St. Leonard's Hospice York

St Leonard's Hospice

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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

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

- 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 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.
- 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.
- Staff and managers 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:

- Not all staff had had an appraisal
- Many staff did not feel aligned to the service's vision and values and did not understand the long-term strategic view.
- Many staff told us that they did not feel respected, supported and valued and this affected the overall culture within the organisation.
- The service did not have a Freedom to Speak Up Guardian to act as an independent source of advice for staff.
- Although, staff had the opportunity to have contact meetings, there was no system to evidence that all staff had supervision.

Unlike our previous inspection, we did not find substantial evidence of outstanding practice in care and treatment or how the leaders managed the service. However, we did not identify breaches of regulation in the safe, effective, caring and responsive domains. Our inspection found the service now met the rating characteristics of good in most areas.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	Good	

Summary of findings

Contents

Summary of this inspection

Background to St Leonard's Hospice

St. Leonard's Hospice York is a 20 bed in-patient hospice care unit (IPU) and a hospice-at-home service. At the time of inspection, the hospice had no more than nine beds open. The hospice holds condition specific clinics, has a social work team, a bereavement support service, therapy services, an education department, a fundraising department and a team of volunteers. The hospice-at-home team provide hospice care in the local community.

The care provided by the hospice is for people that live in the York area of North Yorkshire and Ryedale and some parts of the East Riding of Yorkshire. The service is a registered charity with a board of trustees.

The hospice was last inspected in 2016 and was rated outstanding overall. It was found to be outstanding in the effective and well led domains and good in the safe, caring and responsive domains.

The service is registered to provide:

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

We carried out this inspection as a response to concerns raised about the service and the service had not been inspected since 2016.

How we carried out this inspection

We visited the inpatient unit and the hospice at home team. We held interviews with service leads and executives. We spoke with 32 staff including managers, nurses, health care assistants, doctors, consultants, volunteers and non-clinical staff. We also spoke with four inpatients and their 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 four patient care records. We also received feedback about the service from people who contacted the CQC via the CQC website.

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.

Areas for improvement

Action the service MUST take to improve:

- The service must appoint a Freedom to Speak Up Guardian to act as an independent and impartial source of advice to staff at any stage of raising a concern.
- The service must implement an effective system to ensure all directors, including trustees, are assessed in line with the requirements of the fit and proper persons regulations.
- The service must continue to work to address a divided culture within staff teams and between staff and managers.

Action the service SHOULD take to improve:

Summary of this inspection

- The service should ensure that all staff have an appraisal.
- The service should consider having an annual quality account
- The service should implement an effective system to evidence and provide assurance that all staff receive supervision to enable them to carry out their roles.

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	Good	Requires Improvement	Good
Overall	Good	Good	Good	Good	Requires Improvement	Good

Good

Hospice services for adults

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Requires Improvement

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.

Mandatory training was comprehensive and met the needs of patients and staff.

Training needs were identified for different teams and specific roles. This included staff and volunteers, for example, in relation to moving and handling training. Other mandatory training included modules in infection prevention and control, health and safety and basic life support. All staff received end of life care training. Additional competency training modules including for syringe drivers (a battery operated pump that delivers continuous administration of medicines) and wound care were completed. Staff told us they were given time to complete these modules within their working hours.

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

There was an online electronic management system used to provide training and monitor training compliance. This system was also used to provide additional training to support professional development.

Mandatory training compliance was at 96% for staff.

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. The hospice had aligned their safeguarding training requirements with the local NHS Trust and national guidance. This included level three adult safeguarding for senior clinical staff and level two adult and child safeguarding training for registered nurses. Many nurses were working to or had completed level three training.

The hospice safeguarding lead was trained to level five. Level two adult safeguarding training compliance and level two child safeguarding compliance was at 94%. All senior nurses who covered shifts and provided on-call cover had level three adult and children safeguarding training across all clinical services.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. There was clear guidance within the safeguarding policies about how to escalate concerns. Flow charts were on display throughout the unit indicating the safeguarding referral process. Staff reported that they understood the requirements and knew who to raise concerns with.

The hospice had an internal safeguarding panel which was chaired by the Chief Executive Officer. The panel had representations from the inpatient unit, hospice at home, the medical team and social work. There was an invitation to other heads of department from across the wider hospice team to attend also. The meeting had a standard agenda that included safeguarding incident reporting, policy reviews, education and training and local and national guidance. Members of the safeguarding panel had level three safeguarding training.

Cleanliness, infection control and hygiene

Staff used infection control measures when treating patients and transporting patients after death.

Areas were clean and had suitable furnishings which were clean and well-maintained. The service generally performed well for cleanliness. Weekly infection control audits were undertaken. Each audit had 30 points to check on the checklist. We reviewed the six most recent audits and noted the comments and findings which found areas to be clean but there was no scoring method alongside this to detail how well the service did overall.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Staff followed infection control principles including the use of personal protective equipment (PPE).

