

Saint Catherines Hospice Trust

St Catherine's Hospice - Scarborough

Inspection report

Throxenby Lane

Newby

Scarborough

YO12 5RE

Tel: 01723351421

www.stcatherineshospice-nyorks.org

Date of inspection visit: 4 November 2021

Date of publication: 18/01/2022

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

Ratings

Overall rating for this location

Good



Are services safe?

Good



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Outstanding



Are services well-led?

Good



Summary of findings

Overall summary

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


- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- 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.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- The mandatory training target was lower than expected.
- Nursing staff had not completed level three safeguarding training.
- Hospice leads had not monitored Mental Capacity Act and Deprivation of Liberty Safeguards training compliance as part of their mandatory training programme.
- Anonymised patient surveys were not carried out for all patient services, including the inpatient and community services.
- Medicines policy and procedures were in the process of being updated and currently contained out of date guidance.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	Good 	Our rating of this service went down. We rated it as good. See the summary above for details.

Summary of findings

Contents

Summary of this inspection

Background to St Catherine's Hospice - Scarborough	5
Information about St Catherine's Hospice - Scarborough	5

Our findings from this inspection

Overview of ratings	8
Our findings by main service	9

Summary of this inspection

Background to St Catherine's Hospice - Scarborough

St Catherine's Hospice is operated by St Catherine's Hospice Trust. The hospice opened at its current site in 2004. It is an independent hospice in Scarborough, North Yorkshire. The hospice primarily serves the communities of the Scarborough and Filey area. It also accepts patient

referrals from outside this area. The hospice provides inpatient beds, a hospice at home

service, specialist palliative care services, outpatient services including a lymphoedema clinic, therapy and counselling services, a specialist palliative social work service and an out of hours telephone support line. The hospice provides care to adult patients and support to

their families.

At the time of the inspection, the clinical service director was the registered manager for the service. A registered manager is a person who has registered with the CQC to manage the service. They have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations about how the service is run.

The service is registered with the CQC to provide:

Personal Care

Treatment of disease, disorder and injury

Diagnostic and screening procedures

Transport services, triage and medical advice provided remotely.

How we carried out this inspection

We visited the inpatient unit and spoke with staff delivering hospice at home, clinical nurse specialist and bereavement and counselling services. We held interviews with service leads and executives. We spoke with 31 staff including nurses, health care assistants, clinical nurse specialists, doctors, bereavement and counselling staff, catering staff, reception and non-clinical staff. We also spoke with three patients and their relatives who had experienced support from hospice staff. We observed care and treatment provided in the inpatient unit, visited a patient in their home, reviewed data about the service and reviewed 10 patient care and treatment records. At the time of the inspection the hospice was caring for eight patients on the inpatient unit.

The inspection was led by a CQC inspector. The inspection team included a pharmacy inspector and specialist advisor in palliative and end of life care, and was overseen by Head of Hospital Inspections. 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.

Summary of this inspection

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

Outstanding practice

We found the following outstanding practice:

- We saw outstanding practice in the availability of medicines that could be given intrathecally at the hospice if required for pain relief. This is when a patient receives medicines directly into the spine. A patient had recently received treatment with intrathecal morphine successfully.
- There were innovative approaches to providing integrated person-centred pathways of care that involve other service providers. Hospice staff worked collaboratively with other services to develop multidisciplinary approaches to care for patients with specific conditions. The hospice had a neurological clinical nurse specialist service. They worked jointly to set up and participate in multidisciplinary team (MDT) meetings for patients' neurological conditions. These were held every three months with involvement from neurology and respiratory consultants, the home ventilation team and neurology clinical nurse specialists (CNS) from both the hospice and the acute trust. A nutrition and gastric neurology MDT was also in operation, providing support for patients whose neurological condition had affected their ability to eat and drink. MDT discussions included assessing the requirements for artificial feeding.
- There was a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that meets these needs, which is accessible and promotes equality. The hospice recognised that patients with a learning disability required additional support to access hospice services in a timely way. They worked with other services to improve this.
- Patients could access services in a way and a time that suited them. The hospice was not contracted to provide both registered nurses and healthcare assistants across a 24-hour period for the hospice at home service. The hospice, aimed to provide healthcare assistant cover for each shift and registered nursing cover for as many shifts as possible, including overnight. They continued to provide this service using charitable funds. Staff went out of their way to respond to patients in need of care, such as nursing staff visiting a patient at home prior to their shift starting in order to provide pain relief.
- The hospice worked with another local hospice in a formal collaboration to provide education and outreach support to organisations across the region who were caring for patients at the end of life during the pandemic. Virtual sessions included training and support sessions for staff to support the care of patients within their services.
- The patient and family support team had developed guidance on assessing patients at risk of potential suicide. The pack incorporated assessment tools to offer practical support, guidance and structure when supporting patients at risk of suicide.

Areas for improvement

Action the service **MUST** take is necessary to comply with its legal obligations. Action a service **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:

- Consider action to improve the mandatory training target and compliance against it, including an agreed target completion date.
- Support nursing staff to complete level three safeguarding training.

Summary of this inspection

- Ensure that staff complete formal Mental Capacity Act and Deprivation of Liberty Safeguards training as part of their mandatory training programme.
- Strengthen governance processes to ensure patient outcomes are monitored to drive improvement.
- Consider the use of anonymised patient surveys as a measure of satisfaction with services alongside the qualitative feedback obtained currently.
- Ensure that the medicines policy and procedures are updated in line with relevant guidance.
- Continue with plans to add medicines training to the mandatory training requirement.






Our findings

Overview of ratings

Our ratings for this location are:

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

Hospice services for adults

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

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.

Staff received mandatory training. Completed training compliance ranged between 79% and 91%. Fire safety and infection control was at 91%, data security was recorded at 79% and moving and handling and resuscitation training was at 89%. Managers told us that the compliance target for mandatory training was 80%, but that they were aiming for 90%. The mandatory training was mostly comprehensive and met the needs of patients and staff.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. They had received equality and diversity training and had an understanding of caring for patients with protected characteristics. In addition, face to face dementia training was part of the core training programme within the hospice.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had some training on how to recognise and report abuse and they knew how to apply it, although not all nursing staff had completed level three safeguarding training.

