Marie Curie

Marie Curie Hospice and Community Services North East

Inspection report

Marie Curie Drive
Elswick
Newcastle Upon Tyne
NE4 6SS
Tel: 01912191000
www.mariecurie.org.uk/en-gb/nurses-hospices/our-hospices/newcastle

Date of inspection visit: 23 to 24 January 2024
Date of publication: 22/03/2024

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

Ratings

Overall rating for this location	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Outstanding ☆
Are services caring?	Outstanding ☆
Are services responsive to people's needs?	Good ●
Are services well-led?	Outstanding ☆

Summary of findings

Overall summary

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

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided a high standard of evidence-based care and treatment, consistently gave patients enough to eat and drink in response to individualised plans, 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 and those close to them, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff were consistently committed to treating patients and those close to them with compassion and kindness, respected their privacy and dignity, found innovative ways to meet their individual needs, and helped them understand their conditions. They provided strong, caring and respectful emotional support to patients, and those close to them. Staff worked in partnership with patients and those close to them and were intuitive to their needs.
- The hospice was an active partner in planning care to meet the needs of local people. The service actively engaged with extensive local organisations to understand the changing needs of the local populations. They took account of patients' individual needs and made it easy for people to give feedback. People could access the service when they needed it.
- Leaders were dedicated to providing an inclusive, compassionate and highly effective service. They ran services well using reliable information systems and consistently supported staff to develop their skills and succeed in the delivery of a high-quality service. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued and were focussed on providing best practice to meet the needs of patients and those close to them. Staff were clear about their roles and accountabilities. The service was consistently committed to seeking constructive engagement with patients, those close to them and the community to plan and manage services. All staff were empowered and committed to improving services.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	**Outstanding** ☆	Our rating of this service stayed the same. We rated it as outstanding We rated this service as outstanding overall because it was good in safe, and responsive and outstanding in effective, caring and well led.

Summary of findings

Contents

Summary of this inspection

Background to Marie Curie Hospice and Community Services North East

Marie Curie is a charitable organisation, registered with the Charity Commission, which raises funds to offer care and support through terminal illness. First established in 1948, the service has been caring for people living with any terminal illness, and their families, for over 60 years. Marie Curie is the UK's largest charitable employer of palliative nurses and professionals. It is also the largest charitable funder of palliative care research.

The Marie Curie Hospice and Community Services North East offers individualised holistic care, guidance and support to adults with life shortening conditions and terminal illness. This includes people requiring symptom control, psychological support, rehabilitation and end-of-life care. In addition to a team of highly experienced doctors and nurses, the hospice has specialists in a wide range of roles including physiotherapy, occupational therapy, social work and bereavement support. Support services are extended to those close to patients including families, children and carers. Support continues into bereavement and beyond.

The North East services provide regulated activities including in-patient care, urgent hospice at home care, hospice at home planned overnight care, a wellbeing hub for outpatient and group support. Additional voluntary led services include a companionship service.

Marie Curie Hospice and Community services North East cover a large geographical area and provide services within the North East and North Cumbria Integrated Care system. Community services are specifically commissioned by local authorities in conjunction with North of England Commissioning Support. Commissioned services are provided specifically for the local area for which they are commissioned and is based on local identified need. In-patient and wellbeing hub services are provided through 50 % commissioned funding and 50% charity funding.

The service was registered for the treatment of disease, disorder or injury and had a registered manager in place.

We last inspected the service in 2016 when it received a rating of 'outstanding'.

How we carried out this inspection

The inspection team included two CQC inspectors and a specialist advisor with a background in nursing and end of life care CQC. There was an offsite CQC operational manager.

The inspection was a short notice announced inspection.

During our inspection we spoke to members of senior leadership and staff across the organisation including nursing, healthcare assistant, housekeeping, facilities, administrative, medical and AHP staff. This included staff across a range of services provided. We spoke to patients and those close to them and observed interactions between staff and patients. We reviewed sets of clinical notes and policies.

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.

Summary of this inspection

Outstanding practice

We found the following outstanding practice:

- The service had led the way in pressure ulcer care for end-of-life care, completing project work and publishing findings in a national journal. This work had been recognised by the National Institute for Clinical Excellence (NICE) for future reference in the NICE Medical Technology Guidance.
- The service provided excellent individualised dietary support for patients. The dietician and chefs had worked closely together to ensure needs and preferences were met for each individual. Individualised nutritional plans had been created. There had been contribution to evidence based work published nationally.
- The service provided appropriate and timely support beyond day to day care in recognition of the emotional needs of patients when there was a loss amongst a peer group.
- The service had embedded strong quality assurance, safety and support systems for staff working alone in the community.

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 consider updating the standard operating procedure for safeguarding referrals North East to include local authority contacts for referrals in the Teesside area.

Our findings

Overview of ratings

Our ratings for this location are:

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

Outstanding

Hospice services for adults

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

Is the service safe?

Good

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

Mandatory training

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

Staff received and kept up-to-date with their mandatory training. Training compliance for both on-site and community staff was 95% against the organisations target compliance of 95%.

The mandatory training was comprehensive and met the needs of patients and staff. All volunteers also received comprehensive mandatory training before starting in their roles.

Training modules included safeguard training for adults and children, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS) training. Other modules included code of conduct, health and safety, moving and handling, basic life support (BLS) resuscitation, medicines management, data protection, diversity and equality and infection protection and control (IPC).

The service had an onsite clinical educator to support staff with training needs. The clinical educator planned face to face training throughout the year to meet the needs of staff working within different settings. For example, they were running a pilot with community staff with a mix of face to face and virtual training.

There was a bi-monthly meeting with managers to monitor local training compliance and review current training needs. Scheduled training included, for example, blood transfusion, syringe drivers, medical gases, basic life support, catheter care, symptom management, recognising and responding to dying, duty of candour, documentation and record keeping, lone working and personal safety. Additional training was provided according to staff role and need. We saw there was a comprehensive training plan in place for 2024. The clinical educator worked closely with the Marie Curie Yorkshire clinical educator to share ideas and learning plans.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. The service planned to review further training options available in 2024 to ensure the most appropriate training was being provided in these areas.

Managers monitored mandatory training locally and alerted staff when they needed to update their training. Staff received notifications electronically through the training portal when e-learning training was due to expire. Protected time was given to complete training and staff received prompts from team leads when training was due.

Compliance data was reviewed at local level at the monthly place-based governance meeting. Training compliance data was pulled through to an escalation report quarterly. This information was then escalated to the board. Data was analysed monthly at both information and governance meetings and the quality trustee committee meeting.

The board also had oversight of training analysis data compliance through the audit and risk committee. At the end of each committee meeting the minutes were forwarded to the board of trustees for review and feedback where necessary.

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.

All staff and volunteers received training specific for their role on how to recognise and report abuse. All staff received mandatory training in safeguarding adults and children. Training compliance data provided showed current compliance for safeguarding adults (levels one and two) was 98% for community and hospice staff. Safeguarding children (levels one and two) was 98% for hospice staff and 99% for community staff. The organisations target compliance was 95%. The service completed level three safeguarding children training over and above their mandatory requirements as this was considered good practice. At the time of inspection there was a shortfall of staff having completed this training. We heard this was a result of lack of availability of local training places following the COVID-19 pandemic. We saw evidence of actions to book staff on to future training. The service had effective systems and processes in place to ensure regular supervision of staff regarding safeguarding.