On the inpatient unit, staff ensured they were bare below the elbow, followed hand hygiene protocols and changed PPE between patient contact.

For every community visit, staff changed all PPE before entering the patient's home and removed it once outside and disposed of it in sealed plastic bags.

Areas of the inpatient unit had been repurposed to reduce risks of COVID-19 transmission. Every patient stayed in a single room with bathroom facilities to minimise contamination risks associated with sharing rooms.

The service used infection control measures to prevent the spread of infection before and after the patient died. There were suitable arrangements with funeral directors for the transfer of the deceased

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. We observed staff responding promptly to patient's needs.

The design of the environment followed national guidance. All clinical areas had floor coverings which were easy to clean. Safety checks and maintenance plans were adhered to. There were risk assessments for fire safety, water safety and building and grounds maintenance. Action taken to minimise risks was timely and there was a regular schedule of assessment and works by external contractors.

The service had enough suitable equipment to help them to safely care for patients. Clinical equipment, including beds, hoists and assisted baths were regularly maintained. Equipment that was faulty was repaired or replaced.

Staff carried out daily safety checks of emergency equipment. Equipment used for emergency situations was appropriate and accessible for staff when needed. This was checked daily and single use equipment was within 'use by' dates.

The In-patient unit had 12 single rooms with ensuite facilities, and two four-bed bays with bathrooms which had not been used since 2020 due to the Covid-19 pandemic.

Staff disposed of clinical waste safely. Staff segregated clinical waste and stored it securely within designated storage areas. Sharps waste was stored in line with requirements using colour coded pharmaceutical waste bins that were appropriately labelled.

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 nationally recognised tools to identify deteriorating patients and escalated them appropriately in line with patient's wishes. Patients had a treatment escalation plan detailing the level of treatment deemed appropriate. A number of assessment tools were used including IPOS (Integrated Palliative care Outcome Scale), the Barthel scale and the Karnofsky Performance Scale Index. These assessments were used to compare effectiveness of different therapies, to measure performance in activities of daily living and to assess the prognosis in individual patients. They were completed and discussed at the weekly multidisciplinary team. The treatment escalation plans included clear instructions where it was no longer appropriate or wished for a patient to be admitted to hospital should their condition deteriorate.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed four patient records and saw that risk assessments were routinely completed on admission and regularly reviewed. This included the assessment of the risk of pressure sores, falls, the use of bed rails, malnutrition and dehydration and moving and handling. Falls sensors were fitted to beds or chairs for patients at risk of falling. Patients who scored high on risk assessments were located in the side rooms closest to the nurses' station.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients including if they were thought to be at risk of self-harm or suicide. The service had access to a clinical psychologist through the local NHS trust, who provided support for hospice patients and their families. Staff could also access the local mental health trust for further support.

Shift changes and handovers included all necessary key information to keep patients safe. This gave key information including treatment escalation plans, do not attempt cardiopulmonary resuscitation (DNACPR) decisions and patient's care wishes. Staff had enough time and opportunity to discuss changes in patients' conditions and other care information.

Nurse staffing

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

The service had enough nursing and support staff to keep patients safe by varying the number of beds it opened. 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.

The service had seen staff numbers reduce over the previous 12 months prior to inspection. Nursing staff numbers had decreased significantly due to sickness, the Covid-19 pandemic and resignations.

Bed occupancy had shifted to reflect the staffing levels. Managers calculated how many beds to open based on nurse and health care assistant numbers. For instance, if there were only five beds open, the planned numbers needed were two nurses and two healthcare assistants during the day and two nurses plus one healthcare assistant overnight.

There was a workforce plan to recruit and some appointments had been made but there remained nurse vacancies. The board and managers had explored opportunities and implemented some options to bolster staffing.

Medical staffing

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

The service had enough medical staff to keep patients safe whilst they were able to vary bed numbers. There were only two whole time equivalent consultants in specialist palliative care employed by the hospice. In addition, there were staff grade doctors, advanced clinical practitioners and an associate care practitioner.

The medical workforce was deemed 'fragile' with only two consultants. The hospice worked on a reduced bed base and doctors worked flexibly in the daytime covering the inpatient unit.

Out of hours cover was from 5pm to 9am weekdays and 9am Saturday to 9am Monday was a single doctor or advance nurse practitioner cover (with support from a regional consultant in palliative care). At weekends, the on-call doctor was solely based on the hospice in-patient unit and not visiting patients in the community or hospital.

The hospice had also recruited additional medical cover. However, these were trainees and supernumerary.

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 records were in both electronic and paper format.