Clinical staff received training specific for their role on how to recognise and report abuse. Training was provided at level one and level two for safeguarding adults and children. Training compliance records showed that 79% of staff had completed safeguarding adult training at level two and 75% had completed safeguarding children training at level two. The hospice safeguarding lead was trained to safeguarding level 4 and the clinical services director, counselling and social work staff were trained to level three. However, there was no record of nursing staff on the inpatient unit having completed level three safeguarding training. Non-clinical staff, including trustees received safeguarding training relevant to their role.

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. The hospice had updated their safeguarding policy in line with intercollegiate safeguarding guidance. There was clear guidance on the recognition of abuse and safeguarding was discussed at handovers and multidisciplinary meetings. A safeguarding hub on the hospice intranet had been created, providing tools and resources to staff to enhance their skills and knowledge.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The hospice had a dedicated safeguarding lead. Staff knew how to report concerns and how to make a safeguarding referral. Senior staff had received additional training on assessment processes and decision making.

Staff followed safe procedures for children visiting the ward. This included ensuring that children were always accompanied by a parent or guardian.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. We observed that all areas were tidy and free from clutter and visibly clean.

The service generally performed well for cleanliness. The most recent infection control audit in 2019 showed that patient areas were 95% compliant. Hand hygiene was at 96%. The hospice had not undertaken a full audit in 2020 due to Covid-19 specific arrangements in place. The hospice had a new infection control group in place, and they were in the process of undertaking the 2021 infection control audit at the time of the inspection.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. This included additional cleaning to high touch areas during the pandemic and hospice leads purchased ultraviolet light (UVC) sterilising devices for enhanced cleaning devices.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff were seen to be using PPE in line with guidance. Regular audits of PPE compliance on the inpatient unit and for the hospice at home team were undertaken. Hospice leads purchased additional PPE during the pandemic, including enhanced PPE that was beyond the requirements of national guidance in order to keep staff and patients safe. Audit areas included the use of personal protective equipment, Covid-19 screening and hand hygiene compliance.

The hospice followed national guidance relating to the pandemic. They had reduced footfall within the hospice, implemented social distancing and ensured appropriate screening of all visitors. This included regular testing for Covid-19 for visitors on arrival and for staff in line with government guidance. They had a hand washing station at the entrance to the hospice and encouraged visitors to use it. There was appropriate signage reminding visitors of the requirements to reduce risk. The hospice delineated between 'hot' and 'cold' areas of the building and segregated clinical and non-clinical staff to ensure a safe environment. In addition they had safely admitted patients with covid-19 and had not experienced an outbreak within the hospice.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff used infection control measures when transporting patients after death. There was a cold body store and this was monitored to ensure safety, including daily records of temperatures.

Hospice services for adults

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 reported that staff always ensured their call bells were in reach and answered within a reasonable time.

The design of the environment followed national guidance. Patients were cared for in single rooms with en-suite facilities.

Staff carried out daily safety checks of specialist equipment. Clinical equipment, including beds, hoists and assisted baths were regularly maintained and registered to an asset register, to enable close monitoring. Calibration of medical devices was carried out annually. Equipment that was faulty was repaired or replaced. Equipment used for emergency situations was appropriate and accessible for staff when needed. We saw this was logged as checked monthly and single use equipment was within 'use by' dates.

The service had enough suitable equipment to help them to safely care for patients. Syringe pumps were available in line with recommended guidelines and were appropriately checked during administration.

Staff disposed of clinical waste safely. Waste was discarded in appropriately colour coded bags. Sharps bins were correctly labelled and disposed of within the appropriate timeline in line with national guidance.

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 completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. Admission assessments included the risk of falls, nutrition, confusion and pressure ulcers. In addition, individual risk assessments were carried out for patients in the community in relation to domiciliary care visits during the pandemic. Risk assessments we reviewed were regularly updated, both routinely and in response to changes in the patient's condition. Risk assessments were accessible electronically to all staff involved in the patient's care.

Staff knew about and dealt with any specific risk issues. This included the risk of sepsis and venous thromboembolism (blood clots). Staff used recognised tools and compliance with these were subject to regular audits. Audits we viewed showed that risks were appropriately identified. Risks were discussed at daily safety huddles. Staff understood how to escalate specific issues. Treatment escalation plans were in place so that all staff were aware of the escalation plans for each patient.

There was a first aid and clinical emergency procedure in place. This had been updated since the beginning of the pandemic to include emergencies related to Covid-19.

Patients were appropriately referred to hospital and were accompanied by staff. Patients had treatment escalation plans with the level of care and treatment appropriate and there were emergency plans in place that included calling 999 if patients deteriorated and required urgent hospital assessment.

Hospice services for adults

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). Staff understood referral processes and mental health risks were identified and discussed as part of daily safety huddles.

Staff shared key information to keep patients safe when handing over their care to others. This included physical, psychological and social issues. Shift changes and handovers included all necessary key information to keep patients safe. Handovers involved medical, nursing, allied health and counselling staff. Discussions were comprehensive and included all aspects of the patient's care. A July 2021 handover audit showed 100% compliance with the requirements for information sharing.

Nurse staffing

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, and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe. Nursing shift cover on the inpatient unit included a minimum of two registered nurses with support from a senior nurse during daytime shifts. Healthcare assistant cover was between two and three during the day and one at night. At the time of the inspection there were eight inpatient beds in use.

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. At the time of inspection, the hospice had 4.43 whole time equivalent (WTE) healthcare assistant vacancies and 1.54 WTE registered nurse vacancies. They had recently appointed new staff who were due to commence in post in the coming weeks. Managers adjusted workloads in response to staffing shortages. For example, by reducing bed occupancy for limited periods of time. We saw that bed occupancy was scheduled to increase from eight to ten in line with increased staffing numbers.

The number of nurses and healthcare assistants matched the planned numbers. Rotas showed that planned numbers were complied with through the use of bank staff or shift changes as required.

Managers made sure all bank and agency staff had a full induction and understood the service. They used regular bank staff to ensure familiarity with the service and ensured that induction, competency assessments and training was completed for these staff.