The service had a designated trustee safeguarding lead, a head of safeguarding and a named safeguarding lead locally. The corporate executive lead responsible for safeguarding across the organisation was the chief nursing officer (CNO). The CNO was responsible for ensuring the organisation discharges its statutory and regulatory responsibilities.

The service had a corporate policy in place for adult and children safeguarding concerns. The policy was in date with a review date of October 2024. The service had a local standard operating procedure (SOP) for adult and children safeguarding concerns. This was in date with a review date of September 2024. The policy included links to the range of different local authority areas that the service covered, however, did not include Middlesbrough area.

The policy referenced national guidelines and contained links to local authority safeguarding information and PREVENT. PREVENT is a government led programme which aims to safeguard vulnerable people from being drawn into terrorism.

The service provided three monthly safeguarding supervision meetings for all staff to attend. We reviewed minutes from these sessions. The minutes evidenced thorough review and reflection of all safeguard concerns raised by staff across the teams within the service during the time period since the previous meeting. Safeguarding training compliance was shared at these meetings along with information from the organisations wider safeguarding assurance group. We saw evidence that the format of these meetings were reviewed to ensure they met the needs of all staff. There was also evidence of wider learning instigated from safeguarding incidents discussed, for example, the understanding of trauma informed care.

Face to face courses for clinical and non-clinical staff were facilitated by external agencies for safeguarding, Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act (MCA).

The service met the Fit and Proper Persons Requirement (FPPR) (Regulation 5 and 19 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that staff are fit and proper to carry out individual roles.

All staff including clinical, non-clinical and volunteers had disclosure and barring service (DBS) checks in place, we saw evidence to support this. The tracker is reviewed quarterly by central HR business partners, and DBS checks renewed within three years. This information was stored securely at corporate level and could be accessed locally for assurance and oversight.

Staff we spoke with could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff we spoke with were able to describe situations that had required safeguarding discussions. Staff working within the community were articulate in sharing examples of patients' home and family circumstances that required further review, for example poor living conditions and risk of rats. Staff were clear about when to raise concerns and when to consider assessments of capacity in relation to the potential risks that patients faced within some situations.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were clear that there was always a manager available to raise concerns with.

All safeguarding referrals were also recorded on the organisations incident reporting system to ensure manager oversight and review of themes, trends and training needs.

Staff were aware of the impact of visiting the ward environment on children and made arrangements for children to access family members bedroom areas once signed in via the outside of the building directly into bedrooms to avoid the need to walk through the ward environment as appropriate.

Cleanliness, infection control and hygiene

Staff used infection control measures when visiting patients in the community, on wards and when transporting patients after death.

In patient areas, the wellbeing hub, communal and public areas were clean and had suitable furnishings which were clean and well-maintained. We saw housekeeping staff actively maintaining the cleanliness of the environment throughout the inspection.

Nationally there was a Marie Curie infection, prevention and control (IPC) quality improvement programme. There was a national policy that set out clear governance guidance for place-based services. There were national monthly meetings for local IPC leads to attend. National IPC information was fed into the local service through the bi-monthly clinical effectiveness meeting. The service had a local IPC lead in place and a community link IPC nurse. Local actions were derived out of national findings and local audits as needed. The service was compliant with all IPC practices at the time of inspection.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We also reviewed the cleaning schedule for the mortuary.

We observed staff following infection control principles including the use of personal protective equipment (PPE). We saw posters promoting awareness of covid-19 and best practices to minimise risk of spread. Staff told us that clear signage would be used on bedroom doors in the in-patient unit where there were any patients with infection risk.

Regular hand hygiene audits were carried out both on the in-patient unit and within patient homes on community visits. We saw evidence of 100% compliance for the most recent hand hygiene audit for in patients. For community staff during the most recent audit we saw 100% compliance with of 17 of 20 areas, 75%, 88.9% and 90% on the other three areas. We saw evidence of an action plan completed immediately following this audit with actions related to the areas where 100% compliance had not been achieved.

We also saw evidence of food safety and hygiene audits that included compliance with personal hygiene practices for kitchen staff.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw evidence to support this during the inspection.

We heard about how staff in community teams would assess IPC risks within patient's homes and would work with families to manage these risks to ensure safe practices could be carried out. We heard this was done sensitively, respecting the way that patients and those close to them chose to live.

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 hospice environment was designed to meet the needs of patients and those close to them attending for stays within the in-patient service, support from the wellbeing hub and those attending for children's and young person's support. Access to the building was via level access into an open and spacious reception area with clear signage to areas of the building.

Access to the in-patient and wellbeing services were via a lift or stairs to the ground floor. Both were accessible directly from the main reception. On the ground floor there was clear definition between the in-patient unit and the wellbeing centre. PPE and hand gels were readily available at the entrance. The areas were bright and spacious.

Children and young people visiting for appointments with the children and young person's service accessed the services via the main reception and into therapy rooms on level access directly through the reception area. Staff told us this was planned so that young people and children did not need to walk through the rest of the building should they find it emotionally challenging.

The in-patient unit was an older building undergoing a programme of renovation The service had secured funding to refurbish inpatient and outpatient areas. Some of the refurbishment work had been completed pre COVID-19. Work was stopped due to the pandemic. Senior leaders told us refurbishment work had recommenced. A patient bay had recently been refurbished to include a sitting and eating area.

Closed circuit television (CCTV) was in use at the entrance and perimeters of the building. The service had security officers in place 24 hours a day seven days a week. Entry to the premises was via automatic doors. Reception staff had a clear line of sight and could see CCTV footage of external areas. There was a sign in and out register.

Access to restricted areas such as administration and storage areas, was controlled with swipe card access and key-pad locks.

Piped oxygen was available in newly refurbished rooms. Un-piped oxygen was still being used in rooms that had not been refurbished.

Patients could reach call bells and staff responded quickly when called. Patients had options of using wrist pendants and buzzers. All call bells alerted a bleeper that was carried around by the named member of staff for each bed area. This meant patients were not disturbed by buzzers going off and staff were able to respond directly.

CCTV was in use in bedroom areas when there was a clinical need and with patients consent. There was clear signage advising of CCTV use.

The environment was audited annually by an external health and safety company. At the most recent audit the team were awarded with a five-star rating and comments received included 'the standard of health and safety management at this hospice is exceptional'.

Staff carried out daily safety checks of specialist equipment.

Fire alarms were tested weekly. We saw evidence of clear signage on fire test day during our inspection. We also observed members of the estates team alerting staff and patients.

The service had suitable facilities to meet the needs of patients and those close to them. In-patient areas provided communal spaces and large bedrooms with options for family members to stay overnight. The in-patient unit had 18 in-patient beds all with on suite bathroom facilities. Two suites had been adapted with kitchen areas to allow for families to carry out daily routines in privacy and to support rehabilitation activities. Two rooms were adapted specifically for patients with a higher risk of falls and were located close to the nurse's station.

Consideration had been given to patients varying individual needs and sensitivities. For example, the mirrors in patient rooms and bathroom had been fitted with roller blinds for patietn choice as staff recognised not all patients wanted to see themselves.

The in-patient area had a spa bath with adjustable mood ceiling lights. The bathroom was spacious and had recently been refurbished. We heard examples of flexible working to allow patients attending the wellbeing hub to also access this resource.

Level access garden areas were accessible from in-patient rooms and the wellbeing hub.

There was a well-being hub area where groups took place for out-patients. This was fully equipped. All areas were easily accessible. There was a communal kitchen area and separate open spaces for craft work for groups or individual use. There was an outdoor seating area directly accessed from the hub. We heard that the well-being hub space had also been used to provide, for example, a decorated space for couples to have anniversary meals provided when they weren't able to go out.