Records had individual assessment and care plan documents which were personalised and included patient wishes and consent to share information. When patients transferred into or out of the hospice, there were no delays in staff accessing their records.

Hospice at home and community staff recorded updates on the electronic patient record system when they got back to the hospice. Paper records kept in patient's homes were used by other community nurses who recorded information in them that needed to be shared.

An audit of record compliance was carried out quarterly. The audits compared findings each quarter to check for improvements or deterioration of quality in record keeping. The findings and learning from the audit were shared with the clinical governance committee and staff. For example, there was low compliance in the recording of protected characteristics in patient notes. Managers concluded from these results that further education and training around disability status and protected characteristics was needed.

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. We looked at four treatment charts and five patient records on the inpatient unit. Allergies were recorded. Administration of medicines were accurately recorded, and explanations were given if medicines were not given for any reason. Staff made sure patients received their medicines, especially those that were time specific. The service had a service level agreement with a national community pharmacy service to provide clinical pharmacy and medicine supply service. Staff told us they were able to obtain medicines promptly.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Staff stored, handled and recorded controlled drugs in line with requirements. The inpatient unit had locked cupboards on walls within treatment and patient rooms. We saw checks on temperatures were completed and logged by staff daily, and stocks of medicines were checked by registered nurses

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. The service and the local pharmacy company completed medicines audits which included checks on staff compliance with policies, medicine errors and the administration and recording of controlled drugs. Incidents involving medicines were investigated and actions to improve practice were monitored to prevent a recurrence of the incidents.

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. Incidents were recorded on the electronic record system and reviewed by senior staff on a weekly basis. Staff felt confident about reporting incidents and there was a good reporting culture. Incidents recorded included medicines, falls, pressure ulcers, accidents and staffing issues. Serious incidents were reported externally in line with national guidance, for example, pressure ulcers of grade three or above.

Good

Hospice services for adults

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. This included an apology at the time of the incident and an explanation of investigation findings and actions to minimise the reoccurrence.

Staff received feedback from investigation of incidents, both internal and external to the service. Data on incident reporting was collated, reviewed and shared routinely at a range of internal meetings. Trends were identified and experiences shared to improve quality and safety across the region. The hospice had a 'Risky Business' publication to share learning across the organisation.

Staff met to discuss the feedback and look at improvements to patient care. There was evidence that changes had been made as a result of feedback. were implemented to ensure training and competency assessments were completed in a timely way.

Are Hospice services for adults effective?

Good

Our rating of effective went down. 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.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff had received training in the Mental Health Act and understood the principles of caring for patients who were subject to it. This included ensuring that patients had access to relevant advocates to support their rights and wishes.

At all meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Staff recognised these aspects of care as equal to those relating to physical needs.

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.

We saw nurses talk to patients about nutrition and hydration, the use of nutritional supplements and finding out foods that patients could tolerate and would prefer. Hospice catering staff met with patients to discuss preferences and

created individualised meals to promote nutrition, comfort and preferences. Staff told us that catering staff went out of their way to ensure patients had the food they wanted. One patient told us that there were ''loads of choices. Food is nourishing and incredible. In the last three weeks not one meal has been repeated on the menu. Portion size is more than adequate. In between mealtimes there are plenty of snacks and drinks available''.

Staff fully and accurately completed patients' fluid and nutrition charts where needed and encouraged intake in line with patient wishes. Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it.

When patients were no longer able to eat or drink, or when intake was minimal due to overall deterioration in their health, staff prioritised the delivery of oral care in line with evidence-based practice. The focus of this was to promote comfort. Information about mouth care was available to patients and their relatives and staff supported relatives who wished to be involved in this aspect of their loved one's care.

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. Patients had access to pain relief when they needed it. Anticipatory medicines were prescribed for patients on the inpatient unit and ad hoc medicines in the community for symptom control. These were medicines prescribed to be administered as needed and not as a regular prescription. For example, medicine for nausea, agitation, breathlessness and pain relief. Medicines were prescribed and given as needed.

Patients were admitted to the inpatient unit to assess and manage their symptoms so that they could be effectively controlled. Assessment of needs included patient wishes to ensure that priorities for symptom management were in line with this. Complementary therapies were used alongside pharmacological interventions for pain relief.

Patients received pain relief soon after requesting it. We observed staff responding promptly when patients were in pain and there were ongoing assessment processes in place to establish the effectiveness of medicines given.

Staff prescribed, administered and recorded pain relief accurately. Medicine and pain assessment charts were completed as soon as pain relief was administered. The effectiveness of pain relief was routinely evaluated.

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. They participated in the hospice UK benchmarking activity which showed the hospice performed largely in line with other similar services over time. Benchmarking data was focused on patient safety and risks in relation to falls, pressure ulcers and medicines incidents. Where benchmarking showed an increased level of risk, for example, in falls or pressure ulcers, the hospice took action to improve. This was using deep dives and changes to work practices as necessary.

