North Yorkshire Hospice Care

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Inspection report

Saint Michael's Hospice, Crimple House
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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?	Outstanding
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

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

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 and understood how to protect patients from abuse. The service-controlled infection risk well. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment and gave patients 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.
- 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:

- Checks of emergency medications were not always effective.
- Staff were not always deployed in a way which enabled people to always access the service when they needed it.

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 North Yorkshire Hospice Care

Saint Michael's Hospice is operated by North Yorkshire Hospice Care (NYHC).

North Yorkshire Hospice Care (NYHC) is an independent charity with a family of services, these included Saint Michaels Hospice, Herriot Hospice Homecare and Just 'B'. The services span the Harrogate and Rural district, and the Hambleton and Richmondshire district in North Yorkshire.

The hospice provided a range of services including inpatient and community end of life care, symptom management, wellbeing services, a breathlessness outpatient clinic and lymphoedema management to people.

The service is registered to provide treatment of disease, disorder to people over 18 years of age. The service had a registered manager and controlled drugs accountable officer in place at the time of inspection.

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 22 and 23 November 2023 as part of our routine inspection programme. The hospice was registered in October 2010 and was last inspected in October 2015. There was a registered manager in post during the inspection.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? We rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

During the inspection:

- We spoke with a range of people working at the service, including 1 manager, 2 nursing staff, 2 doctors, 1 student nurse, 2 support staff, the medical director, 3 head of services managers, 1 trainee nurse associate, clinical practice educator, wellbeing lead, safeguarding and resilience lead, the chef and dietician.
- We spoke with 3 patients and 1 family.
- We reviewed 3 patient records.
- We conducted 1 home visit.
- We reviewed 7 staff, practising privileges and director files, including checking the service had completed fit and proper persons checks in line with the regulation.

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:

Summary of this inspection

- The service utilised and developed its relationships with external professionals to ensure patients received an exceptional service that proactively identified and addressed their needs such as implementing a service level agreement with the NHS dietitian to proactively review people using the service to identify if they could benefit from dietician support.
- The hospice supported neighbouring services by taking a proactive approach in gathering the preferences of different patient groups with complex needs and/or approaching the end of their life to develop advance care plans, supporting as many people as possible to receive care in line with their wishes.
- The service proactively sought and in schemes that would both benefit the service and support the local community, such as the kickstart scheme, in which the service gave placements to 16–24-year-olds without employment.
- The service worked with stakeholders to identify the needs of the local community and surrounding areas and tailored its approach, including introducing new roles such as the care connector role, to meet this need and improve outcomes for people, particularly in rural areas.
- The service actively sought to increase the accessibility of services to populations less likely to seek or receive healthcare, such as the homeless, and tailored care to meet their needs.
- The service collaborated with partners to create service level agreements, such as with the Citizen's Advice Bureau (CAB), to widen the scope of information and benefits available to patients.
- The service worked collaboratively with other organisations within their integrated care system (ICS) to develop hospice services and offered the West Yorkshire grief and loss line, for people in their locality.
- The service actively sought to engage with groups identified as having protected characteristics under the Equality Act 2010 to identify ways of minimalizing health inequalities and improve the accessibility and equity of services to these communities.
- Consideration of people's privacy and dignity and choices were consistently embedded in everything that staff do, including awareness of any specific needs as these are recorded and communicated.
- People's feedback consistently showed they felt cared for and that they matter, care given was described as excellent and invaluable.

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:

- The service should ensure that safety checks of emergency medications are thorough and that any discrepancies noted are actioned in a timely way.
- The service should ensure that staff are aware of the processes and equipment in place to respond in emergency situations, such as being required to perform cardiopulmonary resuscitation.
- The service should ensure it uses benchmarking information to improve outcomes for people using the service.
- The service should consider the way in which staff are deployed to reduce the likelihood of bed closures to support the wider system's access and flow.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Hospice services for adults

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

Is the service safe?

Good

Mandatory training

The service provided mandatory training in key skills to all staff. Managers monitored compliance with mandatory training and were taking measures to ensure everyone completed it.

Clinical staff, including medical, received mandatory training. All staff were compliant with the services target compliance figure of 90% apart from infection prevention and control levels 1 and 2 and medication awareness for which staff were 81-87% compliant. All training was scheduled to bring staff up to the compliance target by December 2023 and the service had now staggered the training for staff across the year to ensure compliance figures remained within targets.

Patient facing staff who worked with bereavement and support staff received and kept up to date with their mandatory training.

The mandatory training was comprehensive and met the needs of patients and staff, this included modules such as, but not limited to, fire safety, equality diversity and human rights, infection prevention and control, information governance and moving and handling.

Managers monitored staff compliance with mandatory training with the support of a clinical practice educator, and informed staff when training updates were required.

The human resources (HR) team supported managers in monitoring mandatory training and alerted staff when training updates were required.

Clinical staff had completed training on autism awareness and in addition the Oliver McGowan disabilities and autism training. Managers were currently seeking a training package for staff in dementia awareness.

Staff we spoke with told us that managers supported them with mandatory training needs and that they had time to complete this.

Good

Hospice services for adults

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.

The service had both adult and child safeguarding policies in place. The policies were in date and in line with national guidelines. The service had recently completed a comprehensive review of their safeguarding processes with the aim of embedding 'Safeguarding is everyone's responsibility' as part of the NYHC culture.

The service had a designated safeguarding team whose aim was to ensure safeguarding knowledge was embedded and respond to and manage safeguarding risks. Staff told us they were aware of the safeguarding team, and they had had positive experiences of raising concerns with them and receiving a timely response.