The service had a gym which included multiple pieces of gym equipment for in-patient and out-patient use.

There were two clinic rooms for out-patient clinics of which one was also a treatment room.

There was a kitchen and café facility between the in-patient and wellbeing hub with level access to a kitchen garden maintained by volunteers. There was outdoor seating available directly from the indoor café seating area. Adaptive cups and cutlery would be provided in the café according to need.

There was access to a reflection room for all staff, patients and visitors to use. This supported multifaith use.

Hoists were available and used where needed. These were mobile hoists as the team recognised the building was older and had not been built to support ceiling track hoists safely.

There was a first aid kit in the reception area and trained first aider on site.

There was multiple office space available for all staff who required office space. There was also access to two conference rooms which were used for larger conference facilities and meetings.

All fire extinguisher appliances that we saw were signposted and serviced within an appropriate timescale. Fire exits and corridors were clear of obstructions. The service had a fire evacuation plan and conducted quarterly fire evacuation drills. There were clearly identified fire wardens daily.

There were systems for recording the service and planned preventive maintenance of equipment, identified through a central log and equipment compliance stickers, which indicated dates tests were completed and next due. All equipment that we reviewed was appropriately serviced. There was a very well-respected onsite maintenance team that responded quickly to any repairs required.

During inspection we observed a plant access door which was unlocked. The cupboard contained an electrical distribution board. This was a risk as patients and members of the public had access to the cupboard which was a hazard. We escalated this with the facilities manager. Electrical safety work had recently been completed by an external contractor the day before. The work had been signed off and the contractors had left site. The door had not been locked when they had completed the work. The service took immediate action to lock the door. Staff understood the importance of checking work completed by external contractors when work was signed off.

Staff disposed of clinical waste safely.

Substances hazardous to health were stored safely.

Assessing and responding to patient risk

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

The service had clearly defined inclusion and exclusion criteria for the safe acceptance of patients. We saw evidence to support this for in-patient services, urgent hospice care at home and the overnight planned community service.

The service had a standard operating procedure (SOP) in place to support the in-patient admission process. This included rationale to support planned and out of hours admission. There was a clear system in place to assess known infection risks and potential skin damage pre-admission. An admission assessment would be carried out jointly between medical and nursing staff where possible. All risk assessments were to be completed within six hours of admission. Admission processes were regularly audited to ensure standards were met.

Hospice services for adults

The urgent hospice care at home and overnight planned services accepted referrals from district nurses and would request an up-to-date risk assessment be provided as part of the referral process. If these were not up to date the staff would complete an incident form and ensure this was fed back to the district nurse teams. Staff had clear processes to follow to escalate risk for patients within the community. For example, hospice care at home referrals asked that a patient had a district nurse and a GP willing to care for the patient at home.

Staff used the nationally recognised National Early Warning Score 2 (NEWS2) tool to identify deteriorating patients alongside their clinical knowledge, judgement and expertise and escalated them appropriately.

Staff were proactive in completing risk assessments for each patient on admission to the inpatient unit and arrival to the wellbeing centre. Care plans were devised accordingly to manage individual patients identified risks. For each individual a set of risks were reviewed daily, this included, for example, skin pressure and nutrition. All risks were reviewed on a weekly basis or sooner if clinical presentation or circumstances indicated a need for review. Assessments included the use of the IPOS (Integrated Palliative care Outcome Scale) which measures symptoms and concerns that matter to individuals in relation to physical, social, psychological and spiritual needs. We reviewed care plans and saw evidence of detailed evaluations of patients needs that reflected staff understanding of changing risks and the needs of those close to patients.

Community staff carried out dynamic risk assessments as they entered a patient's home and throughout the duration of the visit. The overnight planed service team completed hourly documentation to reflect risk. Notes were reviewed each morning by members of senior nurse staff within the team to review for any significant changes or concerns.

Staff knew about and dealt with any specific risk issues including falls, moving and handling, bed rails, infection control, skin pressure and wound care, nutrition and hydration. Staff used the Avoiding Falls Level of Observation Assessment Tool (AFLOAT) to determine the recommended level of observation for falls risk according to clinical presentation. The Braden score tool was used alongside body mapping to assess skin damage. The service had an identified lead tissue viability nurse.

Occupational therapy staff also completed a nationally recognised tool to assess disability and to monitor changes in disability over time. This includes a list of common daily living activities and measures the changes in ability to function and the amount of assistance required by an individual. Staff used this tool to ensure risk was minimised whilst promoting independence appropriately for individuals.

We saw evidence of a focus chart in use. This prompted staff to ensure regular checking of feet, orientation, continence, understanding patients' needs, skin and position. We also saw clearly displayed 'call don't fall' posters.

Staff we spoke with were aware of how to access 24-hour mental health support through local mental health services including the mental health crisis service. Staff told us they would contact mental health services if they were concerned about risks due to mental health deterioration.

There was a policy in place for management of self-harm and suicidal thoughts. This policy clearly outlined processes to follow within each of the hospice and community team areas should a patient actively self-harm or express thoughts. The policy also covered processes for those close to patients and staff members expressing thoughts of self-harm or suicide. Processes included risk assessment, referrals as required and observations within the least restrictive means. We saw evidence of active reference to supporting any individual in such circumstances within safeguard supervision notes.

Staff shared key information to keep patients safe when handing over their care to others.

Shift changes and handovers included all necessary key information to keep patients safe. During inspection we observed a daily admissions and handover meeting on the in-patient unit. This was a multidisciplinary meeting (MDT) including ward manager and nurse staff, medical staff, chaplain, occupational therapists, physiotherapists and social workers. The meeting followed a SBAR (situation, background, assessment and recommendation) format to guide discussion regarding admissions. This ensured thorough discussion regarding risks including, for example, advanced decision care plans, observation levels, wider needs such as external appointments and support.

Nurse staffing

The service had enough nursing and allied healthcare professional 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.

The service had enough nursing, medical and allied healthcare professional (AHP) and support staff to keep patients safe. On the day of inspection, the in-patient unit was staffed to meet the number of in-patients. There was also a dedicated clinical nurse in charge and one nurse on an office day. Each shift was covered with the correct ratio of registered nurses and healthcare assistants according to planned verses actual staffing records. We saw evidence to support staffing met the planned numbers.

The service had reviewed nationally recognised safe staffing tools and concluded that recognised tools were not suitable for hospice use as they did not take into account additional time spent on activities such as supporting families, care after death or advanced care planning. The team had devised and shared a tool that was trialled in all Marie Curie hospices. This tool was used twice a year over a six-week period to review the overall acuity on the in-patient unit. Alongside this tool a red flag indicator was developed for more regular use to manage any immediate shortfalls of staffing.

The managers could adjust staffing levels daily according to the needs of patients. If minimal staffing levels could not be achieved, then consideration would be given to the ability to take admissions and bed numbers could be reduced to ensure safety of those using the service.

The hospice care at home overnight service was a commissioned service and staff were recruited to meet the commissioned hours.

The service had stable vacancy and turnover rates. We saw that vacancies were filled as staff left.

The North East service had stable sickness rates over the previous six months at an average of 11-12%.

Managers limited their use of bank and agency staff and requested staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service.

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.

The service had a vacancy for one consultant in palliative care at the time of inspection. This had been identified on the service risk register. However, managers mitigated risks by adjusting the number of beds available within the in-patient unit to ensure safe staffing. The team were actively recruiting to additional medical posts at the time of the inspection.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. There was a mixed team of speciality doctors, GP trainees, non-medical prescribers, associate nurse consultant and advanced nurse practitioner staff. We heard that this team worked well together with a good range of clinical skills and experience.