Medical staffing

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

The service had enough medical staff to keep patients safe. In normal working hours (Monday to Friday 8-6pm) medical cover to the inpatient unit and wellbeing centre was provided by junior doctors on rotation who received direct supervision by the Consultants. On average, there were 2.5-3 whole time equivalent (WTE) junior doctors providing day to day cover for the inpatient unit.

Hospice services for adults

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Saint Catherine's Hospice employed three specialist palliative care consultants (2.4 WTE) and a specialty doctor (0.6WTE) to provide senior cover from Monday to Friday 8-6pm. Consultants undertook patient reviews in the hospice, local acute trust and community throughout the week and provided junior doctor supervision and training.

The monthly medical rota was designed to ensure there as a consultant available to provide advice at all times. Within the inpatient unit the hospice trained foundation year two, general practice trainees and doctors on the local deanery specialist palliative care medical scheme.

The service always had a consultant on call during evenings and weekends. The junior medical team and contracted GPs shared the first on call medical rota duties during evenings and weekends. Specialist palliative care consultant cover was from 12 consultants working in regional palliative care units as the second doctor on call to provide specialist advice as necessary.

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. Shared electronic records were accessible to all staff involved in patient care. Records we reviewed were comprehensive and stored securely. We reviewed two sets of records for patients on the inpatient unit and found these had been fully completed. Referrals could be made using electronic referral forms or by phone if the referral was urgent.

Records were regularly audited to ensure they were properly maintained. We viewed the results of an audit and saw that this included assurances that records were completed, and that risk assessments and care plans were completed within the required timescales.

When patients transferred to a new team, for example, when transferred from community to hospice, there were no delays in staff accessing their records. Staff reported that up to date patient information was available and accessible in all hospice settings.

Records were stored securely. The electronic patient record system was appropriately security protected and paper records were kept secure. Record audits were regularly completed and action to improve discussed by the clinical governance group and shared with staff. Information was shared with patient's GPs and other professionals involved in their care, with appropriate consent arrangements in place.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Medicines were supplied by an external community pharmacy. A pharmacist visited once a week to review prescriptions and provide advice. Pharmacists were contactable the rest of the time but provided no support with stock management and sometimes the delivery of medicines was slow, where things ordered on Fridays did not get delivered until Tuesday. However, there was a system of using prescriptions locally to supply anything needed urgently. Emergency medicines were available should they be required.

Hospice services for adults

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. We saw a nurse explaining anti-sickness medicines to a patient. Prescribing was clear, safe and appropriate to be able to respond to symptoms that patients may experience during their stay. Prescribing did not always include an indication, frequency or maximum dose on commonly used medicines but this had been identified by the hospice and was on an action plan to address. Patients received prompt and adequate pain relief and we saw that medicines were individually titrated to people's needs including for one patient who was particularly sensitive to the side effects of medicines. People receiving medicines by syringe pumps (medicines delivered through the skin) were regularly monitored. We saw that staff responded appropriately to a patient who did not like having the syringe pump in place and had found an alternative way to give the medicines. One patient told us 'they are wonderful people, I have concerns about medicines when I leave but they do explain everything'.

Staff completed medicines records accurately and kept them up to date.

We saw that medicines could be given intrathecally at the hospice if required for pain relief. This is when a patient receives medicines directly into the spine. A patient had recently received treatment with intrathecal morphine successfully.

Staff stored and managed all medicines and prescribing documents safely. The current medicine policy was being reviewed as part of a regular review process.

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, although we were told medicines reconciliation was completed by doctors on initial admission to the hospice.

Medicines were prescribed off-label (where a medicine is used for a condition or purpose other than for which it has been approved) 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 there was a leaflet currently being completed to give patients information about this.

There was a procedure in place to allow people to self-administer their own medicines if they wished however the policy referenced Nursing and Midwifery Council standards which were withdrawn in January 2019, it was overdue for review.

Staff learned from safety alerts and incidents to improve practice. There was evidence that actions had been completed, processes revised, and learning shared with hospice staff. The service conducted audits to assess compliance against the medicines policy including management of Controlled Drugs. The results of the audits were reviewed at monthly Medicines Management Meetings.

Medicines training was not mandatory, but it had been identified that it should be included in the mandatory training programme and audited. The staff we spoke with said they had done medicines training and their competency was checked annually. The pharmacy service provided educational materials and training via e-learning seminars.

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.

Hospice services for adults

Staff knew, and received training in, what incidents to report and how to report them. Incidents were reported using an electronic reporting system and staff understood what constituted an incident or near miss and how to report them.

Staff raised concerns and reported incidents and near misses in line with provider policy. We saw that a range of incidents were reported and that this included near misses. We reviewed records that showed there had been 32 incidents since April 2021, 19 near misses and 36 incidents from external organisations (where the responsibility lay externally).

Incidents relating to patient falls, medicines and pressure ulcers were submitted to Hospice UK as part of national benchmarking activities. We saw that incidents were rated in terms of patient harm, with the majority resulting in no or low harm. There were no serious harm incidents in the data from the last year.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong. Apologies and explanations were given as soon as an incident occurred.

There was a process for dealing with safety alerts that were relevant to the hospice. These were recorded and acted on and reviewed at clinical governance meetings.

Staff received feedback from investigation of incidents, both internal and external to the service. Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Incidents were investigated usually within a week of occurring. We saw that this was the case for most clinical incidents, but some investigations had been delayed due to staffing issues, although prioritised based on risk. We saw clinical governance meeting records, where this was discussed, and a decision taken to add this to the risk register. Other action planned included investigation training for staff involved in this process.

Staff met to discuss the feedback and look at improvements to patient care. We saw that action was taken to mitigate risks associated with incidents. This included the use of fall sensors and increased monitoring as appropriate, and the use of additional pressure relieving equipment in response to evidence of skin damage, where a patient's health had deteriorated, and additional risk was evident. The hospice had set up a tissue viability group in the weeks before the inspection. The group was chaired by clinical nurse specialist and safeguarding lead and involved social work input and participation from nursing staff from across the hospice. Part of the role of the group was to review pressure ulcer incidents and report back to the clinical governance group.

Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

The service continually monitored safety performance. They participated in the Hospice UK safety benchmarking process. This included reporting incidents relating to falls, pressure ulcers and medicines incidents. We saw that the hospice benchmarked against previous years' results. They took action to improve, for example, by setting up a tissue viability group with a remit for focusing on the incidence of pressure ulcers and explore ways to improve.

