracked over time to support the identification of areas for improvement. Where variations in performance were apparent, action was taken to make improvements.

There were effective arrangements to ensure data and statutory notifications were submitted to external bodies, as required. This included local commissioners and the Care Quality Commission (CQC). Quality dashboards were shared with commissioners to report on performance.

Staff had access to up-to-date information about patients' care and treatment. The system was aligned with those used by local GPs and community services to ensure integration and access to information. The information systems were secure, with systems encrypted and password protected.

Engagement

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

The hospice worked in partnership with other services to ensure the end of life care needs of the local community were met. They hosted the Leeds palliative care network, working with NHS, community and voluntary services to improve care.

Staff views were sought and acted on. There was a hospice engagement group with representation from all services and departments within the hospice. An in-house staff survey was undertaken in 2020 to find out about staff experience of working at the hospice during the pandemic. Results showed that 94% were satisfied with how services were managed and were confident in the service's ability to plan for the future. Results for communication were 86% and support for wellbeing was 85%. Hospice leads recognised the importance of staff engagement and participated in the Times top 100 'not for profit' organisations staff survey, moving from 76th in 2017 to 18th in 2020. The surveys helped identify key areas for focused improvement. This included improving engagement, work-life balance, improved interdepartmental collaboration and building a wellbeing focus. Progress had been made against the identified objectives. This included action to develop a range of staff wellbeing initiatives. Staff told us they felt listened to and able to contribute to improving quality within the hospice.

There was a whistleblowing policy in place with clearly identified 'speaking up' guardians and champions so that staff knew who to contact if they had concerns. Staff we spoke with told us they felt able to raise concerns without fear and believed that their concerns would be listened to and acted on. We saw evidence of this when reviewing the actions taken by the hospice to address concerns as they arose.



Hospice services for adults

Patient and family views were collated through a range of surveys and feedback mechanisms including real time feedback, patient surveys and a bereaved carers survey. Results were collated using a reporting dashboard and feedback was captured within a service improvement register to with key considerations and actions. Emerging and recurring themes were identified. Results from surveys of patient and family views were consistently positive about their experience within the hospice.

Learning, continuous improvement and innovation

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

There were a range of quality improvement activities within the hospice and staff actively participated in these. We saw that services were regularly reviewed to ensure they met the needs of patients and the local community. There were clear quality improvement aims within the annual quality account that included safety, patient experience and effectiveness. The quality account was reviewed and updated annually.

Innovation was at the heart of delivering high quality end of life care and staff and leaders worked collaboratively with other providers in the local community to develop these. They worked in partnership to identify health inequality within the wider health system. Improvement activities included increasing access to services for patient groups that were underrepresented. Examples included inclusion activities to engage with more diverse groups within the local community to expand access to services for people from minority ethnic backgrounds. Specific activities included working with the hospice involvement group to raise awareness of services for advocates in their local communities and holding a myth buster event for migrant services in the city. In addition, the hospice had developed a widening access project for homeless and vulnerably housed people in the city.

The hospice continually evaluated the services in relation to the complexity of patients and took action to meet those needs, including training staff in supporting patients requiring aerosol generating procedures so they could expand access to patients with related complex needs.

The hospice participated in and led research projects relating to improved palliative and end of life care. As a result of this the hospice's academic unit of palliative care were invited to submit evidence from their research to the All-Party Parliamentary Group on End of Life Care which made recommendations to Department of Health. The lead academic, on behalf of Faculty of Pain Medicine, led the development of an NHS specification for provision of specialist pain services for patients with cancer and other advanced diseases. This multi-stakeholder initiative involved the Faculty of Clinical Oncology, Royal College Physicians and Association for Cancer Physicians and built on research contributions to NICE opioids guidance and NHS Service Standards for cancer pain. The specification was published in autumn 2018 and was intended to improve access to better pain management for patients with cancer and reduce variation across the UK.

Members of the hospice clinical and academic team had actively participated in publishing research articles. These included national and European journals, sharing best practice in relation to aspects of palliative care including pain management and identifying patients with palliative care needs.

In 2017 the hospice was the first hospice to be recognised as a university teaching hospice, reflecting their research and teaching activity in collaboration with the local university. Feedback from the chief executive of the local medical school described the research from the hospice team as pioneering.



Hospice services for adults

The hospice shared learning from their development work, audit and research activities. This included the delivery of presentations and learning activities to a wide range of other providers. Examples included a 2019 Hospice UK webinar and sharing free clinical resources on their work on blood transfusions in palliative care. Presentations for 2021 included inclusion and engagement work, the homeless project, the formation of support services during the pandemic and self-management for breathlessness, fatigue and anxiety.

Staff and volunteers had been recognised for their work. This included the Nursing Times 2021 team of the year award for the widening access to palliative and end of life care for homeless and vulnerably housed people in Leeds. Two hospice volunteers had been recognised by Hospice UK, one for their work on the gardens and the other for their spiritual support role.