The service always had a consultant on call during evenings and weekends. The service was supported by a local palliative care consultant rota reaching across other local hospice and NHS organisations. The acting medical director and medical secretary had oversight of the rota daily and ensured any gaps were filled.

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. The service used a recognised electronic patient record system.

The e-record system was comprehensive, easily accessible and had clearly identifiable flags to highlight risk and concerns. Electronic records were accessed by a secure smart card system. Some warnings were set to flash up when accessing a patient record, for example, safeguarding concerns.

We saw evidence of protected characteristics recorded. We reviewed risk assessments that had been completed and saw care plans that were determined following completion of risk assessments. We saw evidence of spiritual and psychological needs recorded within the notes. We saw multiple detailed evaluations of care.

The service had a member of nursing staff who was also an electronic patient record lead and worked closely with information technology to embed clinical recording needs within the system to ensure a responsive system. For example, a tab had been added to highlight when advanced care planning documents needed to be included.

When patients transferred to a new team, there were no delays in staff accessing their records. The system used was a universal system used by general practitioners and district nurses.

Records were stored securely. There was a clinical records policy which was in date along with policies for records retention and disposal guidelines.

Record keeping audits were routinely carried out in relation to specific aspects of care, for example, but not limited to, mouthcare and advanced care planning. We reviewed recent audits and found evidence of action plans where any areas had been below target.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. There was a pharmacist post within the hospice. At the time of inspection this post was being covered by a pharmacy technician through a service level agreement with the local NHS trust.

We saw patients with allergies were identified through the use of coloured wrist bands.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Pharmacy staff would provide information to patients and relatives about medicines that patients were given to take home.

Electronic prescribing and medication administration (ePMA) was embedded in the in-patient unit. A change from paper records had been made in 2019 following a recognition of a high level of medication error reporting and a need to maintain similar practices to local NHS organisations. This supported staff moving to roles in the hospice from local hospitals. All records were stored securely in the electronic system.

Staff stored and managed all medicines and prescribing documents safely. We saw prescription pads stored securely with appropriate recording systems in place. On the inpatient unit patients had individual lockers within bedrooms for safe storage of medicines. All lockers were accessed with a key. Pharmacy staff carried out regular checks on patient lockers.

Some patients were self-administering medication following a risk assessment. There was a statement of purpose in place for this.

Oxygen was stored securely. Staff told us that when oxygen was required in a patient's own home there was a procedure in place to ensure a risk assessment was carried out by the local fire brigade services.

We saw clear processes for disposal of medicines. We saw sharps bins were used appropriately. We saw controlled drug checks were in place along with regular controlled drug audits. The service had a controlled drugs accountable officer.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Pharmacy staff caried out checks to confirm prescriptions received matched the records.

Staff learned from safety alerts and incidents to improve practice. We saw evidence of medication incidents that had occurred elsewhere shared through team meetings.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

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. Staff raised concerns and reported incidents and near misses in line with the service's policy. The service had a procedure in place to ensure incidents and potential incidents were reported swiftly. All staff we spoke with were able to articulate the incident reporting process.

All incidents and accidents were logged onto an electronic system which provided an overview of incidents and any actions required to prevent occurrence. There were checks built into the system to ensure incidents had the required scrutiny from senior managers. This included a weekly clinical review incident meeting to help make sure potential issues or themes were identified and dealt with quickly and to discuss any actions from previous incidents.

Outstanding ☆

Hospice services for adults

The registered manager reviewed the categorisation codes of all incidents to ensure the correct recording and appropriate investigation was instigated. The executive and quality team instigated a monthly incident and risk management group meeting where incidents were discussed. We reviewed meeting minutes from December 2023. The agenda included incident review, complaints, medicines management, estates, PSIRF, safeguarding, risk assessments, Central Alerting System (CAS) alerts, falls and risk register. At this meeting themes and trends were analysed to ensure patient safety incident response plans were instigated and in place. Placed based incidents were split by individual teams for example, in-patient and hospice at home service.

Serious incidents (SI) were reviewed centrally at Marie Curie national SI panels with learning shared locally and centrally through quality group and via individual line managers. Incidents were benchmarked across the organisation centrally. At local level, SI investigations were reviewed monthly and action plans monitored to ensure completion of the governance loop.

Incidents were shared through handovers and team meetings on a regular basis. We also saw a display board detailing the level of incidents and categories within the past month for staff and visitors to see.

Team managers reviewed any incidents relating to their areas for example, wellbeing hub, urgent hospice care at home.

The service had a tissue viability link nurse who supported patients and staff surrounding pressure damage and management. We saw a visual display identifying on the day of inspection it had been 69 days since a patient had developed pressure damage whilst in hospice care.

The service had a falls lead who regularly reviewed falls risk minimisation.

The service had no 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, both internal and external to the service. The were no recent incidents rated as severe harm.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Managers debriefed and supported staff after any serious incident. There was a rota on display for all staff to identify which member of senior management was available for support each day.

Is the service effective?

Outstanding ☆

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

Hospice services for adults

Evidence-based care and treatment

The service provided holistic care and treatment based on national guidance and evidence-based practice to achieve effective outcomes. Managers checked to make sure staff followed guidance. The service supported all staff to actively reviewed the evidence base on a regular basis.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. All policies we reviewed were up to date and in line with best practice. We saw evidence of the service reflecting upon processes and ensuring that policy was adapted as and when needed to best meet the needs of people and families using hospice care.

Nationally the Marie Curie organisation reviewed all National Institute for Clinical Excellence (NICE) guidance regularly. Senior leadership locally would complete gap analysis and feed information into relevant meetings on a monthly basis.

We saw an example of evidence of progression with implementation of NICE guidance for mouth care. An initial audit had taken place in 2021 to measure standards against NICE guidance and Royal College of Nursing (RCN) guidelines. This had identified areas for improvement. A re-audit was completed in 2023 which evidenced areas of compliance with further evidence of specific actions for the local service provision. These actions were clearly outlined with completion dates for February 2024.

The service provided evidence-based practices including cognitive behavioural therapy, art therapy, creative writing and children's counselling services. The wellbeing hub used the evidence around social inclusion to plan and deliver appropriate groups such as baking and gardening. The bereavement team facilitated a walk and talk group in recognition of the growing evidence base for this kind of intervention. There team were aware of the evidence base for cognitive stimulation groups and planned to introduce these into the wellbeing hub.

Staff told us about a journal club that had been set up recently to support review of articles and carrying out of evidence-based practice appropriate to hospice care. We saw there was a rota in place for monthly meetings throughout 2024.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. During our inspection we attended a handover meeting and heard conversations where staff referred to patients needs holistically.

Nutrition and hydration

Staff consistently gave patients the right amount of 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 consistently made sure all patients had the right amount to eat and drink, particularly those with specialist nutrition and hydration needs. We also saw that the needs of those visiting patients were catered for during times when the café was not open for service.

The service had a dedicated number of dietician hours through a service level agreement with the local NHS trust. This allowed for all in patients to have a nutritional screen on admission and to have a nutrition care plan devised according to individual need. We saw evidence of individualised nutritional care plans.