The safeguarding leads and champions had a higher level of safeguarding training than support staff and had developed a safeguarding training framework made in line with policy and intercollegiate guidance.

Staff received training specific for their role on how to recognise and report abuse. All staff and volunteers were compliant with the 90% compliance target for level 1,2 and 3 safeguarding adults training. Patient facing clinical staff were 83% compliant in completing level 2 and 3 safeguarding children.

Volunteers (when in post) also received safeguarding training. At the time of the inspection volunteers were working in reception, fundraising, and administration (although not in the inpatient unit) and these had completed both adults and children safeguarding where relevant.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff gave examples of when safeguarding's had been raised, managed, and investigated, resulting in positive outcomes for people using the service.

Staff knew how to identify adults 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. The safeguarding team empowered staff to make referrals with them and were educated on what information was needed to support their referral being investigated by the local authority.

All staff files reviewed had fully completed enhanced DBS checks and all results were appropriate for the roles being undertaken.

Cleanliness, infection control and hygiene

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

The service's infection, prevention, and control (IPC) policies and procedures were up to date and in line with national guidance.

Ward and communal areas were clean and had suitable furnishings which were clean and well-maintained. The inpatient unit was bright and visibly clean. Patients each had separate rooms, with ensuite bathrooms.

Hand washing facilities and hand sanitisers were available in patients' rooms, throughout the ward, and communal areas.

Staff followed infection control principles including the use of personal protective equipment (PPE), there was plenty of PPE in don and doffing areas. There was clear signage for staffing on application of PPE and hand hygiene techniques.

Staff cleaned equipment after contact and labelled equipment to show when it was last cleaned using 'I am clean' stickers.

We reviewed the results of the latest IPC audit provided for 2022, this was a consolidation of various IPC audit results to demonstrate the overall service IPC compliance and saw that 80% of staff were compliant. The audit was due to be reviewed again in three months.

Staff signed and dated cleaning checklists for each task as it was completed and there were no gaps in the signing of any records.

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.

The service had suitable facilities to meet the needs of patients' families when visiting the service.

The design of the environment followed national guidance and patients were offered individual private rooms all with ensuite and hoist facilities. Different sized options of room were offered to people based on their needs, for example those with respiratory difficulty could be offered a smaller room to support them in moving around independently.

The environment was light and bright with comfortable furniture and surroundings were pleasantly decorated. The appearance of the service had been considered and efforts were made to make the environment inviting. Volunteers were in place to replace fresh flowers daily and there were a variety of outdoor spaces for people to enjoy including the gardens and balcony.

The service had suitable facilities to meet the needs of patients' families including quiet spaces and communal kitchen and lounge areas. There were both separate overnight facilities and the ability to add additional sleeping space in people's rooms for relatives and loved ones.

The service had enough suitable equipment to help them to safely care for patients. Staff we spoke with told us if they needed additional equipment, they could raise this with a head of service, and this would be actioned quickly.

The service had furniture available for use by patients with bariatric needs. Staff knew how to make referrals to external services for specialist equipment.

Patients could reach call bells and we observed staff respond quickly when called.

Equipment was serviced and checked by the maintenance company and a service level agreement and schedule of works was kept up to date.

Syringe pumps were serviced and tested, and staff knew how to report any concerns with specialist equipment.

Staff disposed of clinical waste safely. A service level agreement for safe disposal was in place. We saw the use of colour coded laundry bags and bin bags for the disposal of clinical waste. Clinical waste was also double bagged and stored in a secure area.

There was a cooling blanket stored securely and records were kept of servicing and maintenance checks and staff knew how and when to use this.

Staff received a health and safety assessment during their induction.

We saw that all chemicals were stored securely and appropriately in line with Control of Substances Hazardous to Health Regulations 2002. Stock was rotated appropriately and stored safely.

Assessing and responding to patient risk

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

Staff were not always aware of the procedure to carry out cardiopulmonary resuscitation (CPR) for someone nursed in bed. We enquired as to the process to carry out CPR in the event of respiratory arrest, a member of the senior management team attempted to locate a CPR pull tab on the bed, but the mattresses did not have them. They told us as an alternative they could hoist someone but could not determine how quickly this would be. Mattresses also had the functionality to be firmed with a push button, but staff spoken with were not aware of this. This posed minimal risk to patients due to the service type, within 4 years less than 1% of people using the service did not have a DNACPR in place.

We saw mouth care sponges in use to hydrate mouths and guidance to staff in people's care plans about how to deliver mouth care using sponges. A medical health safety alert (MHRA) issued in 2012 stated that foam heads of oral swabs may detach from the stick during use. This may present a choking hazard for patients. Following the inspection, the service provided us with a mouth care review which showed how oral care sponges were assessed and used only in line with best practice for sensory pleasures and moistening the mouth. We reviewed the inpatient and community nursing clinical services development plan which stated that improving mouth care planning had been completed in February 2022. We did not see oral sponges in use within the community setting.

Staff used tools to identify deteriorating patients, records demonstrated that patient's observation were regularly taken with signs of deterioration recognised and escalated appropriately. The service also used the Australia-modified Karnofsky Performance Status (AMKPS) to assess a patients physical functionality based on to perform common tasks relating to activity, work, and self-care, The organisation utilised AMKPS as part of OACC (Outcomes Assessment Collective Collaborative) which included, Barthel (activities of daily living), iPos (integrated palliative care outcome scale) and Gaslight (goal attaining scale).