Patient outcomes were monitored using a suite of assessment tools and reviewed at the weekly multidisciplinary team meeting. The Outcome Assessment and Complexity Collaborative (OACC) suite of measures were used. The impact of clinical interventions were measured to show if the patient had the most appropriate care possible and what difference it made to their lives.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The service had a plan of annual audits which were reported to the executive team and commissioners. Improvement actions were identified following these audits and demonstrated how staff compliance with practice had improved. For example, only 40% of records audited in June 2021 had a skin assessment. After a focus on this lack of compliance, 100% of patients had a skin assessment in the audit period ending in December 2021.

Managers shared and made sure staff understood information from the audits. We saw information was presented to the clinical governance group.

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. Senior staff had completed specialist modules in palliative and end of life care. Some nursing staff had completed advanced nurse practitioner training.

Managers gave all new staff a full induction tailored to their role before they started work. Managers commenced the induction phase with new employees before their start date by giving them access to 'the hub' which was an online reward, recognition and staff engagement platform

Training and competency assessments were carried out and there were a series of checklist to complete before being deemed competent. Probationary reviews occurred after the first, third and sixth month of starting work. Staff worked shadow shifts for four weeks or until confident and probation plans included achievable goals with support provided based on individual needs.

As well as mandatory training, new clinical staff completed essential skills training which included verification of death, medicines management and other training specific to their roles.

Managers supported staff to develop through yearly, constructive appraisals of their work. Overall, 71% of staff had received a formal appraisal in the last year. This had been impacted by the sickness. However, the hospice had a plan to address this and improve completion levels in the coming months

The hospice had a policy that managers met with their staff members on a one to one basis at least once every two calendar months. These contact meetings were established to encourage people to talk openly about their needs. However, there was no system to evidence that all staff had access to supervision.

Managers supported staff to develop through regular, constructive clinical supervision of their work. The clinical educators supported the learning and development needs of staff. There was a clear, structured training programme that was accessible to staff internally and externally. Managers made sure staff received any specialist training for their role. Subjects end of life care and symptom management.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. This included attendance at specialist conferences as well as external training courses.

Managers recruited, trained and supported volunteers to support patients in the service. Volunteers were trained to fulfil their role and had regular supportive meetings with managers to identify training needs and support.

Multidisciplinary working

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

There was a meeting held every morning led by the nurse in charge of the inpatient shift. Staff from the family care team, the discharge team, palliative care team, doctors and hospice at home team were present at the meeting. The hospice at home also met each as a team every morning. This afforded the opportunity to discuss staffing levels, individual patients and needs of that patients with a collaborative approach.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. There was a weekly multidisciplinary meeting held on the inpatient unit with input from medical staff, nurses and allied healthcare professionals such as social workers.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff attended external multidisciplinary meetings to ensure palliative care input for patients in the community or other inpatient settings

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. There were psychological and support services available for patients who required additional specialist support.

Seven-day services

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

Consultants led daily weekday ward rounds and provided an on-call service at weekends. Patients were reviewed by consultants as required. Out of hours on call arrangements were in place so that staff could access support as needed. Hospice services were available 24 hours, seven days a week.

Specialist nursing and medical support was available seven days a week and patients were reviewed daily. Specialist consultants were always available for advice. 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.

The hospice at home service functioned between 8am and midnight. There was no overnight provision.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards/units.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Good

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. They used agreed personalised measures that limit patients' liberty.

Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records. Informed consent was obtained for invasive procedures such as blood transfusions which required written consent. Written consent for sharing information was also sought.

Do not attempt cardiopulmonary decisions (DNACPR) were made appropriately and in line with national guidance. There was evidence of discussion with patients and those close to them.

Staff received and kept up to date with training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, MCA and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff described situations where mental capacity assessments and best interest decisions had been made. They were aware of how to access independent mental capacity advocates as a legal safeguard for patients who lacked the capacity to make specific decisions.

Managers monitored the use of DoLS and made sure staff knew how to complete them. Managers monitored how well the service followed the MCA and made changes to practice when necessary. They audited DoLS to ensure that approved documentation and processes were followed.

Are Hospice services for adults caring?

Good

Our rating of caring stayed the same. 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, giving them the time to interact. They introduced themselves and explained the focus of their visit / care.

Patients said staff treated them well and with kindness. We were given examples of when staff had gone out of their way to support people. This included arranging a wedding for a patient who wished to marry their partner at the hospice and a Viking style funeral was organised for another individual.

Staff followed policy to keep patient care and treatment confidential. They were discreet in their interactions and took time to ensure privacy and dignity.