Staff used the safety data to further improve services. They reviewed data and fed back to staff, involving them in discussions around improvements. Safety data was reported on a monthly basis and reviewed by the clinical governance group. This included pressure ulcers, falls and medicines incidents. Action to improve included the development of a tissue viability group to closely monitor and take action to improve.

Hospice services for adults

Are Hospice services for adults effective?

Good 

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

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.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Organisational and care policies took account of relevant national guidance, for example NICE Quality Standard 13 End of life care for adults and NICE guidance 31 Care of Dying Adults in the Last Days of Life. Patients had personalised care plans and assessments took account of people's emotional, spiritual and social needs. Care in the last days and hours of life delivered the Five Priorities for Care of the Dying Person.

Care plans were developed with input from the patient and those close to them. They included support for patient's psychological, social and spiritual support needs. Recommended summary plans for emergency care (ReSPECT) forms were completed in line with national guidance. They included personalised care decisions in relation to treatment and care in an emergency, including balancing living for as long as possible with quality of life issues.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Handover and multidisciplinary records reflected discussions about all aspects of the wellbeing of patients and those close to them. Handovers were held at shift changes and included personalised discussions about patient's needs including emotional and spiritual needs.

The service participated in national research projects to benefit patients. This included the Resolve study to work with specialist palliative care services to help implement outcome measures into routine clinical practice. Participation in a delirium in hospice patients study increased staff recognition and discussion of issues relating to delirium. This provided staff with the opportunity to improve knowledge and skills in this area.

Staff protected the rights of patients with protected characteristics. They recognised that patients with a learning disability often presented to palliative care services late in their disease and worked with specialist staff to address this. They had a focus on raising awareness to community groups of hospice services and recognition of dying within this group of patients. This included close working with learning disability services within the community.

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. Catering staff focused on providing food to meet patients needs and wishes during admission. There was a range of

Hospice services for adults

menu options available and staff supported and encouraged patients to eat and drink. A nutrition and hydration observational survey was routinely carried out by senior staff. This included monitoring aspects of meal provision such as any disturbances to mealtimes, the presentation of food, appropriate dining facilities and that appropriate assistance was given to those patients requiring it.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. This supported the monitoring of nutritional and hydration intake and the identification of risks.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Assessments in the last days of life included a review of nutrition and hydration needs, with appropriate discussion with the patient and their family to ensure that these needs were met. This included discussions with medical staff on the appropriateness of artificial feeding and hydration. Care plans included nutrition and hydration needs and were individualised to ensure that needs were met. Staff had received training in fortifying food, to ensure that patients at risk of malnutrition were given appropriate nutrition. This included tips to increase the nutritional value of common foods. Additional focus of the training included comfort measures and the provision of nutrition to meet the needs of patients with dementia. Intentional rounding within the inpatient unit included offering patient's food and drink everyone to two hours.

Oral assessments were routinely undertaken using an adapted screening tool and care was planned using the care of the dying care plan tool.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. Staff routinely referred patients for specialist support when needed. They had protocols for patients with swallowing difficulties and planned care appropriately.

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. We observed staff assessing patient's pain and pain control appropriately.

Patients received pain relief soon after requesting it. Patient's reported that they received pain relief promptly and on time, including where they requested it for breakthrough pain.

Staff prescribed, administered and recorded pain relief accurately. Anticipatory medicines were appropriately prescribed for patients in the last days of life. Staff had received syringe pump (a machine that allows for continuous administration of medicines) training and competency assessment. They regularly checked administration and assessed the effectiveness of pain relief and adjusted this within prescribing guidelines as required.

At the time of inspection an anticipatory prescribing audit and pain management audit to improve the assessments of patients' breakthrough pain were in progress. Results from an ongoing advance care planning audit showed that 90% of patients cared for by the hospice had an advance care plan in place where their wishes for the end of their life were incorporated.

Hospice services for adults

Patient outcomes

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

Managers and staff used the results to improve patients' outcomes. The service used the Australia-modified Karnofsky performance scale (AkPs) to identify patients' overall status and ability to carry out activities of daily living. Patient outcomes were discussed at handovers and multidisciplinary team meetings. This helped clinical staff to evaluate the effectiveness of their treatment and care and informed discussions with patients and their family about changes to treatment and care.

The hospice used the Palliative care outcome score (IPOS) in the community and outpatient services to understand the overall experience and status of patients at a specific point in time. A review of the use of outcome measures was undertaken in November 2020. This identified that the use of outcome measures had been implemented across all departments within the hospice and identified potential improvements in consistency. Actions included additional training for staff although this had not yet been implemented at the time of inspection.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. A range of audits were carried out, including those relating to advance care planning, completion of patient records, 'do not attempt cardiopulmonary resuscitation' decision making, anticipatory prescribing and pain management. We saw that some audits had been delayed in 2021 due to staffing and training issues impacted by the pandemic. However, there was evidence of audit being used to make improvements. Examples included amendments to pain assessment tools as a result of an annual pain audit and improvements to advance care planning record completion.

Managers used information from the audits to improve care and treatment. Improvement is checked and monitored. Audits were reviewed by the hospice audit group, with presentations at multidisciplinary meetings. Re-audits were planned and audits in progress had completion and feedback dates associated with them.

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. Managers gave all new staff a full induction tailored to their role before they started work. Induction included shadowing opportunities for new staff and induction training programmes. New staff also received probationary reviews during their first few months at the hospice and individual performance and development goals were set.

Managers supported staff to develop through yearly, constructive appraisals of their work. Appraisal achievement on the inpatient unit had been impacted by the pandemic and there were plans in place to ensure all staff received an appraisal in the coming months. At the time of the inspection inpatient unit appraisal achievement was at 81%. Clinical nurse specialist (CNS) and patient and family services team appraisal rates were 100%.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Staff had access to group and individual supervision. Senior staff with line management responsibilities received training in coaching skills. External coaching was also provided for some staff as part of engagement with the local integrated care system.