Staff responded to patient deterioration in line with their advance care plans, wishes and do not attempt cardiopulmonary resuscitation (DNACPR) status. DNACPR documentation was completed correctly and involved the patient or made best interest decisions where appropriate.

Staff completed risk assessments for each patient on arrival, using recognised tools, and reviewed these regularly, including after any incident. Comprehensive plans of care were developed for patients based on risk factors identified in assessments.

Patients identified as requiring enhanced care/observation through the dependency tool were flagged to ensure appropriate measures were in place to support and maintain a safe environment.

Staff knew about and dealt with any specific risk issues such as sepsis, Venous thromboembolism (VTE), falls and pressure ulcers. The service had guidance in place to support staff in identifying and responding to VTE and we saw risk assessments completed for people at risk appropriately. There was sepsis signage within the building.

Staff used a recognised tool to assess the risk of patients developing pressure ulcers on admission and implemented the Skin, Surface, Keep moving, Incontinence and Nutrition and hydration (SSKIN) bundle appropriately for patients at risk. We saw appropriate referrals made to tissue viability nursing when required and pressure relieving equipment in place.

The service had a falls policy in place. Staff appropriately assessed people's risk of falls on admission and reviewed these risks regularly and after any incident. The service ensured that equipment was in place to reduce the likelihood of falls for example, a larger call bell to prompt people to seek assistance for mobility and floor and audio sensors.

The service had 24-hour access to the JustB wellbeing and mental health support services, a partner service registered by the provider, for people experiencing mental ill health in relation to their diagnosis. The hospice had fast track pathways for people receiving end of life care to access support and counselling.

Staff completed risk assessments for patients thought to be at risk of mental ill health such as experiencing anxiety or panic attacks.

Staff had good links with, and shared key information to keep patients safe when handing over their care to others such as the specialist palliative care and district nursing team.

Shift changes and handovers included all necessary information to keep patients safe. A key element of the huddle was to provide daily assurance and mitigate risk in relation to safe staffing in accordance with patient acuity and dependency, skill mix and staff numbers.

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, however these were not always deployed effectively. Managers regularly reviewed and adjusted staffing levels and skill mix and gave staff a full induction.

Managers calculated and reviewed the number and grade of nurses (RGN) and healthcare assistants (HCA) needed for each shift using an establishment policy which determined the staffing number should equal 4-6 staff during an early shift, and 2-3 staff during a late shift. The number of RGN's and HCA's met numbers determined by the daily review apart from one occasion, however, if there was a lack of staff availability, the service closed access to patients beds. Staff numbers were provided for the month in which the inspection was carried out, we saw several examples where bed numbers had been reduced, the maximum number of staff had not been deployed, and patients were waiting on the waiting list.

Good

Hospice services for adults

The service had enough nursing and support staff to keep patients safe, however these were not always deployed effectively. Staff told us that if actual staff numbers varied from the planned numbers this affected the patient experience. We were told that RGN staff would sometimes be used to compensate for a shortage of HCA's. Staff told us that if RGN's were rostered into the HCA role, they would not complete nursing tasks on that shift as this affected the experience patients received.

Staffing reviews were conducted daily and when actual numbers did not meet the planned numbers, admissions into inpatient beds were reduced. The inpatient unit could accommodate a maximum of 10 people, there were 7 people within the inpatient unit at the time of inspection with 2 beds closed to admissions. Staff told us the week prior; admissions had been limited to 6 patients.

There were enough staff to support patients within the community as packages of care were accepted dependant on staff availability. The needs of patients were assessed by identifying how many hours of care and staff members were required to provide care, the service would then confirm if they could deliver this.

The services vacancy rate was 2.5 full time equivalent (FTE) healthcare assistant positions against a 120% staffing establishment. The service currently had 105% nursing establishment.

The service had low sickness rates.

The service had low turnover rates.

The service used bank staff that offered a minimum of 2-4 bank shifts a week to support the service and maintain competencies.

The service did not use agency staff.

There was an on-call rota of medical staff employed by NYHC, between 5pm and 8am every day to support staff with medical advice and support. Staff could access advice from staff within the hospice within office hours. All staff were able to electronically prescribe to support staff.

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.

When patients received input from multi-disciplinary teams, there were no delays in staff accessing their records. Records were paper based and could be shared easily with partner services.

Records were stored securely in a specific locked room to maintain confidentiality.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. Safety checks of emergency medications were not always effective.

Staff followed systems and processes to prescribe and administer medicines safely.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

The service had a self-administration policy to empower patients to manage their own medications where they wish to, to increase confidence and independence and in the event of discharge, minimise the disruption to a person's medications regime. Staff conducted daily reviews to ensure self-administration and level of supervision was still appropriate. Each of the 10 inpatient rooms had a medicine cabinet mounted on the wall for if the person wished to self-administer medications.

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

Staff stored and managed all medicines and prescribing documents safely. There was restricted access to medication rooms controlled by a fob system and control drugs were stored securely with additional key access held by a named nurse. Oxygen cylinders were stored securely and fridge temperatures were checked and within range.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Staff ordered medications for patients twice a week. Medications were ordered from a non-local pharmacy and took 2 days to arrive, we saw no evidence that this had impact on the timely administration of patient medication.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Syringe drivers were correctly prescribed with the duration of infusion clearly indicated and evidence of appropriate and timely administration.