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. They recognised the totality of patient's care needs, assessing them holistically to ensure that emotional and social aspects of their care were considered. They took action to ensure patients stayed connected with their loved ones, even when communication was difficult. Staff supported them to stay connected using electronic devices for phone and video calls when physical visits were not possible.

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. We observed staff sitting with patients and family members, giving them time to talk. Staff were kind and caring and recognised the emotional needs of patients. They responded promptly to both verbal and non-verbal cues about people's emotional needs.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Clinical staff had attended advanced communication training and understood the importance of clear, honest and compassionate communication for patients at the end of life.

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. The multidisciplinary team consisted of social work and bereavement staff. They worked collaboratively with clinical staff to support the emotional as well as social and physical needs of patients. Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Staff often went above and beyond to meet patients' special requests or wishes. Staff arranged an afternoon tea for a patient and their family who loved a particular teashop. Staff collected a hamper from this shop and held the tea party on the patient's balcony. A patient who was returning home overseas had a meeting with the hospice chef who then prepared food from their country of origin. The hospice also liaised with other services to ensure travel, medicines and discharge arrangements were ready for his journey home.

A therapy dog visited the patients in the hospice. Pet therapy was arranged by the occupational therapist and the pat dog visited on a weekly basis. Patients own pets were able to visit the hospice and one patient had weekly visits from their dog.

The hospice used the HOPE tool (quality measurement to support spiritual care and assessment). This was completed after the patient had settled into the hospice. It was completed by the spiritual care lead who was an ordained member of the clergy.

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.

Good

Hospice services for adults

Staff made sure patients and those close to them understood their care and treatment. Patients were assessed daily on the inpatient unit and medical staff gave them time to discuss their treatment. Nurses and members of the multidisciplinary team gave information about care interventions, ensuring patients understood and were involved in all care decisions.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The hospice invited feedback by mailing out questionnaires before the Covid-19 pandemic. Managers were looking at better ways to capture feedback. There was a standardised patient feedback form available in the hospice and feedback could be given via the website.

The hospice participated in the annual national 'Famcare' bereavement survey where those close to patients that had died in the care of hospice staff provided feedback. Feedback was consistently positive in 2021. Most survey participants said they were very satisfied or satisfied with the care delivered. This included areas such as emotional support for patients and their families, attention to symptoms and their management, dignity and comfort, and inclusion in decision making and delivery of care.

One patient and their family told us that ''the team are amazing'' and when first admitted into unit, they were given days to live. Once in the hospice, nurses and doctors brought them ''back to life with the right care and treatment''. Two years later, they were ''still here and using the service. Hospice team never give up on us and have improved the quality of life and given the family more time''.

Are Hospice services for adults responsive?

Good

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

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 community and the inpatient unit services offered a flexible and responsive service to meet the needs of the patients who used the service.

Managers told us there were variances in demand for services for both community and the inpatient service, influenced partly by the COVID-19 pandemic. For example, inpatient activity was below target as a result of the pandemic with an increase in patients wishing to be cared for in their own homes. As a result, activity within the community and hospice at home services had increased.

The leadership team recognised ongoing increases in the proportion of patients wishing to be cared for at home as well as a projected increase in older and more frail people in the community. The expansion of the hospice at home and community teams had been incorporated into the organisational strategy.

The senior leadership team worked collaboratively with partner organisations to explore service development to meet the changing needs of the local community.

Good

Hospice services for adults

Senior hospice staff had worked collaboratively to meet the needs of the local community during the COVID-19 pandemic.

The service had systems to help care for patients and their relatives who needed additional support or specialist intervention.

The family support team responded to the needs of the community by attending the daily morning multidisciplinary team meeting with community colleagues. They picked up on patient psycho-social issues that presented at that meeting and responded where possible. Due to visiting restrictions during the Covid-19 pandemic there was often reluctance from patients and families to accept care in the hospice. This support offered access to some hospice services whilst they remained at home.

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.

The hospice had suitable facilities to meet the needs of patients' families. Rooms were spacious and equipped with bathroom facilities. There were suitable facilities for patients requiring assistance with hygiene needs, including disability access bathrooms and assisted baths.

Each of the bedrooms had double doors leading out onto a balcony overlooking the surrounding countryside. This provision enabled staff to push the beds out into the fresh air if people expressed this wish. Quiet and tranquil gardens were maintained by the gardening staff at the hospice, providing people and relatives with areas where they could sit and talk or just enjoy a peaceful moment.

Staff kept detailed records of patient preferences including advance care plans and treatment escalation plans, which documented how they wanted to be treated at the end of their life.

There were individualised care plans on the inpatient unit and in the community. Staff responded promptly to patient's preferred place of care when nearing the end of their life. Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff provided care after death, which included honouring spiritual and cultural wishes of the deceased person and their family and carers. Records also detailed patient's funeral wishes and where their remains would go after cremation.