Hospice services for adults

The clinical educators supported the learning and development needs of staff. A range of training was available for internal and external staff, including local care homes. Courses included advanced communication skills, dementia care and nurse mentorship.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Briefing communications were sent to all staff on a regular basis and included updates to policies as well as other information about changes and hospice updates. Regular meetings were held, for example, on the inpatient unit where team leaders facilitated team discussions.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. A range of competency assessments were incorporated into training programmes. Specific competencies for nurses included the administration of medicines via different routes as well as competency in the use of syringe drivers. The hospice had trained and developed two nursing associates. Staff working within the wellbeing services had completed training in spiritual care and mindfulness to enhance their skills and the services delivered.

Managers made sure staff received any specialist training for their role. All clinical staff had the opportunity to complete internal advanced palliative care training, with courses for registered nurses as well as those specific to health care assistants. In addition, clinical nurse specialists had been supported to complete pain and symptom management and palliative care modules at master's level. There were two development posts within the clinical nurse specialist team, where nurses were supported in their development into the CNS role.

The hospice supported student placements, including student nurses, counsellors, social workers, physiotherapists and occupational therapists. They also supported placements for medical students from two local medical schools. Staff had received specific training to support students.

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 team meetings (MDT) to discuss patients and improve their care, these were held within the inpatient and community teams. The community team had a daily referral meeting that also incorporated discussions on symptom management and care for patients on their caseload. These meetings involved nurses, the community palliative care consultant, social workers and a registrar from the acute trust.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff worked closely with other services including GPs, district nurses and the local acute trust. There was evidence of multidisciplinary working within the hospice, including close working between nursing, medical, social work, allied health professionals and therapy staff. Meetings included junior medical staff on placement at Saint Catherine's, and a palliative medicine consultant who was employed by Saint Catherine's and provided sessions into acute hospital trust.

Hospice staff worked collaboratively with other services to develop multidisciplinary approaches to care for patients with specific conditions. The hospice had a neurological clinical nurse specialist service (CNS). They worked jointly to set up and participate in MDT meetings for patients' neurological conditions. These were held every three months with involvement from neurology and respiratory consultants, the home ventilation team and neurology CNS' from both the

Hospice services for adults

hospice and the acute trust. A nutrition and gastric neurology MDT was also in operation, providing support for patients whose neurological condition had affected their ability to eat and drink. MDT discussions included assessing the requirements for artificial feeding. CNS' attended multidisciplinary team meetings at GP practices for patients being cared for in the community.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. The patient and family support team had developed and launched guidance in November 2021 on assessing patients at risk of potential suicide. The pack incorporated assessment tools to offer practical support, guidance and structure when supporting patients at risk of suicide.

Seven-day services

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

Medical staff led daily ward rounds on the inpatient unit and there was consultant cover with regular ward rounds during the week. Patients were reviewed as required out of hours.

The clinical nurse specialist team was contracted to provide a five day a week service from Monday to Friday. Hospice at Home services were available seven days a week, including some overnight cover. The contractual arrangement did not cover both healthcare assistant and registered nursing shifts. Therefore, the hospice provided healthcare assistant cover for every shift and registered nursing cover for as many shifts as possible. When no out of hours hospice at home registered nursing service was available, responsibility within the community was with the on-call GP and 111 service with support from the specialist palliative care on call system as required. Patients could access inpatient and hospice at home services seven days a week.

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 support for patients. Patient information was available, providing advice and guidance on issues such as sleep. Members of the multidisciplinary team provided health promotion advice and patients had access to dietetic and nutrition advice.

Staff assessed each patient's health when admitted and provided support for any individual needs to live as well as possible. Assessments were holistic and included emotional and social support needs. The support needs of those close to patients were also assessed and staff took action to meet the needs both within the hospice and community service.

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. Mental capacity assessments were carried out routinely as part of assessment processes across the hospice.

Hospice services for adults

Staff gained consent from patients for their care and treatment in line with legislation and guidance. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. This included following advance care plans that had previously been developed with input from the patient and those close to them.

Staff made sure patients consented to treatment based on all the information available. Information leaflets were available to support explanations for treatments and staff took time to ensure patients had the information required.

Staff clearly recorded consent in the patients' records. This was routinely audited to identify any gaps and improvements required.

However, staff did not receive and keep up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Managers told us that this had previously been a mandatory training module but that due to personnel changes had not recently been included in the current training provision. This meant that while some staff had completed the training historically, there was no way of monitoring what proportion of staff had, and staff had not completed recent training updates. They recognised that staff required more up to date training and were working towards implementing it back into the mandatory requirement for patient facing staff. We saw that recent 'bite size' face to face training had been provided for nursing staff in addition to the requirement for them to complete the e-learning mandatory module going forwards.

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.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. Audits of records included how well mental capacity assessments were completed and additional learning was provided when required.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation.

Are Hospice services for adults caring?

Our rating of caring went down. We rated it as good.

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. They took action to respect patient's privacy and dignity.

Hospice services for adults

Patients said staff treated them well and with kindness. Feedback from patients and those close to them was consistently positive and included examples of where staff had been kind and supported them with compassion. Patients told us that staff were helpful and quick to provide support when needed. One patient told us that 'nothing was too much trouble' for staff who were kind and friendly and that they would 'not want to be cared for anywhere else'.

Staff followed policy to keep patient care and treatment confidential. Conversations about care and treatment were held discreetly.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff had received training on different aspects of mental health including caring for patients with dementia or delirium.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

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. Feedback from patients and those close to them was consistently positive about the support and advice given to them. We reviewed patient stories that were collated on the inpatient unit and in the community. These consistently demonstrated the support given to patients and their families. Support included staff following up family members at home following the death of their loved one.

Bereavement and family support staff were available on the inpatient unit to provide additional support and bereavement follow up support was available to family members and those close to patients. Counsellors provided a bereavement service to both adults and children. Patient feedback on their counselling experience was positive, with most respondents scoring highly for their experience. For example, 85% gave their counsellor the top rating for feeling listened to and understood, those feeling that the counsellors approach was right for them was at 86% for the top score.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Patient facing staff had received training in advanced communication skills. Feedback from patients and those close to them were positive about how staff communicated with them and the kindness and empathy displayed.