Staff checks of emergency medications were not always effective. We identified 2 products within emergency medications that were out of date, however the checks completed at the beginning of the month only identified 1 product as being out of date and no action had taken place. We raised this with a nurse who immediately removed and replaced the products.

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 did not always ensure that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them and gave examples of when they had done this. Staff raised concerns and reported incidents and near misses in line with the service's policy.

The service had not had any never events.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Staff received feedback from investigation of incidents through group case reviews on clinical training days and individually through appraisal.

Good

Hospice services for adults

The clinical incident group (CIG) investigated incidents thoroughly. The CIG group was responsible for the review, risk rating and investigation of adverse events that related to clinical services, review themes and trends and embed a culture of learning from events within the service.

There was evidence that changes had been made because of incidents. From the most recently occurring incident reviewed, the organisation had identified a comprehensive set of actions to avoid reoccurrence including developing the escalation framework, including a 'fresh eyes' approach, development of the shift co-ordinator training and competency framework including prioritisation and resilience support for the IPU team. All actions were complete or in the process of being implemented by the time of inspection.

Patients and their families were involved in these investigations. Managers debriefed and supported staff after any serious incident.

Is the service effective?

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 had access to and followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

Clinical practice was audited, and findings were positive. We were assured that the service's processes ensured staff followed national guidance and evidence-based practice.

Staff undertook wellbeing assessments and at handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives, and carers.

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. There were a range of food and drinks available all day rather than only at specific mealtimes and with plentiful options for people with allergies, specialist diets or modified textures.

Staff fully and accurately completed patients' fluid and nutrition charts where needed.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition and made appropriate referrals when required.

Specialist support from staff such as dietitians was available for patients who needed it. The service had a service level agreement in place for which the local NHS dietitian visited the hospice for 3.75 hours a week to review both referrals made, but also proactively review other people using the service to identify if they could benefit from dietician support.

Catering staff developed menus and had these assessed by a local dietician to ensure that menus met the specific dietary needs of people using the service.

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.

Staff completed holistic care plans to attempt to find the best way to reduce people's pain, these included pain assessments, medications, and complimentary therapies.

Patients received pain relief soon after requesting it. We observed a person expressing pain who was responded to with care and offered comforts while awaiting pain relief. A nurse attended shortly after to provide this appropriately.

Staff prescribed, administered, and recorded pain relief accurately.

Patient outcomes

Staff monitored the effectiveness of care and treatment and used the findings to improve outcomes for patients. The service had achieved gold standard framework accreditation.

The service participated in relevant national clinical audits such as Hospice UK benchmarking. Outcomes for patients including falls, pressure ulcers and medications incidents, were over the national average for other small hospices, small hospices can accommodate up to 10 inpatient beds. Hospice UK benchmarking information reviewed between April and June 2023 showed that the number of falls averaged 12 over the national average, however the service was under the national average for the severity of harm caused by falls. The number of medication incidents was 1.2 over the national average, however incidents occurred were of lower severity than the national average. The service averaged having 12 pressure ulcers occurring above the national average and of a similar severity of harm.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time and used information from the audits to improve care and treatment.

Managers shared and made sure staff understood information from the audits. These were displayed on clinical governance notice boards and key areas and improvements were discussed within team meetings.

The service worked with hospices in the local area to develop services for people with dementia.

The service was accredited by the gold standard framework, an accreditation scheme focussed on providing people with excellent care towards the end of their life.

Good

Hospice services for adults

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.

Managers gave all new staff, volunteers, and students a full induction tailored to their role before they started work.

Student nurses felt they received comprehensive learning opportunities and were well supported by hospice staff.

Managers supported staff to develop through yearly, constructive appraisals of their work. Appraisals allowed for discussion, set objectives for the year ahead and identified any mandatory training needs. Staff were up to date with their appraisals and told us they found appraisals a positive experience.

The service had also introduced group supervisions where themes were identified, and staff collectively discussed their thoughts around this topic. This allowed managers to identify improvement areas and the training and support needs of staff.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The service had a comprehensive competency framework to ensure that staff were upskilled in specialisms relating to their role.

The service offered RGN and HCA staff members a 12-month training and development plan to provide them with specialist skills as part of a progression pathway. Staff who completed the programme were offered a 'specialist' position in their role for 2 years which included additional tasks and taking a lead on specific patient complexities.

The clinical educators supported the learning and development needs of staff through a robust competency framework, scheduling mandatory training and quarterly training days.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified poor staff performance promptly and supported staff to improve. We saw evidence where poor performance had been investigated and addressed and measures brought in to ensure performance issues did not continue across the workforce.

Managers recruited and trained volunteers to support patients in the service.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff had daily safety huddles and an additional safety huddle for medical staff.

Staff worked with other agencies when required to care for patients. We observed staff having constructive conversations with external professionals in regard to patients' health. The service utilised internal and external expertise such as their Motoneuron disease Nurse Specialists, Lymphoedema Nurse Specialist, or external expertise such as the speech and language therapist (SALT) team, psychiatry team and dementia specialist nurses to improve patient care.

Staff signposted patients to mental health and wellbeing services when they showed signs of mental ill health, depression, or anxiety.

Seven-day services

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

Patients' records showed they received a daily review, including on weekends since the day of their admission.

Staff could call for support from doctors and other disciplines, including mental health services from the external JustB service, 24 hours a day, seven days a week.

Health promotion

Staff gave patients practical support to help them live well.

The service had relevant information promoting healthy lifestyles and support on the inpatient unit.

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

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 understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff told us they would always firstly assume a person had capacity to make their own decisions.