The hospice teams worked together to improve patients' quality of life. This included therapists supporting patients to improve their mobility or the use of complementary therapies to support the management of symptoms.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. There was an accessible information standard assessment on the electronic patient record and staff assessed patient's information and communication needs.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Catering staff met with patients daily to identify their food and drink preferences and adapted menus to meet their needs. Managers had engaged with local cultural community groups to better understand how staff could meet different needs.

Patients were encouraged and supported to maintain relationships with people that mattered to them. During the COVID-19 pandemic this included the identification of nominated visitors for each patient, expanded to include additional visitors during the last days or hours of life. Electronic devices were available to support connecting patients with people close to them.

The hospice worked in partnership with a charity to offer patients the opportunity to make an audio recording of their biography for friends and family to listen to. Staff and volunteers had undertaken specialist training to enable them to work with patients to prepare and record these biographies.

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.

Patients were referred to the service by a healthcare professional and there was a criteria for admission. Patients needed to be diagnosed with a life-limiting illness and whose needs were deemed to not be met by current providers.

Patients, carers and healthcare teams could access the Single Point of Contact (SPOC) service which was set up during 2020 as response to the Covid-19 pandemic. SPOC had taken over 20000 calls since inception. It was run in collaboration with an NHS trust and coordinated the Marie Curie out of hours response and supported the community palliative care team triage nurse and service.

The hospice aimed to admit patients referred urgently within 24 hours and those through less urgent were discussed at the daily handover and triage meeting every morning. Patients highlighted as priorities by the referring teams present were discussed alongside referrals from all other sources. Priority was given to those patients in the greatest need through poorly controlled symptoms, extreme distress or risk of acute admission to hospital without intervention. The potential for admission was then balanced against bed availability, pending discharges and staffing levels.

Managers and staff worked to make sure that they started discharge planning as early as possible. They identified patient's preferred place of care at the time of admissions or entry to the service. Staff worked with patients to identify individual goals which included plans to support discharge home where this was a priority. The focus of the service was to provide support for patients to live well when nearing the end of life and staff recognised the importance of patients being at home when this was their choice.

Hospice at home was piloting a triage system. Staff had devised an assessment tool to use when contacting patients over the telephone to formally assess need, urgency of need and to signpost individuals to other services where required.

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.

Patients, relatives and carers knew how to complain or raise concerns. Staff understood the policy on complaints and knew how to handle them. They encouraged patients and their families to provide feedback and recorded complaints irrespective of whether they were made formally or not.

Good

Hospice services for adults

Managers investigated complaints and identified themes. In addition, informal complaints were recorded and acted on. The person making the complaint was asked about the outcome they were hoping for. We viewed records of complaints and saw that these were taken seriously by staff and included a full investigation.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Patients and relatives who complained or shared concerns were kept informed at every stage of the complaint process, including investigation and action to address their concerns.

Managers shared feedback from complaints with staff and learning was used to improve the service. For example, a family member had complained about the lack of contact after their relative had died. The service apologised, explained that this had been missed due to staff shortages at that time and offered ongoing bereavement support. An additional social worker was employed to directly improve responsiveness.

Are Hospice services for adults well-led?

Requires Improvement

Our rating of well-led went down. We rated it as requires improvement.

Leadership

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

The leadership structure consisted of trustees, the executive team and heads of department. Leaders had the required level of capacity and capability to lead the service.

Trustees met five times each year and individual trustees chaired various sub-committees with attendance from senior leaders. Changes had been made to the way trustees were appointed. The majority of trustees had been approached to serve on the board by colleagues or others who felt they might be a good fit. Following an external review, vacancies were advertised and there were two new external appointments. However, not all trustees had undergone full fit and proper person requirement checks for directors. Some appointments lacked evidence of a robust recruitment process, evidence of a competency based interview, references, occupational health checks and an annual appraisal. This constituted a breach of regulation. This regulation is about ensuring that registered providers have individuals who are fit and proper to carry out the important role of director to make sure that providers meet the existing requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Since the inspection, the leadership team had made efforts to remedy this by introducing a checklist to ensure that all trustees would have the necessary requirements to meet this statutory obligation.

Trustees maintained oversight of operational and sustainability issues through attendance at sub-committees. Quality and safety of care were clearly prioritised at all levels of the organisation and performance data was shared at relevant sub-committees, board meetings and operational meetings. Reports to the board were comprehensive and included relevant safety and improvement data so that they could effectively manage performance.

Good

Hospice services for adults

Executive and operational leads had effective oversight of the local health economy. They were active in local and national networks. They provided leadership across the region in relation to end of life care and the strategic direction of services.