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. Support was available on an individual basis. Written feedback from patients and those close to them included that there was a strong person-centred culture within the hospice. We saw examples of individual care decisions and staff made every effort to meet the holistic needs of patients in their care. Examples included a patient who was able to have their dog with them on the inpatient unit at the end of life. A family were accommodated on the inpatient unit for several weeks when their relative was at the end of life. This enabled family members to stay with them, including their children. Staff organised for a separate dedicated wing within the hospice for this purpose. They also enabled friends of the patient to visit outside due to social distancing rules and carried out individual risk assessments to facilitate this process.

Hospice services for adults

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. Staff collated patient stories to reflect on the care delivered to each of them. We viewed examples of the patient stories and saw consistently that these were positive and demonstrated that patients and those close to them were carefully considered as part of the services delivered.

We viewed feedback that included positive experiences of the services offered. For example, feedback from a trainee who had shadowed the nurse working in the lymphoedema clinic spoke of the kind and caring approach of the nurse. It included that the staff member had adapted their approach to suit the individual needs of patients, including those with anxiety and a learning difficulty. Time was taken to explain their condition, encouraging them to speak freely and making them feel at ease.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. A patient and family survey of their experience of treatment and care was not carried out. However, feedback cards were given to patients and those close to them and this information was collected by the hospice's communication team.

Staff supported patients to make advance decisions about their care. Staff ensured patients on the inpatient unit and those in the community were involved in decisions about their care. Patient wishes and preferences were recorded as part of care planning processes. Staff focused on support for advance care planning and monitored achievement of this. We saw from the most recent figures that 90% of patients had received support in recording their wishes and preferences at the end of life in an advance care plan. The hospice also used an electronic palliative care co-ordination system to record and share individual's care preferences about their care at the end of life.

Patients gave positive feedback about the service. Feedback from a patient using the lymphoedema service stated that they couldn't think of a way that the service could be improved. Another patient said that they had received support from the hospice to come to terms with a 'life changing way of life'. A relative commented on the friendliness of staff not involved in patient care, describing them as 'friendly and polite'. Other comments on the staff included that they were polite, helpful, caring and approachable and that they gave 'unfailing' support and treated patients and visitors with warmth. One family member stated that staff 'surrounded us in love and helped us though.' However, the survey had limited quantitative survey data and did not undertake patient or family surveys within the inpatient and community services.

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 proactively 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.

Hospice services for adults

Managers planned and organised services, so they met the needs of the local population. Services were designed to meet the needs of different groups and provided flexibility and choice for patients wishing to be cared for in different care environments, including their own homes.

The hospice provided services based on identified needs. For example, they provided a hospice at home night service, despite limited funding for this. They provided hospice care to people with cancer and other conditions. They had a neurological clinical nurse specialist team who supported patients with conditions such as Parkinson's Disease, Motor Neurone Disease and Multiple sclerosis. Staff had worked collaboratively with the Leeds respiratory service to support patients with complex respiratory symptoms resulting from their neurological disease. They had set up joint respiratory and neurological outpatient clinics for patients able to travel. These were ordinarily held every three months, however had been paused during the pandemic and were in the process of restarting at the time of the inspection. Patients unable to be seen in an outpatient setting were seen at home. The neurological CNS' supported care homes with the care of patients with Parkinson's disease, including the provision of education to support symptom management. A telephone response service was in place for neurology patients and the health and care professionals looking after them. The CNS' also had honorary contracts to provide in-reach service to the local acute hospital to review patients with a neurological condition requiring palliative care support.

Hospice leads worked in partnership with other providers across the integrated care system to improve care for patients. They were involved in a collaborative partnership with other hospices to provide a learning tool (Project ECHO) for colleagues across the health and social care community. This involved providing online collaborative learning resources and sharing time and experience to lead discussions and present topics to enable best practice. This involved the provision of a series of free virtual reflective learning sessions by video to support care staff during Covid-19. Sessions included support for care staff, mindfulness techniques, bereavement support and advance care planning. Other examples of sessions facilitated included palliative care emergencies and managing seizures. In 2020/21 the project supported staff from 150 organisations and subsequently supported the care of 2,500 care home residents. Feedback from staff participating included that they felt more connected and less isolated.

Facilities and premises were appropriate for the services being delivered.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. There were clear guidelines for support and staff had received training to recognise when emergency support was required. Staff had received training on different aspects of mental health including caring for patients with dementia or delirium.

The service had systems to help care for patients in need of additional support or specialist intervention. Counselling, mental health services and complementary therapies were available on the inpatient unit and within the wellbeing centre. At the time of the inspection day and wellbeing services were in the process of opening after a period of being impacted by the pandemic.

The hospice at home service worked collaboratively with district nurses and Marie Curie to provide a 24-hour service for support in patient's own homes. This included supporting the fast track discharge of patients in hospital at the end of life who wished to die at home. Hospice leads told us there were some gaps in funding provision for overnight services and that the hospice at home team helped to fill those gaps, however, there were some issues with staffing that impacted this. During the times that the hospice was unable to provide an overnight service, this reverted to NHS 111.

At the start of the pandemic hospice leads and staff worked to move some services online, including virtual consultant and clinic appointment, using existing information technology.

Hospice services for adults

Meeting people's individual needs

People's individual needs and preferences were central to the delivery of services. 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 mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Individual needs were assessed, and staff worked proactively with other providers to meet those needs. Staff had received training in supporting patients with dementia.

The inpatient ward was designed to meet the needs of patients living with dementia. The wellbeing centre had been redesigned to make it more accessible for people with dementia and the inpatient unit used visible prompts and signage to ensure that patients with dementia could navigate the care environment.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents. Staff had attended dementia awareness training. Leaders were committed to working collaboratively with partners to improve access to specialist palliative care services for people in the community with a learning disability. They recognised that patients with a learning disability were often referred to palliative care late in their disease trajectory, meaning that opportunities to support them to plan their care were limited. At the time of the inspection the hospice was applying for grant funding to develop a project to work with other services to collaboratively address this issue.

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 interpreters and signers and had access to communication aids as required.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Catering staff were responsive to the needs of individual patients and staff assessed these needs prior to and on admission.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff could access interpreters and use communication prompts as required. They demonstrated an awareness of different communication needs and how to make information accessible for individual patients.