Staff gained consent from patients for all aspects of their care and treatment in line with legislation and guidance. We observed staff seeking verbal consent from patients and documenting when given consent in people's records.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions and considered whether relatives or loved ones had power of attorney when making decisions on patient's behalf.

Staff made sure patients consented to treatment based on all the information available and asked people which aspects of their care they would like to receive information about, such as whether their condition was deteriorating.

Staff clearly recorded consent in the patients' records. Staff gained consent to take photographs and make records of people's care delivery and supported people to understand why these were required and how this would inform them about how best to care for them.

Good

Hospice services for adults

Clinical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff understood the relevant consent and decision-making requirements of legislation and guidance and they knew who to contact for advice.

Managers implemented and monitored the use of Deprivation of Liberty Safeguards and made sure these were in line with approved documentation.

Is the service caring?

Outstanding ☆

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff interactions with people using services, care given was respectful, kept the person informed of what care would take place and maintained their dignity at all possible opportunities.

People said staff treated them well and with kindness and were “exceptional”. One person told us staff were very respectful and that they helped them understand their rights and made them feel safe to raise any worries. They told us it was the little things that mattered and that staff always remembered to bring them their newspaper, bring in fresh flowers and gave them the foods they liked.

Feedback from relatives and loved ones of people using services was consistently positive. They told us staff were excellent, caring, and thoughtful and that their support had been invaluable.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the personal, cultural, social, and religious needs of patients and how they may relate to care needs. Staff completed (psycho-spiritual) wellbeing assessments to identify how patients felt on a scale from highly anxious to having inner peace. The assessment was then used to identify resources and interventions that could be used to support and improve their score on the wellbeing scale.

The service held religious discussion sessions to discuss patients with religious and spiritual beliefs. Staff could make suggestions about what they needed, such as training, to better people’s experience of care. There was currently no specific space for people to practice their religious and spiritual beliefs, this was identified as part of both the sparkle project and Fairness, Respect, Equality, Diversity, Inclusion, Engagement (FREDIE) workplans.

When people passed away staff continued to care for the person with dignity and respect. Staff gave the deceased a full wash and change before being collected by the funeral director where all bedroom doors were closed as the person passed through the hospice, and staff stood to pay their respects.

Volunteers were used extensively throughout the hospice and in the bereavement, counselling and befriending services.

A student nurse on placement at the hospice told us that they felt the service gave the best care they had ever seen, patients were always spoken about with compassion and respect and that all staff would stop what they were doing to comfort and support families and loved ones.

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 a community visit in which the HCA staff immediately built a constructive relationship with family members having only met them that day. The family were having a specialist bed brought into the home and the HCA staff supported the family to decide how this could be brought in with minimum disruption to their relative. The HCA liaised with the district nurses to arrange this at the family's request.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. There were spaces for quiet reflection and sensitive conversations that patients could use at any time.

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 wellbeing team had a range of services to offer people based on their needs, this included 1 to 1 private discussions, welfare phone calls and visits from volunteers and the share and support group. Loved ones also benefitted from wellbeing services, we saw how during a first session of wellbeing services a loved one had shared how tiring caring responsibilities had come, both financially and in being unable to continue their interests and plan for the future. After 6 sessions the service had supported them to secure grants, funding for social care and subsequently they had been able to recommence their interests. We also saw examples where the service had kept in touch with loved ones of people who had passed away to continually offer ongoing wellbeing, counselling, and support services.

Staff used assessments to individualise patient care. For one person, this holistic approach to assessment had enabled the service to review the current care a person was receiving and adapt their medication regime, tailor pressure relieving interventions and care approach to dementia which resulted in deescalated behaviours and a more comfortable experience.

We saw staff had strived to ensure people reached their goals when approaching the end of their lives such as meeting their birth families and arranged and accommodated visits from family from overseas.

Staff considered patient lifestyle's when delivering care, including the situations of their relatives and loved ones and were mindful of how this may impact the health of their patient. For one person using the service, staff recognised that caring responsibilities were posing difficulty for the patient whilst managing their own health. Staff supported the patient to access financial grants for occupational therapy equipment for their relative as well as acquiring an adult social care package to reduce their caring responsibilities and enable them to further focus on their own physical health.

Good

Hospice services for adults

The service's 'share and support group' offered a 3-hour supportive gathering at St Michael's Hospice where people identified outcomes they wished to achieve. The service shared testimonies from attendees who stated they valued a service that allowed them to talk freely about their medical and emotional needs.

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. All patient records reviewed demonstrated how patients and their loved ones were involved in the planning of their care and that this communication was ongoing during any decisions made during treatment.

Staff talked with patients, in a way they could understand, using communication aids where necessary. Staff discussed with patients how they wished to be communicated with including when they would and would not like to receive information in relation to their care. Relatives said that conversations and communication were held sensitively and ensured that their relative's input was sought throughout.

The service had developed flash cards for staff to refer to if people raised potentially sensitive topics of conversation such as their sexuality to ensure they received politically correct and impartial answers.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Feedback surveys and thanks given from patients, relatives and their loved ones described the service as wonderful and endlessly compassionate.

Patients gave positive feedback about the service. We saw large amounts of positive feedback in relation to treatment provided by staff at the hospice including that they were given "incredible care by an incredible team."

Staff supported patients to make informed decisions about their care. They supported patients to make advanced decisions, and these were documented in patient records including how they would like to be informed of their care, involved in decision making, appointing a power of attorney, whether to be admitted to hospital and preferred places of death. The service asked patients to select their 1st, 2nd and 3rd choices of preferred place of death to ensure that their place of death would still be in line with their preferences if there was any reason, they were unable to receive their first choice.