Leaders recognised the challenges and priorities faced by the hospice. The hospice was undergoing a period of flux due to changes of priorities and needs for hospice patients. The leadership team was under significant pressure due to workforce and cultural issues within the service. Leadership was under scrutiny and this impacted on the whole team.

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. Not all staff understood the vision and strategy.

The vision for the service was to build on a tradition of delivering excellent palliative and end of life care to the community through a process of strategic planning and change management led at every stage by shared values of excellence, integrity and respect. The aim was to build a one hospice culture based on and driven by these shared values.

The overarching values were 'excellence, integrity and respect and our staff endeavour to be caring, competent, committed, courageous, compassionate and good communicators'.

The model of care was changing within the hospice. Day services that were once available in its Sunflower Centre were suspended due to Covid-19 restrictions. These services were previously used by a small number of patients. Rather than reopening the Sunflower Centre, plans were being made to consider how to serve needs better in the wider community. Managers shared their vision of how the service would meet local priorities and needs of the community with an increased focus on providing services in the community rather than in inpatient settings.

The service used a strategy balanced scorecard system to capture and communicate strategic aims. The strategy was said to be developing. Staff working in the inpatient unit were unclear about the vision. Whilst they observed changes, staff did not support service reconfigurations nor either understand or knew the rationales for these.

Culture

Staff did not always feel respected, supported and valued. They were, however, focused on the needs of patients receiving care. Some staff felt the service did not have always have an open culture where staff could raise concerns without fear.

The hospice had a divided culture following changes to the services offered and because of disciplinary processes in the previous year which had meant some staff had left the service. Prior to and during the inspection we received a significant amount of feedback from staff and other stakeholders with most sharing concerns about the culture of the hospice. Some staff described the culture as 'toxic' and described a disconnect between teams and between staff and managers. Some staff spoke of feeling fearful of raising concerns with leaders. There was a perception that speaking out would have unfavourable consequences.

Managers were aware of the cultural issues in the hospice and acted to improve relationships, including introducing external support for the service. Managers told us a significant amount of management time was spent dealing with culture change. The action taken had not resolved the service's cultural issues by the time of inspection.

Good

Hospice services for adults

The hospice had adopted a restorative practice approach to enable teams and individuals to work well together. This focused on conversations to improve relationships, ensure everyone had a voice, support effective problem solving and create a non-blame environment.

There was a whistleblowing policy but no freedom to speak up guardian to support and guide staff to speak up where they had concerns. This was a requirement of services who held the type of contract that the hospice did with its commissioners.

However, there was a clear focus among staff teams and leaders to provide high quality care. The needs of patients and their families were central to the ethos of the service

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.

There was a well embedded governance structure to ensure organisational, team and individual responsibility and accountability. Clear goals and ambitions were set out within the organisational strategy. Senior leaders and trustees worked together to deliver the strategy. Individual trustees chaired each of the service's sub-committees with cooperative leadership from relevant members of the senior management team. This ensured overarching accountability as well as appropriate challenge and scrutiny between strategic and operational delivery.

Management Board meetings were held every three months, the executive team met monthly, the senior management team met formally every month and informally every week. Sub committees included clinical, non-clinical, finance, strategy and renumeration. Monthly reports from each of the sub-groups went to the board of trustees and the executive management team.

We reviewed meeting minutes and saw that performance, staffing, finance, quality and patient safety information, and performance against the strategy was discussed at each level. Committees received and reviewed the minutes and actions of related subcommittees.

The hospice commissioned an external governance review in 2020. As a result of this, actions were created and progress against actions were monitored.

Levels of governance and management functioned effectively and interacted appropriately. Governance within the hospice was overseen by the board of trustees and executive management team through the quality and governance framework. The quality and governance framework provided a clear structure for reporting on a range of metrics. This included key performance indicators that were reported internally to the management board and externally to commissioners

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.

There were clear arrangements for identifying, recording and managing risks. Risk assessments identified and escalated relevant risks and issues and identified actions to reduce their impact. Risk registers were regularly reviewed and updated.

Managers understood service's main risks, and these matched the risks identified on the hospice's risk register. Control measures were in place. For example, clinical staff shortages were consistently identified as one of the higher risks. Action to address this included offering competitive terms and conditions, the creation of flexible roles and development opportunities and working collaboratively with other organisations to address staffing shortfalls and the commencement of apprenticeship programmes. The risk register covered all areas of the service. Risks were rated by the potential impact on safety. Actions were taken to put in control measures to reduce the impact of the risk.

There were effective lone working arrangements to keep staff safe for those travelling into the community. Risks relating to lone working had been assessed. There was a business continuity plan that detailed processes and actions to be implemented at a time of unplanned disruption.

Performance data was analysed and presented at both committee and board meetings. There was evidence of board influence over performance management and recommendations to service leads. For example, in relation to deeper exploration of incidents on the inpatient unit.