The service had suitable facilities to meet the needs of patients' families. During the pandemic families could visit or stay with patients in their rooms. They were encouraged to wear personal protective equipment in line with guidance. Families were offered refreshments. Ordinarily, there was a family area that could accommodate overnight stays; however, this was not in use during the pandemic.

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. We reviewed waiting times as part of our inspection and saw that the average wait for an inpatient bed was one day. The hospice held a waiting list and we saw in the week leading up to the inspection there were between zero and four patients waiting for a bed on any one day. This was managed effectively through daily referral meetings and the provision of hospice at home and clinical nurse specialist support for patients at home waiting for an admission. The wait for hospice at home services was one day and the average wait for clinical nurse specialist input was five days, although urgent support was generally provided within one day.

Hospice services for adults

Occupancy of the inpatient unit was between 88% and 100% based on the eight beds available at the time of the inspection. Plans were in place to increase bed availability to 10 by the middle of November 2021 with an increase in staffing due to recent recruitment.

Patients and those close to them could access support 24 hours a day, seven days a week. A palliative care advice line was run by the hospice and this provided out of hours support from nurses for patients and professionals.

The hospice was not contracted to provide both healthcare assistant and registered nursing cover for the hospice at home service 24 hours a day. However, they provided 24-hour healthcare assistant cover, with registered nursing cover for as many shifts as possible through the use of charitable funds. They worked to ensure that patients received care when they needed it. Staff went out of their way to respond to patients in need of care, such as nursing staff visiting a patient at home prior to their shift starting in order to provide pain relief.

Managers and staff worked to ensure discharge planning was started as early as possible. Discharge plans were commenced at the point of admission to the inpatient unit, with assessments of discharge needs carried out. Staff worked with other local services to support prompt discharge. The hospice at home service provided a dedicated rapid discharge service for patients whose preferred place of care was in their own home.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. There was a multidisciplinary approach to discharge planning. Staff referred patients appropriately to other services to support their discharge.

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. They were encouraged to raise concerns verbally and given information on how to raise a formal complaint.

Staff understood the policy on complaints and knew how to handle them. They worked to resolve complaints promptly and referred patients to senior staff when this was not possible. Both formal and information complaints were recorded.

Managers investigated complaints and identified themes. All complaints were investigated by senior staff. Investigations involved speaking with those involved to identify any issues and these were acted on promptly.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Information about the outcomes of complaints was shared with the complainant and staff involved. Learning was shared to minimise the risk of repeat issues.

Staff could give examples of how they used patient feedback to improve daily practice. Staff told us about a complaint relating to a family unable to access support for symptom management during the night for a patient. At the time, there was no nurse available through the hospice as this was an additional service that was not funded through a service level agreement. While the hospice endeavoured to provide nursing cover at night this was not always possible. When this was the case, care was accessed through the NHS 111 service for patients requiring symptom management. In this situation the patient had been unable to access additional medication overnight due to delays in a GP visiting. Hospice leads investigated the complaint and passed on concerns to the 111 service. In addition, they provided an explanation

Hospice services for adults

to the family and reflected on what action could be taken to support patients and families if this situation occurred again. As a result, they had agreed that a healthcare assistant would visit to provide additional support while waiting for a GP visit. In this case we were told that a member of the hospice nursing team had visited the patient at home prior to starting their shift to provide support with controlling their symptoms.

Are Hospice services for adults well-led?

Good 

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

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.

The hospice was led by a senior management team which included a chief executive, clinical services director and business and people leads. The senior management team was supported by and reported to a board of trustees.

Most staff reported that leaders were visible and approachable. However, some staff on the inpatient unit told us they would appreciate a more visible presence from the leadership team. Leaders told us that visibility of both senior leaders and the board of trustees had been impacted by the pandemic and restrictions to movement within the hospice as result. However, the clinical services director regularly worked on the inpatient unit to provide support to staff.

We saw that staff had opportunities to develop their skills and take on more senior roles. This included staff recruited to clinical nurse specialist development roles. Hospice leaders were aware that some staff wanted more development opportunities, as indicated by staff survey results. An October 2021 briefing from the survey results included action to improve development opportunities for staff, as well as increasing the visibility of trustees within the staff teams.

Departments within the hospice were managed by operational leads. Staff reported they felt supported by team and department leads to deliver care and services.

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 strategy was aligned to their vision to be a leading provider for specialist palliative and end of life care, working collaboratively to deliver safe and quality patient centred services. The strategy was also linked to the national Ambitions for Palliative and End of Life Care (2021-2026) and focused on sustainability of services.

Hospice leads identified strategic intents for the next 18 to 36 months. This included continued collaborative working across the integrated care system, work on inclusion and expanding access to services, supporting patients earlier in their disease trajectory, wellbeing service development and actions for continued learning and innovation.

Hospice services for adults

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.

Staff we spoke with told us they worked well as a team and supported each other to deliver high quality care. Staff survey results from 2021 showed high levels of positive feedback in relation to the quality of care they felt able to provide, making a difference and enjoying their work. The survey identified some issues with inter department communication, confidence in leadership and job security. Hospice leads told us that service restructures in 2017 and 2020 had impacted on morale. We viewed a board briefing paper on the survey results and saw these highlighted aspects for improvement including communication, development opportunities and action to improve the hospice's impact on environment.

Staff had received training in equality and diversity, and we saw that improving equality of access to services was a clear focus for the hospice. Staff were supported in their career development and we saw examples of development roles within community services and staff who had been supported to complete specialist and masters level training. There was a commitment from hospice leads to further develop training and career opportunities for staff.

Patients, their families and staff could raise concerns without fear. We saw examples of where concerns had been investigated with a view to ensuring improvements.

The hospice had a whistleblowing policy with named freedom to speak up guardians who staff could approach with concerns. There were clear processes for investigation and learning from concerns, as well as support for staff raising them.

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.

The hospice had a clear governance framework where staff were clear about their roles and accountabilities. There were effective structures, processes and systems of accountability to support good quality, sustainable services. There was evidence of improvements to governance processes since our previous inspection of the hospice. Processes where improvements were seen included trustee recruitment, oversight of human resources information and staffing, and analysis of complaints and incidents. We also saw that the process for updating policies and procedures included making these available electronically so that all staff could access them, including on mobile devices. Policies we saw, including safeguarding and freedom to speak up policies had been reviewed and ratified by the board and were accessible to all staff.