All food preparation was carried out on site by a dedicated catering team. In addition to the nutritional screen a chef would visit each patient on arrival to discuss preferences. Preferences were considered in conjunction with the patient food requirements form completed by clinicians to ensure individual requirements were fully met. Textured or pureed diets were provided for along with any other specialist or cultural dietary requirements. If there were not sufficient ingredients in stock to meet certain dietary requirements, the kitchen supervisor or head chef would go out to purchase what was needed, for example, they would make use of food stores within the local Asian community.

There was a menu available daily and this had recently been updated to ensure all allergy information was correctly identified following an audit that had highlighted this as a requirement.

Staff fully and accurately completed patients' fluid and food intake in records where needed. Modified diets were recorded and shared on the handover sheet.

Staff used a specifically designed tool to meet the needs of palliative care patients nationally to monitor patients at risk of malnutrition and identify nutritional needs.

The dietician and catering team worked together to ensure compliance with the International Dysphagia Diet Standard Initiative (IDDSI) (2019).

Information leaflets were available for patient's offering advice on nutrition and hydration and difficulty swallowing.

Staff were aware of how to make referrals for speech and language therapy should this be needed.

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 range of recognised pain assessment tools according to individual need alongside individual discussion with patients about pain. A nationally recognised pain assessment tool had been set up on the e-record system for use. This tool allows health professionals to assess and evaluate the nature of pain that an individual is experiencing. Staff gave pain relief in line with individual needs and best practice.

We observed pain management was discussed for all patients at daily handover meetings and regularly with patients.

Patients received pain relief soon after requesting it. Patients we spoke to told us their needs were met in a timely way. Pain relief medications were prescribed following initial assessment and could be administered orally, via skin patches or infusion pumps. Syringe drivers were used within the unit to administer some pain medication. A syringe driver (or syringe pump) is a small battery-powered pump. It delivers a steady stream of medication through a small plastic tube under the patient's skin. Syringe drivers were used for medicines that help with pain, sickness, seizures, agitation and breathing problems. Information leaflets were available for patient's offering advice on syringe drivers and managing pain.

Staff prescribed, administered and recorded pain relief accurately.

In addition to the recognised medical interventions, patients were able to access alternative therapies and activities as a means of pain relief, for example, the Spa bath and reflexology sessions. The rooms used were specially adapted and equipped to provide a very calm and relaxing environment.

Patient outcomes

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

The service participated in a comprehensive range of Marie Curie national and local level audits. We reviewed the national annual schedule of clinical audits 2023 to 2024 for both the in-patient and community services. Scheduled audits included IPC, IDDSI, mouth care, duty of candour, safeguarding, tissue viability, falls, controlled drugs accountable officer, record keeping, bed rails assessments. We saw evidence of care of the dying audits which included preferred place of care. The service scored 100% compliance for this question. There were additional local audits including wrist band compliance and admissions.

The audit schedule outlined the frequency of audits and the staff group responsible. There was a national oversight of audit completion with national analysis of trends and themes for organisation wide sharing. We saw evidence of local implementation of action plans where actions were identified from audits. There was national oversight of the progress on action plans. A red, amber, green (RAG) rating was used to determine the progress of audits and action plans. This was reviewed locally through the governance structure.

We saw opportunities throughout the hospice building for feedback to be given either through completing written feedback or use of QR codes. Community teams contacted patients and families on a regular basis to carry out quality checks and provided feedback forms in information packs given out allowing for feedback and concerns to be addressed immediately.

Outcomes for patients were positive, consistent and met expectations. We saw clear evidence that any outliers were reviewed, and actions taken accordingly.

We reviewed action plans created following audits where scores fell short of the accepted standard. All action plans were detailed with clear areas for improvement, staff responsible and timelines. The audit programme evidenced repeated audits took place.

Thorough action plans and evidence of completion provided assurance that audit results were used effectively to constantly improve patient outcomes and ensure best possible care and treatment was provided.

Managers shared and made sure staff understood information from the audits. We saw an example of a presentation provided to staff at a clinical team meeting following an advanced care planning audit. This clearly evidenced the current position from the most recent audit and improvements that had been made since the previous audit cycle for advanced care planning.

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. The team was made up of nurse consultant, advanced nurse practitioners, nurses, health care assistants, occupational therapists, physiotherapists, social workers, cognitive behavioural therapists, counsellors, children and young person's worker, complementary therapists.

Managers gave all new staff a full induction tailored to their role before they started work. We spoke to staff who were on induction or recently had completed an induction within the hospice and the community services. Staff across the services felt the induction had been beneficial and met their needs. Staff told us the induction allowed time for shadowing opportunities and staff working within the community had felt very supported by experienced members of the community team.

Managers told us that inductions were implemented over a two-week period as a minimum with staff being supernumerary during this time period. Staff were allocated six hours of protected time to complete electronic mandatory training and face to face sessions were planned in during the induction period. Following induction there was a set of competencies identified for staff to work through. The service had an induction framework check list covering expected roles and responsibilities. We saw evidence to support this.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff told us they were supported to develop within the service and had opportunities to complete additional training. Managers within the hospice care at home service recognised that this service alone provided less opportunity for development due to the specifically defined nature of the role, however, staff had opportunities within the wider service to progress should they choose to.

We heard examples of how managers were inclusive of staff with differing learning needs and staff were supported to ensure they had appropriate additional resources to achieve required learning. For example, extra time would be given on an individual basis for staff with dyslexia.

All staff were offered resilience-based supervision and the service had 14 resilience-based supervisors with more staff booked on the training to become supervisors during 2024. Staff and managers told us about clearly defined supervision processes within each service and clinical speciality. For example, community nursing staff would have monthly peer supervision sessions. AHP's were supported to access local palliative care AHP networks and national Marie Curie AHP networks for peer support and learning. Medical staff accessed journal clubs with peer palliative care colleagues within other local organisations. All staff had individual clinical supervision on a regular basis with additional ad hoc supervision available on request.

Additional clinical supervision sessions were provided at times of increased need, for example, following on from or during management of a particularly complex patient or an incident. These sessions would be facilitated by a member of the bereavement team. The team were also reviewing evidence around 'compassionate circles' as a further means of support for staff.

The clinical educator regularly reviewed training needs and worked jointly with Marie Curie Yorkshire to share experiences and identify needs. This supported review of the best methods for ensuring community staff could access training as needed. For example, a hybrid training plan was being trialled including both face to face and virtual training. Managers and clinical educators worked together with staff to ensure staff were able to identify training needs and have these met. We heard, for example, if there was a patient admission planned with a condition that staff were unfamiliar with, training would be sought and provided.

The service invested in ensuring that community staff maintained competencies in a thorough and supportive way. For example, the senior nurses within the hospice planned care at home overnight service reviewed the health care assistants' documentation daily following on from each shift. This allowed a quality check of the care provided along with identification of any learning needs and support for staff. This was also in line with policy regarding countersigning of records until record keeping competencies were achieved.

Occupational therapists and physiotherapists worked towards meeting a Marie Curie national competency framework.

Staff in each of the local services were able to clearly describe the meeting frameworks. Staff had the option to attend face to face or virtually and time was allowed within working hours or arrangements for overtime made to support each staff member to attend. Information was shared with staff when they could not attend. Managers set a minimum of six team meetings per year that should be attended.

Managers made sure staff received any specialist training for their role. We heard that skills drills training was provided for nurses and additional training would be provided, for example, syringe pump drivers, medical gases, verification of death. Healthcare assistants received additional training dependent on role for example, clinical observations, bladder scanner and reablement training.

During inspection we saw clear evidence of a close working relationship between managers and staff. This close working relationship enabled managers to identify poor staff performance promptly and support staff to improve. Managers of community services had a daily overview of the care being provided by community staff. Unannounced quality visits were carried out by senior nurses for the hospice care at home planned overnight service.