Wellbeing services identified and therefore tailored each person's care based on their individual needs. They collaborated with local charities and support schemes to access financial and social support, used internal volunteers to enable people to broaden their access to appointments and places of interest and supported people to make advanced decisions such as will writing and funeral planning.

Is the service responsive?

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.

Good

Hospice services for adults

Managers planned and organised services, so they met the needs of the local population. Leaders spoke daily with the Integrated Care System (ICS) to review and discuss capacity.

The service had accessed the governmental 'kickstart scheme,' which aimed to upskill 16–24-year-olds to improve employability. NYHC had welcomed 18 kickstart employees and offered them placements within the service, many of these placements had gone on to achieve secure employment or further study with 2 employees being offered paid roles within the organisation.

The service worked with the local authority to identify the needs of the local community and provide services where able. The service was delivering a pilot contract aiming to ensure sustainability of domiciliary care services to rural areas within their community.

The service had introduced the care connector role to the area of Reeth, classed as 'super rural' and the local people being identified as at risk of not receiving care fast enough to stay at home resulting in unnecessary hospital admissions or relocating to adult social care settings outside their community. The care connector role worked to receive referrals from this community, identify services available and provide support to individuals. This had resulted in people from this population receiving over 800 hours of personalised care and support, 150 face to face visits and over 43 referrals to other agencies for collaborative care.

The service had worked with a homeless charity and the police to actively reach the homeless population and offer advanced care planning support to GP's and district nurses. This had resulted in 5 people considered homeless requiring palliative or end of life services receiving the care they needed.

The service offered "Breathing Space," an MDT breathlessness service to support patients, with a palliative diagnosis of any condition and symptoms of breathlessness. Patients were encouraged to bring a main carer with them when they attend appointments in order to improve carer confidence in supporting the patient.

The service offered complimentary advanced care planning (ACP) services to people currently residing in care homes. People could be referred by care staff or their GP if appropriate and would receive an educational video in what ACP is followed by a call from a trained volunteer advanced care planner to discuss and develop a plan of their future wishes.

Facilities and premises were appropriate for the services being delivered and continued to be considered and renovated to meet patients' preferences and needs. The service was currently collecting feedback from staff, patients, and their loved ones to renovate inpatient services and referred to this as the sparkle project.

Staff could access emergency mental health and wellbeing support 24 hours a day 7 days a week for patients from another of the providers services called JustB.

The service had systems to help care for patients in need of additional support or specialist intervention. Acuity of patients was reviewed each morning to ensure that there were appropriate resources in place for people with additional and complex needs.

Meeting people's individual needs

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

The ward was adapted to meet the needs of patients living with dementia and included signage and dementia friendly clocks. The service supported relatives and those close to them to complete "This is me" documentation to enable care to be individualised to patients.

NYHC had created the 'Purple thread' work stream to develop services for people with dementia such as improving the environment for people with dementia and increasing EOL and dementia training and education.

The service had information leaflets and translation services available in languages spoken by the patients and local community.

The service had a service level agreement with the Citizen's Advice Bureau (CAB) in which a employee of the CAB offered end of life benefit advice to patients and could be accessed through the wellbeing services within the hospice. This enabled patients to identify benefits available related to sickness and disability, access employment and support allowance, personal independence payments and attendance and carers allowance.

Access and flow

Patients could not always 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 did not always consider the impact of bed closures on the wider system's access and flow. Despite the service having a full establishment of RGN staff, an increased vacancy rate of HCA staff meant staff felt the inpatient experience could be impacted. Daily meetings were held to consider staffing and capacity with bed closures being a regular and likely consideration. At the time of inspection, 2 inpatient beds were closed, despite staffing being in line with the service's clinical service staffing establishment policy, we did not see the consideration of other options to support the wider system.

Managers monitored occupancy levels; the service's 2022 report of bed occupancy had noted a steady reduction in bed occupancy in the last 2 years.

The service had detailed eligibility criteria for admissions to both inpatient and community services.

For planned inpatient admissions, staff worked to obtain as much information as possible from the referrer to prioritise the need for an inpatient bed. Admissions were agreed by the doctor on duty and co-ordinator nurse and therefore, due to the availability of medical staff, occurred mostly in office hours. Referrals that were agreed but unable to admit as there was no bed capacity were placed on the 'Waiting List' awaiting the next available bed. The hospice doctor and co-ordinator nurse reviewed waiting lists each morning to prioritise admissions.

There were arrangements in place for admissions to be arranged out of hours and could occur overnight or at weekends. The nurse in charge would confirm this with the on-call doctor. This could occur prior to receiving the necessary admission request form so as not to cause delay to admission, with the hospice staff ensuring that all required information was gained verbally in the meantime.

Patients wishing to access community services had to meet clear criteria, when a referral was received the home service coordinator would review and attempt to accept appropriate referrals within 24 hours. The service had a contracted service with the Integrated Care Board which ensured either "Silver" or "Gold" referrals which require a 6- or 2-hour referral turnaround time.

Good

Hospice services for adults

Staff planned patients' discharge carefully and supported patients when they were referred or transferred between services. Discharge was based on 5 criteria, a form was filled in and gave comprehensive detail of the patients discharge requirements including home circumstances, transport, and medication, this was done in conjunction with healthcare professionals, the patient and their relatives or loved ones. However, Hospice UK benchmarking data identified that the service had significantly less discharges (9) than other hospices of its size (19.6) for the same quarter.