Hospice governance was monitored through a committee structure where governance and audit, finance and income, and people and resources committees were chaired by members of the board of trustees. Reports from the committees were reviewed at quarterly board meetings and we saw minutes of meetings where more detailed discussion of specific issues was held.

Hospice steering groups provided detailed performance information to relevant committees. For example, clinical governance information was reviewed at regular governance and audit committee meetings.

Hospice services for adults

We viewed a sample of information that was shared with the board of trustees as part of their quarterly meetings. This included safeguarding, incident, complaints and a monthly service activity report.

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.

Leaders and teams had processes to review information and systems to effectively manage risks, issues and performance. Risks were identified and recorded on the hospice risk register and mitigating actions taken to minimise the impact of the risk. Each risk was evaluated using a nationally recognised risk management approach. Risks were rated based on a 'do nothing' approach and re-rated once controls had been identified. Risks we reviewed showed a reduction in risk level once control measures were established and the level of risk was identified as adequate based on this. For example, the risk of infection was mitigated using an ultraviolet sterilisation unit and an increased supply of personal protective equipment during the pandemic.

Hospice leads demonstrated a good understanding of the issues the hospice faced. Risk assessments were carried out when changes or new approaches were implemented. Risks were also identified through incident and complaint reports, audit results and the implementation of new guidelines. A business continuity plan was available, and the hospice had a resilient recovery plan that had been implemented in October 2020 to protect the long-term financial future of the hospice.

Clinical staff recorded patient stories as part of their ongoing review of the care delivered and this was used to reflect on and share performance information on the effectiveness of the services delivered.

Service performance was measured using key performance indicators established by the hospice in line with the monitoring requirements of commissioners. Examples included referral, occupancy, length of stay, waiting times and caseload monitoring to ensure that performance was in line with targets. The hospice participated in benchmarking activity to monitor performance. This included the Hospice UK national benchmarking of incidents such as falls, pressure ulcers and medicines incidents. They also participated in a national staffing survey that benchmarked staff satisfaction with other hospices across the United Kingdom.

Information Management

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

The service collected data and analysed it to understand performance in various areas. Performance information helped leaders to identify themes and trends, for example, in relation to incidents and complaints. Information was then provided to the board for oversight of activities and performance.

Hospice services for adults

The information systems in use were integrated and secure. Notifications were submitted to external organisations as required. Staff had access to electronic patient record systems and care records. They could access these on desktop and mobile computers on the inpatient unit. The electronic patient record system enabled sharing of records between inpatient and community services, including patients' GPs. There were appropriate consent arrangements in place to support this.

Information technology systems had appropriate security measures in place to ensure confidentiality and compliance with information governance requirements. The hospice was registered with the Information Commissioner's Office and there were appropriate arrangements for reporting concerns or incidents.

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.

There were collaborations with partner organisations and commissioners to develop services. This included a collaboration with seven other hospices in the area, through a memorandum of understanding, where the hospices worked together to understand the external environment and how changes impacted on hospice care. Hospice leads developed services in collaboration to meet the need of the local community and leads were actively involved in local networks. This included the local integrated care network and the clinical lead was involved with the local strategic clinical network and the national clinical excellence group. Specific engagement activity included work to address workforce development issues across the region and service needs assessments to look at inequalities across the region. The clinical services director was one of the clinical leads within the regional strategic clinical network.

Staff engagement processes included annual staff surveys that were benchmarked against other hospices. Staff had also been consulted about internal workforce changes at the start of the pandemic, with consultation meetings with staff representatives. There were team meetings held within different departments. Staff told us they weren't always able to attend. 'Briefing in a minute' communications were used to share information with staff about key changes to policy, information updates and on issues such as safety alerts that were relevant to practice. At the start of the pandemic hospice leads implemented COVID-19 monitoring and planning meetings with staff.

Staff actively encouraged patients and those close to them to share their experience of services. Staff used patient stories to reflect on care and identify any themes or areas for improvement. There was a patient and public engagement group that monitored feedback. Feedback was collected from compliments, letters, completed comment cards, complaints, clinical lead visits to the inpatient unit and social media. An anonymised survey was used within the counselling service and we saw that patients' experience of this service was positive. However, the hospice did not conduct anonymised surveys to capture the experience of all aspects of the service.

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.

Staff we spoke with showed a commitment to learning and improvement to meet the needs of patients and those close to them. The service actively participated in national research and innovation projects. This included work to improve patient's outcomes of care received.



Hospice services for adults

Staff were encouraged to participate in improvement activities, and we saw examples of this in relation to the development of a tissue viability group to focus on the improvement of care in relation to pressure ulcers. The Outcome Assessment and Complexity Collaborative (OACC) clinical outcome scores were in use within the inpatient and community services and this had been evaluated externally. We saw that action to improve was incorporated into clinical governance plans.

Specific areas of improvement included the development of mortality review meetings where staff would meet to review patients' care following their death, with the aim of learning and improving care from an evaluation of its effectiveness.

There was a clinical audit cycle in place, with audits including 'do not attempt cardiopulmonary resuscitation', advance care planning, consent and the management of patient records. We saw that some audits had been impacted by the pandemic, however, there were future dates identified to re-audit these areas. We saw evidence of improvement as a result of audits, for example, in relation to the recording of advance care plans.

Hospice leads were committed to finding innovative ways of supporting the needs of the community. The geographical area serviced by the hospice was 1600 square miles which limited the scope for caring for all patients within the hospice. As a result, leads had developed a proposal to take wellbeing services out into the community. They recognised that while video consultations were available for patients in the wider community, not all patients had access to the equipment to support this. Although the hospice had supported patients by loaning equipment, they identified the need for more agile community services. This included the development of a 'bus' to provide clinical care in the community to enable more accessible services in specific localities. At the time of the inspection this project was in development with funding applications complete to support its implementation.

Work on the Echo project (a collaborative approach to sharing specialist palliative care expertise and supporting health and social care workers during the pandemic) delivered support to 150 organisations during the pandemic. This included virtual training and support sessions for staff working across the community, for example, in care homes. This activity was shared with other providers through a joint poster presentation to the 2021 Hospice UK conference.