Managers recruited, trained and supported volunteers to support patients in the service. Volunteers would be matched to roles appropriate to their interests, aspirations and skills. Volunteer coordination staff were aware of possible support needs of volunteers and recognised that depending on personal experience, for example volunteers experiencing bereavement and wanting to offer something back, might require time before entering into direct patient facing roles and other options would be considered.

All volunteers received training and were valued as equal members of staff. There was a clear induction process for volunteers and a handbook to support this process. Volunteers told us they were able to access training opportunities alongside paid staff. Volunteers we spoke to felt valued as part of the team and found their own personal health and well-being benefits in offering their time.

The service had also supported two therapy dogs through their training. There was a service level agreement in place with a local friendship dog charity who put the dogs through an interview and several tests before agreeing they could attend the hospice.

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 were committed to working collaboratively and held regular and effective multidisciplinary (MDT) meetings to discuss patients and improve their care. During inspection we saw evidence of a daily system wide hospice

multi-disciplinary team admissions meeting. This was attended by hospice in-patient unit and well-being hub staff to ensure appropriate clinical triage of patients waiting for admission and ensuring those with the greatest need were prioritised. This included review of referrals into the wellbeing hub and supported joined up working for patients and family members who were accessing multiple services provided by the hospice.

The MDT also extended to administration staff, kitchen and housekeeping staff who would work to meet the needs of patients and those close to them. We saw evidence of patients being supported from the moment they entered the premises.

All staff had a clear understanding of each other's roles and how they worked together to provide holistic care. Staff told us that each profession and staff group was equally respected within the team.

The service had a team of allied health professionals (AHP'S) available to support patients. This team had clearly define roles within each profession and were involved in all aspects of the day to day running of the in-patient and wellbeing hub services.

The service had dietician input for six hours a week through a service level agreement with a local hospital. This was planned to increase in April 2024 to 7.5 hours per week. The dietician worked as part of the MDT to carry out nutritional screening of each patient on admission to the in-patient unit. A screening tool had been developed specifically for the service to meet the needs of palliative care patients. The dietician also offered telephone support for staff when not on site for advice, for example regarding tube enteral feeding.

Dietician support was also offered to patients accessing the wellbeing hub and through virtual phone reviews. Patients would be referred on to the speech and language therapy service for issues regarding swallow.

We heard examples of the MDT working together to provide support groups for patients. For example, the dietician and physiotherapy staff had facilitated a joint exercise group. The occupational therapy and physiotherpay staff had also facilitated a fatigue and breathlessness workshop. This demonstrated effective multi-disciplinary working to meet holistic needs of patients.

Staff worked effectively across health care disciplines and with other agencies when required to care for patients. We heard positive examples of joined up working with the community teams and local district nurses. The urgent hospice care at home service worked with local hospitals to support hospital discharge or with general practitioners (GP's) to support avoidance of admission.

The in-patient team worked closely with another local hospice to manage in-patient need across the area and ensure the best use of bed spaces.

The service was proactive in attending MDT meetings with the heart failure and neurology teams within a local hospital to support patient needs being most appropriately met.

Staff knew how and when to refer patients for mental health assessments when they showed signs of mental ill health or mental distress and risk of harm.

Seven-day services

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

The medical team led daily clinical rounds on the in-patient unit. Referrals for in-patient and community services could be accepted seven days a week.

In-patient services had access to doctors 24 hours a day seven days a week. Community services had clear processes to follow to access district nurses or general practitioners within the community 24 hours, seven days a week.

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

Health promotion

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

Staff assessed each patient's health when admitted to the in-patient unit, wellbeing hub or community services and provided support and advice. The wellbeing hub facilitated a range of groups that supported healthy lifestyles.

Leaflets were available to support health and wellbeing.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff we spoke to told us they would consider, for example, level of confusion, cognition, previous information received about a patient and the decision that was required from a patient when considering the need for a capacity assessment. Community staff shared examples of visiting patient homes where capacity had been questioned as a result of poor living conditions. We heard strong evidence that staff were able to identify the difference between lack of capacity and patients making unwise decisions.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Patients we spoke to told us consent was gained during care. Consent was recorded in records.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff told us detailed discussions would take place at handover meetings. We heard an example of a discussion regarding the need to consider the best interest decision making process.

Staff made sure patients consented to treatment based on all the information available. Patients told us that they felt fully informed before making any decisions.

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

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and Mental Capacity Act 2005. We observed MDT discussion regarding the agreed need to follow the best interest decision making process.

Managers monitored the use of Deprivation of Liberty Safeguards (DoLS) and made sure staff knew how to complete them. The use of DoLS was monitored weekly. All DoLS were reported through the incident reporting system and individual risk assessments for individuals on DoLS were reviewed through daily meetings.

Outstanding ☆

Hospice services for adults

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. Mental capacity assessments would be completed by two professionals. Staff we spoke with were clear that capacity assessments were decision specific and capacity assessments should be carried out by the most appropriate professionals according to the decision to be made.

Staff implemented Deprivation of Liberty Safeguards 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 consistently treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff we spoke to told us they viewed hospice care as a 'stepping stone to the future' and believed that 'everyone deserves a good death and should have choices and quality'.

During our inspection we saw that staff were discreet and responsive when caring for patients from the moment patients, families and those close to them entered the building. We saw evidence of reception staff welcoming people to the service and communicating in a calm, respectful and welcoming manner. We heard that reception staff would anticipate the needs of visitors to the service, for example, one man visiting the wellbeing hub would have a wheelchair ready and waiting and would be supported to choose the lunch he wanted from the canteen on arrival.

Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff and patients we spoke to all told us that staff were able to give time when it was needed. Staff were inspired to offer the best quality care and told us how much they liked working in the service because they were able to give the valued time that individuals needed. For example, we heard one member of staff tell us about being able to spend time with a patient who had clearly needed to recount her journey of care to the hospice. We heard from housekeeping staff who described the service as 'the nicest hospital ward you can imagine' and explained how they also had the flexibility to spend time with patients, particularly those who may not have many visitors.

Patients we spoke to described the wellbeing hub as 'the kindest place you could ever come to' and that they would be in a 'difficult situation without the hospice'. Patients felt that staff were consistently respectful. There was a strong visible person-centred culture.

Staff told us respecting patient's privacy and dignity and choice was paramount. Peoples emotional and social needs were seen as being as important as their physical needs.

Staff followed policy to keep patient care and treatment confidential.

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. We heard an example of a patient with a history of substance and alcohol misuse and the time and respect that was given to understanding the individuals background to ensure individual needs were met in the final days of life. Community staff told us about the range of patient and family circumstances that would be encountered and gave clear examples of the thought and respect that went into ensuring care was provided in the most discrete way within patients own homes, for example, where children may be present. We heard how staff across the services were being supported to consider trauma informed care, for example understanding that all individuals have past experiences that may or may not impact on their wishes for care provision, particularly where care offered was of a more intimate nature such as supporting bathing.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Community staff recognised there were certain practices, for example, removing shoes that were expected within some family homes, however this needed to be balanced against risk and safety for staff. We heard that the community teams would routinely work with patients and families within the community to identify social and cultural norms and communicate effectively to ensure that individual family wishes were respected whilst safety was maintained for staff at all times.

We heard that catering staff were proud to go above and beyond in providing for individual needs, for example, would provide special menus or afternoon teas for patients and those close to them at times such as birthdays or religious celebrations.