The service had a fortnightly 'risk watch' meeting which covered recent incidents. This looked at themes and trends and discussed learning from incidents. Incident investigation outcomes are recorded on their digital system,

However, there had been no annual quality account published since 2019. The service had recently sought to recruit a head of patient safety and quality to develop this as part of the role.

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 a variety of data and analysed it to understand performance, make decisions and improvements. Information was collated and shared with staff, patients and visitors. Patient safety and experience data was displayed on the inpatient unit and included accidents, incidents, errors and patient experience. Benchmarking data was submitted to Hospice UK and data was shared with other providers and commissioners.

Information technology systems were used effectively to monitor and improve care. For example, the hospice had implemented an electronic patient record system that was aligned with primary care services in the region.

The hospice had updated its website in 2021. It was user friendly and contained clear signposting to the service and its resources.

Information governance meetings were held to ensure systems were effective. Any breaches to information standards were reviewed by the group.

There were effective arrangements to ensure that notifications were submitted to external bodies as required. Managers were aware of their responsibilities to monitor the use of data, including breaches and report these appropriately. Notifications to external organisations were clearly identified when the need arose, and these were appropriately submitted

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.

Leaders had a shared purpose and collaborated internally and externally to provide effective services.

Staffing groups were represented at the staff engagement group. There was a staff engagement group page on the Hub and meeting minutes were stored here.

In 2020 there had been an initiative to have more regular spot surveys rather than just one annual staff survey. There had been 11 surveys undertaken since this initiative was commenced. These surveys included a 2020 Covid-19 survey to ask staff what support they needed during the pandemic, a 2021 survey about mandating the Covid-19 vaccine and a Valentine's Day survey in 2021 asking staff to share what they love about the hospice. All surveys had results with outcomes and actions that were shared with all staff. The internal communication and engagement survey opened in April 2022 and was still live at the time of inspection so there were no conclusive results to review.

Managers consistently engaged with external partners and agencies. The hospice was represented at strategic and operational levels within the local health economy. The Chief Executive Officer was part of a local city alliance and its board. There were presentations given at national hospice events on the impact of Covid-19. The hospice also worked in partnership with hospices across the region to develop shared thinking and a collaborative approach to working.

In November 2021 the hospice led a workshop to start stakeholder engagement conversations about the future of hospice services as a way of understanding the needs of patients. This workshop was held with local GPs, service users/ people with lived experience and other agencies. Outcomes from the workshop formed part of the ongoing conversation with teams about how to work to support patients in the local community.

The service has a weekly 'One Hospice' staff bulletin. This aimed to keep all employees, bank workers and volunteers informed on key updates and to also showcase work that was happening within teams across the hospice. Content for the bulletin included good news stories, people and patient stories, events and training updates, wellbeing pieces, welcoming new starters, saying goodbye to colleagues, profiling teams and celebrating milestones.

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.

The hospice was part of Project ECHO. This was a collaborative learning tool designed to enable health and social care professionals to connect with each other globally. ECHO communities worked together to share and benefit from each other's learning and knowledge.

Good

Hospice services for adults

As well as having apprentices, the hospice introduced the role of advanced clinical practitioner and the role of associate practitioner to provide a career pathway for staff and to also improve its skill base.

Managers and staff participated in research and published its annual research report every September. Staff were supported to attend and present research at conferences. The hospice participated in relevant national and local research projects.

The hospice had been part of a programme to support homeless and vulnerably housed people in the local community. The homeless palliative care service ran for 15 months until February 2022 and individuals had been helped by the complex care coordinator going out into the community to bring vulnerable people into the hospice.

Improvements included the expansion of the hospice at home team during the pandemic, working collaboratively with NHS partners to increase the provision of end of life care in people's homes. The result was an increase in hospice at home capacity and enabled more patients to be cared for at home at a time when many were reluctant to access inpatient services due to the risks associated with COVID-19.

At the height of the Covid-19 pandemic, the hospice had looked to help the locality in diverse ways. They responded to help not just patients who were on the end of life pathway but those dying due to Covid-19 illness. They worked with system partners to provide services outside of their usual remit.

The service offered pre bereavement support for families to help a child when their parent was dying. They took referrals from community nurses, hospital teams and GP services. This support was both on an emotional and practical level including help with advanced care planning, will writing and making memory boxes.

Similarly, an offer of support and education was given to a school following a traumatic death. Education and training in bereavement and listening skills was also provided to local solicitors.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service had not appointed a Freedom to Speak Up Guardian to act as an independent and impartial source of advice to staff at any stage of raising a concern. The service had a divided culture within staff teams and between staff and managers.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors **Fit and Proper Persons Requirement:** The service has not ensured there is evidence of adherence to all requirements of Regulation 5: Fit and proper persons: Directors.