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. The service clearly displayed information about how to raise a concern in patient areas.

Managers investigated complaints; the service had only received 1 complaint in the 12 months prior to inspection. This had been addressed in line with policy, with the desired outcome achieved for the complainant and actions in place to reduce the likelihood of a similar incident occurring.

Staff understood the policy on complaints and knew how to handle concerns raised with them.

Managers shared feedback from complaints with staff and learning was used to improve the service, for example a new policy was developed in response to the complaint received.

Is the service 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.

Leaders had the skills, knowledge, and experience to run the service. The registered manager was well supported and received training appropriate to their role.

The organisational leadership team consisted of a chief executive, deputy chief executive, 2 directors with responsibility for clinical services and a director responsible for mental health and emotional wellbeing services. The organisational leadership team was supported by a medical director (consultant in palliative medicine), head of nursing services (registered nurse), head of business intelligence, head of safeguarding, policies, and resilience (social worker), head of people and culture and heads of client services.

Staff told us leaders were visible and approachable.

Staff were offered opportunities to develop their role within the service and were supported to take on more senior roles. The service offered the emerging leaders programme, a two-year in-house leadership development framework aligned to the organisational strategy and values, with the aim to develop leadership skills and embed the services values in their existing workforce.

The service had created development opportunities such as the apprentice advanced clinical practitioner. The programme offered candidates the opportunity to complete training towards becoming a qualified advance clinical practitioners through a combination of university placement and inpatient clinical work within the service allowing their nurses the opportunity to upskill themselves in elements such as advanced clinical assessment and non-medical prescribing.

The service monitored compliance with the Fit and Proper Person Requirement (FPPR) of the Health and Social Care Act. This regulation ensures leaders have the essential skills and competencies to manage an organisation, we checked the service was compliant with this regulation.

Staff and volunteer files had all appropriate documentation to ensure the employment of fit and proper persons, including disclosure and barring services, were checked, and recorded.

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 service had clear values driven by a desire to ensure that in the community it served, everyone receives the care they need, want, and deserve at the end of their lives. Staff shared the vision “to do as much as we can, as well as we can, for as long as we can, for as many as we can,” and the services values were evident in the care delivered by staff.

North Yorkshire Hospice Care was launching its new 3-year strategy in January 2024. The strategy focussed on 4 key areas, meeting unmet need, improving accessibility, nurturing sustainability and collaboration and partnership working. Each work stream had been developed with input from stakeholders and the community the hospice served.

There was a clear vision and a set of values that focussed on the improvement and development of current services before expanding the range of services that could be offered. This work was underpinned by 4 key aspirations, equality and diversity, quality and standards, the team and environmental impact. There was a realistic strategy for achieving the priorities and delivering good quality sustainable care which was reviewed every 3 months.

The strategy was aligned to local plans in the wider health and social care economy, and services had been planned to meet the needs of the relevant population.

Culture

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

The service offered a range of wellbeing services to staff, including a reflective spaces service and staff drop-in service, Schwartz round and salary advances.

The service had an internal resilience group which offered anyone within the organisation a listening space. Internal and external support options were explored and signposted to. Feedback from staff had found the service beneficial and easy to access.

Staff could participate in wellbeing activities for team building and to promote positive wellbeing such as arts and crafts sessions and complimentary therapies. There were specific support groups such as the menopause peer group and the 'early bird run crew,' a non-competitive running and walking group based around fitness, companionship, and positive mental health.

Staff told us they received 'the most amazing support,' from the service.

In the most recent staff survey in 2022, 89.9% of staff had said they would recommend the organisation as an employer. The results of the survey were predominantly positive; however, leaders had still created actions to improve the staff experience such as a staff pay review and recognition scheme.

The service promoted equality and diversity in its daily delivery. A key focus of the new 3-year plan was equality, diversity, and inclusion. To ensure this was embedded the service used the acronym FREDIE and tested areas of the service, such as the environment, to ensure they encompassed fairness, respect, equality, diversity, inclusion, and engagement. There was a strategy in place, and we saw meeting minutes where staff discussed progress against the FREDIE workplan.

The service had a whistleblowing policy that staff were aware of. Staff knew who the freedom to speak up guardian was, and we saw posters of how to access the guardians displayed throughout the service. A freedom to speak up guardian provides a safe space for staff to speak up so potential harm is prevented.

There were mechanisms for providing all staff at every level with the development they needed, including high-quality appraisal and group supervision and informal one-to-one conversations available anytime. The organisation supported staff to progress within the organisation to increase their competencies and staff confirmed this.

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 organisation had clear governance processes in place to collect, review and improve data and manage risk to ensure patients were safe from risk of harm or potential harm. The governance structure identified areas of responsibility and ensured relevant information was both escalated to and disseminated from board level.

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. Monthly staff meetings were held, and staff had the opportunity to access minutes of meetings and add any additional comments when they were unable to attend.

The service had assurance systems to monitor safety through regular clinical and organisational audits and acted when compliance was below the benchmark. There was a specific policy audit framework to ensure policies received review when required and ensure adherence to policy.

There was a clinical services governance group that monitored the quality of clinical services and was a point of escalation for the clinical incident and medications management groups. Incidents, audits, and policy were reviewed for all services at the groups monthly meeting. A quarterly review of data was conducted which identified any themes, trends and increase of clinical incidents. Where increases in incidents had occurred, further work was undertaken to explore reasons and possible ways in which to reduce incidents reoccurring.