Emotional support

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

During our inspection it was clear that emotional support was available to patients and those close to them in a timely way. Patients we spoke to told us they had been able to access pastoral support that had been mood lifting. Other patients told us of the value of being able to attend peer groups in providing emotional support. We also heard that staff were sensitive to, and recognised when, loss within a peer group formed at the hospice might have an impact. For example, a group of patients we spoke to told us they had lost two peers unexpectedly and staff had considered the impact of this and how best to support the group. An afternoon tea had been set up allowing the group time to feel valued and to reflect. We heard how this had exceeded the groups expectations of support.

Staff were highly motivated and recognised when families might need additional support and worked to support family members at times that best met their needs. For example, staff recognised that young people might need extra support around the time of death of a parent. In response to recognising the emotional needs of young people, the young person's counsellor along with support from the wellbeing hub had set up a young person’s support group that met once a week. Staff spoke with pride when explaining how they had seen the young people grow in confidence and find support from peers within the group.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We heard how staff had considered the hospice environment to ensure that patients and those close to them had opportunities within each area for private space to maintain their privacy and dignity during distressing times. We heard that staff were attentive to patient’s needs.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. We heard the service was starting to offer additional training around holding difficult conversations to enhance staff communication skills.

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. We heard examples of how staff considered the needs beyond what was provided within the hospice environment. For example, men attending a baking group that had been facilitated for a set number of weeks had identified that through the group they had formed strong bonds and wished for a continuation of the emotional support they were able to provide each other. The service had linked in with a local gardening group and were planning for the men to be supported in leading their own longer-term group. We heard the men had come together from a range of different backgrounds and had spoken a range of different languages.

The service also held memory events throughout the year within the hospice environment and within local churches and cathedrals.

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.

Patients and those close to them told us that they were active partners in their care and fully involved at all stages. Patient feedback results for November and December 2023 showed 100% of patients from a range of services reported that they always felt involved in decisions about their care and staff responded and listened in a way that was understood. The MDT discussions that we observed demonstrated that patients and those close to them were able to receive a range of information in different ways from a range of health professionals in order to fully understand their condition and decisions to be made. The range of support available from the hospice services across community, wellbeing hub, in-patient and companion service provided evidence that needs were fully understood. For example, people had choices about where and how they were cared for. There were multiple opportunities for medical interventions, therapeutic support such as counselling, complementary therapies and social groups or companionship at home.

Staff found innovative ways to support patients and those close to them, for example, arranging Christmas early for a father to have one last Christmas with his four-year-old child. Each year the maintenance team went above and beyond to create a winter wonderland in the garden area that each in-patient bedroom looked out onto. We heard about an African safari adventure that had been created throughout the building as a surprise for a couple that had not been able to travel but had always hoped to go on safari.

Staff recognised the communication needs of individuals and talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients we spoke with told us they felt respected and fully involved in their care planning. We heard that patients had been able to have frank and healthy conversations of an informative nature that supported shared decision making.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients we spoke to told us that staff were all approachable.

Outstanding ☆

Hospice services for adults

Staff supported patients to make advanced decisions about their care. We saw advanced care plans in place that set out patients preferences for the event of an emergency or change to condition. There was an advanced care plan lead. We saw robust evidence of advanced care plans and do not attempt cardiopulmonary resuscitation (DNACPR) plans in place that had been thoroughly discussed and communicated.

Patients gave positive feedback about the service. Patients we spoke to and feedback from patient and carers experience surveys was consistently positive with care described as 'excellent', 'immediately put at ease', 'very professional'. We heard that families felt the support allowed them, for example, 'to be husband or wife again rather than carer'.

Is the service 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 in-patient, wellbeing hub and community services so they met the needs of the local population. The in-patient unit had been organised to meet a range of needs within the local community. The unit offered consultant led beds, nurse consultant led beds, AHP led reablement beds and complex respite beds. The use of these beds were reviewed on a regular basis and if demand was greater, for example, for nurse led beds rather than AHP led beds at any point in time they would be used according to need. The in-patient referrals were responded to on the day they were submitted. The service worked jointly with another local hospice to ensure bed allocations were managed in the timeliest way. The average waiting time was two to three days. Urgent admissions could be arranged on the same day if there was bed availability.

Staff in the wellbeing hub worked extensively and creatively with the local community to ensure the needs of the local population could be met and people could access services. During 2023 there had been extensive engagement with local NHS trusts, primary care services, local authorities, other palliative care units, social prescribers and the local community including, churches and breakfast clubs, religious communities, carers groups. We heard examples of support being provided within a local church and offering a 'one stop shop' where a range of other local support services were also present. This allowed people to access appropriate services in a timely way. We heard about a satellite service offering physiotherapy, nursing and social work support in a community centre in South Tyneside. This service had been set up in response to the closure of a local independent hospice within the area. The service had facilitated a living well group for carers of people with motor neurone disease. A writing group was facilitated in a library that allowed easier access for people within a range of communities. We heard support had been offered into the local women's refuge. It was clear that person-centred care was being introduced to the local communities to meet the needs of a range of people in innovative ways.

We saw evidence that staff had recognised the population of people accessing the in-patient unit did not always seem to reflect the local black and minority ethnic (BAME) population. In response to these observations a detailed review of data was carried out with actions identified to support reaching the community as a whole.

We also heard that the organisation had become a HAREF ally. HAREF is an organisation that supports mainstream services to work with ethnically marginalised communities.

The Urgent Hospice Care at Home service was commissioned by the Durham Integrated Care Board (ICB) specifically for patients within that area. Referrals were taken from GP's. The service consistently met targets of two-hour response times within the community for 'crisis' support. The service operated seven days a week, 24 hours a day and would support hospital discharge or avoidance of admission.

The hospice at home overnight planned service provided seven night a week support for patients and families. This was a commissioned service divided into two teams covering a wide geographical area including Newcastle, Sunderland, Gateshead, South Tyneside, Durham and Teesside. Managers and staff used a 'virtual ward' caseload tracking system to ensure oversight of the caseload and prioritisation of services to those who most needed it. This system allowed the team to be responsive to change in needs. We also heard how this service had looked at working with a local Jewish community and worked with the Jewish community liaison lead to determine how best to be accepted into the community.

The hospice service had recognised a need for companionship. There was a service provided within Tyne and Wear for individuals in their own homes by specially trained volunteers. Volunteer staff were carefully matched following assessment by the service lead according to the needs and backgrounds of patients to provide a range of emotional and practical support. In recognition of the success of the service, the team were planning to develop a further service for the Durham area. The team recognised a high demand for services within the Durham area alongside some strong links and support for services within the local strategic groups. There were also high levels of fundraising activity within the Durham area.

Community staff received fuel poverty training to support working with families in their own homes.

We heard an example of staff working beyond the regular service provision in recognition of a lower-than-average age of death for homeless people in the Newcastle area. Project work had been undertaken to specifically engage a number of people across hostels in the area. This project enabled staff to identify the challenges to engaging this client group, the benefits of engagement in support of enabling a good quality end of life and death and the direction for the future.

The range of services and project work undertaken by the hospice services evidenced a proactive and responsive approach to meeting differing needs across the large geographical area the hospice services provided for.

Staff knew about and understood the standards for mixed sex accommodation in the in-patient unit. Staff were clear that mixed sex accommodation was not provided, however, gave one example of a husband and wife sharing a room with consent as this was their wish given they both required care.