Findings discussed at clinical service governance group were reported to the leadership team and reports to compiled for the board of trustees, there was direct escalation between the chair of clinical services governance group and chair of the board.

We saw evidence that learning was shared through leadership and team meetings and displayed throughout the service. Day to day learning was shared during the daily safety huddles with appropriate learning shared with the board of trustees.

The organisation had service level agreements in place (SLA) with third party organisations. Some of which included medicines provision and waste management.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. Systems identified relevant risks and issues and therefore actions to reduce their impact. They had plans to cope with unexpected events.

There was a process for identifying, recording, and managing risk. The risk and compliance group kept a workplan to ensure that actions were taken to recognise and reduce risk, and quality standards were maintained for all departments, however these did not always identify the risks found on inspection.

The service used a clinical services provision development and improvement area tool. This covered all areas of the service including inpatient, community, and wellbeing services. The tool broke down improvement areas for each service and the actions required to achieve this improvement. Responsibility for each action was assigned and monthly progress updates were required. However, we saw that actions were not always effective, for inpatient services the 'improving mouth care' action was recorded as complete and being implemented in September 2022 and had not recognise the risk of oral sponges still being in use found on inspection. Following the inspection, the registered manager submitted a mouthcare review summary that had been completed in 2022 that highlighted risks of oral care sponges and limiting their use for sensory pleasures and moistening.

The service had implemented an 'alerts spreadsheet,' this captured any best practice safety alerts issues, and the initial and ongoing response of the service in ensuring safety alerts were implemented.

There was a nursing action plan in addition to the clinical services development tool, in which areas specific to improving nursing provision were identified. Immediate and long-term plans of action were put in place to improve areas such as staffing skill mix, with assigned ownership and deadlines for completion.

Each department had individual risk registers. We reviewed the local risk register which showed it was reviewed and updated by the hospital and area managers. All risks had control measures in place to help reduce any risk and review dates.

The service had an additional high level safeguarding governance risk register. Safeguarding concerns were reviewed monthly to ensure the appropriate and timely action of referrals and RAG (red, amber, green) rated in terms of whether safeguarding's were made within specified metrics.

The service had plans to cope with unexpected events such as an IT failure or staff shortage.

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.

Patient information was recorded in paper records, and the service had introduced e-prescribing. All records were kept secure and were accessible only by appropriate personnel.

Organisational policies and guidelines were stored electronically on a shared drive so staff could easily access them. Each staff member had personalised log in detail to maintain confidentiality and security.

The service submitted statutory notifications to the CQC appropriately.

The organisation submitted data to Hospice UK and could be benchmarked nationally.

The statutory and mandatory training included modules on information governance, with 97-100% of patient facing staff having completed this.

The service had a comprehensive website, which provided patients with information about different care and treatment at the service and how they could access services.

Engagement

Leaders 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.

We saw the service sought feedback for both inpatient and community services. We reviewed feedback and saw that it was positive.

All staff and leaders expressed the invaluable work and contribution of volunteers.

There were positive and collaborative relationships with external partners, the service was in contact with the ICS daily to build an understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs.

The service worked collaboratively with other organisations within their integrated care system (ICS) network to develop hospice services. They currently offered the West Yorkshire grief and loss line, a service offered by a collective of hospices in the area to give bereavement support to people within the ICS, engaged with clinical training opportunities and attended clinical forums about the regional developments within hospice care.

The service engaged with groups identified as having protected characteristics under the Equality Act 2010 to identify ways of minimising health inequalities. The service identified that the demographic of their locality meant they did not reach as many black and minority ethnic (BAME) individual's. Leaders had undertaken analytics of census data to identify how they could further reach this community. The service had begun building relationships with translation services and identifying subject topics people preferred to speak in either their primary or secondary languages in.

The service had actively sought to engage with the LGBT+ community by attending pride events. They were directing their recruitment to actively seek applicants from marginalised communities both to increase equal opportunities and to learn and develop the service from their knowledge and experience. The service had developed clinical education in the medical and pharmacological changes that may be required for a transgender person throughout their transitioning journey based on the experiences of an employee of the service.

The service was working with a prison healthcare service to assist in the support and delivery of end-of-life care in prisons by offering 4 services: clinical supervision, access to on call medics, bereavement support and advanced care planning.

The service actively engaged with the community. Each year the service invited the community to dedicate a light during the festive season in remembrance to those having used hospice services. People were also able to dedicate on the service's tree of life, a tree located in the grounds decorated with engraved bronze, silver, and gold leaves. The service ran a twilight walk for the community to join and partook in local running events to fundraise for the service.

The website had a section specifically for health professional referrals and information.

In the most recent 2022 staff survey 89.9% of staff said they felt communications helped them to feel informed.

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 organisation was committed to continually learning and improving services to benefit patients and the local community. The service took part in research studies such as the Self-Management of Analgesia and Related Treatments in Palliative Care (SMART) feasibility study which aimed to develop a self-management toolkit for patients approaching end of life in the community, and the randomised trial of clinically assisted hydration in patients in the last days of life (CHELsea II Trial).

Staff were encouraged to report incidents via the electronic reporting system, even minor incidents to identify potential themes or issues to improve processes.

The service sought external providers to conduct reviews to identify areas of good practice and areas for potential improvement and actioned these appropriately.

We saw examples of learning from incidents and complaints and were assured that shared learning occurred on a frequent basis. We saw drive and ambition within the leadership and staff teams to continually learn and improve the service.