Facilities and premises were appropriate for the services being delivered. There was a fish tank built into the counter at the main reception and a further fish tank built into an office wall in the waiting area for the children and young people services. Staff working within this office were also attentive to young people who may be looking into the fish tank and would be invited in and offered sweets as appropriate.

Staff could access emergency mental health support 24 hours a day seven days a week for patients with mental health problems, learning disabilities and dementia. Staff were aware of how to access the local community mental health crisis service should this be needed.

The service had systems to help care for patients in need of additional support or specialist intervention. Each service had daily and weekly MDT meetings to ensure changing needs could be met and additional support put in place.

The service offered a reflection room with spiritual care available for all staff, families, patients and those close to them. The service had a dedicated employed chaplain who aimed to meet all patients unless declined. We heard at the start of each in-patient admission a HOPE assessment would be offered and started with each consenting individual. The HOPE approach is a comprehensive method of assessment focussing on understanding a patient's spiritual needs and resources. It includes sources of hope, organized religion, personal spirituality and practices, and effects on medical care and end of life decisions. There was a spiritual care team made up of volunteers including humanist and Church of England (C of E) representation. We heard that the team felt this met the majority of service users' needs based on those currently accessing services. However, we heard there had been previous work carried out to identify the range of cultures accessing services and ensuring that the service had contacts for specific spiritual and faith leaders within the community for access as needed. We heard that further work to review contacts and ensure continued equity to meet individuals needs across the community was to be commenced.

The service had links with local Muslim funeral directors and would also seek advice from the local hospital mortuary team as needed regarding specific faith practices at time of death.

The service had also introduced a children's and young person's worker to support children and young people who were facing or had experienced loss of somebody close to them. Following introduction of this service a safe and appropriate space had been co-created with children and young people for children and young people. We heard about proactive work within local schools to identify need within the wider community. The service was not limited to those who had family members accessing the service and there was recognition of an increase to teenage suicide and sudden unexpected death in children. We heard that engagement with one local secondary school had been successful in achieving eight referrals and this had, therefore, been viewed as a needed resource.

Bereavement support was also available. Until 2020 this service had been offered to families of those accessing the service for end-of-life care. It had been recognised that there was a greater local need, and the service was widened to offer bereavement support to anyone who had experienced bereavement regardless of prior involvement with the service. Cognitive Behavioural therapy (CBT) was also offered following a recognised need for more support for those experiencing complex grief.

Managers monitored and took action to minimise missed appointments. All teams had highly effective systems in place with daily management oversight to ensure cancelled appointments were offered to others. Community teams were proactive in contacting patients and families prior to visits to ensure the planned visit could still go ahead. These systems ensured it was rare for missed appointments. In the event of a missed appointment staff would follow this up.

The service relieved pressure on other statutory services by offering alternatives to hospital admission along with support to district nursing teams and GP surgeries.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff told us patients with dementia would have a 'this is me' document completed, and whiteboards would be used as communication aids. Pictures would also be used to support communication.

In-patients had folders in their rooms that detailed individual likes and dislikes. Patients were able to have their own pictures included on whiteboards in rooms to support conversation.

Managers told us that the building had been reviewed to ensure there were autism friendly spaces.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. For example, there was a hearing loop system throughout the hospice building. Any communication needs were reviewed at initial contact with people using the community services. Communication aids were used where needed.

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

We heard that spiritual, religion and cultural needs were considered throughout assessment and care planning. A local standard operating procedure had been developed for spiritual care. We heard about plans to support staff development in understanding spirituality and spiritual care.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The service had access to telephone and face to face interpreters. The service ensured use of interpreters where clinical decision making was required, for example, advanced decision making.

Patients were given a choice of food and drink to meet their cultural and religious preferences. The dedicated catering team would also ensure individual requirements were met as needed.

The service had a foam machine that produced any flavoured foam for patients who could not swallow, for example lemonade.

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.

The in-patient unit was an 18 bedded area. Referrals were reviewed by the bed manager and discussed on the day of referral. Managers organised the number of available beds according to staffing levels and clinical need to ensure patients were cared for safely. For example, the number of beds available at the time of inspection had been reduced to 12-14 beds whilst the team were waiting the appointment of a second palliative care consultant. We heard that waiting times would not be more than a maximum of five days and the hospice worked jointly with another local hospice to support best use of hospice bed availability across the area. Out of hour admissions were possible when appropriate and needed.

Referrals to the urgent hospice care at home service were received by a single point of access service and handed over to the team. Referrals were allocated throughout a 24-hour period, seven days a week.

Managers and staff monitored length of stay on the in-patient unit and supported discharge planning form the start of the admission. Occupational Therapy staff would carry out environmental visits to support discharge planning.

The hospice care at home overnight planned service, community services and the wellbeing hub had clear referral criteria. They made sure patients and families clearly understood the role of the services and the amount of care that could be expected. Where patients required care beyond the boundaries of what those services could provide the teams were proactive in directing patients and families to alternatives. For example, community services directed people to the hub for group sessions. The hub team was proactive in seeking community resources for ongoing support such as the local community garden project for a group of men who had attended and wanted something further as a group to attend.

The service worked to support patients to remain in their preferred place of death and moved patients only when there was a clear medical reason or in their best interest.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. The MDT would liaise with the district nurse team where needed and ensured all appropriate care and medications were arranged in a timely way for discharge.

Staff supported patients when they were referred or transferred between services. We heard about clear referral processes for patients accessing all services. Staff we spoke to clearly articulated the amount of detail and information that was provided to patients and families at the point of contact for each service. We saw patient and family feedback that evidenced people were made to feel 'immediately at ease'.

All patients and those close to them had access to a 24-hour Marie Curie national helpline.

We heard about a strong relationship with a local ambulance service that provided a specialist ambulance crew for palliative care patients transferring to and from the hospice.

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. Managers made regular contact with community patients to review care provision and seek feedback.

The service clearly displayed information about how to raise a concern in patient areas. This could be done using paper feedback forms or QR codes. All community services provided feedback information in information packs handed out at the start of involvement. We saw evidence of verbal complaints made and recorded appropriately in a timely way by managers.

Staff understood the policy on complaints and knew how to handle them. The service aimed to respond to formal complaints within 20 days or an agreed timescale with the individual.

Managers investigated complaints and identified themes. We reviewed three recent complaint responses and saw clear evidence of family involvement including agreed timeframes, communication processes and agreement regarding actions required following the complaint.

There was clearly documented feedback following the complaint response and clear acknowledgement where families wished to complain and have their complaint investigated but did not wish to have a complaint response sent.

We saw evidence in complaint responses, action plans and team meeting minutes that managers shared feedback from complaints with staff and learning was used to improve the service.

Examples of how they used patient feedback to improve daily practice was displayed on notice boards in the hospice.

Is the service well-led?

Outstanding ☆

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

Leadership

Leaders had an inspiring shared purpose to deliver and motivate staff to succeed. Leaders at all levels demonstrated high levels of integrity, skills, and abilities to run the service. Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The chief executive and the executive leadership team (ELT) had oversight and managed the operational management of the charity, including approval processes for specific decisions, and delegated autonomy to senior managers and local teams to deliver routine day-to-day activities across the charity.

The charity was governed by a board of trustees who were legally responsible for directing the company affairs. The board determines the charity's long-term strategy and approved the annual business plan and budget. The board of trustees comprised of thirteen individuals with a differing balance of skills, experience and knowledge.

Trustees were directors of the charity and had duties under company law as well as charity law. They were expected to maintain the highest standards of integrity and stewardship; to ensure that the organisation was effective, open and accountable; and to ensure a good working relationship with the chief executive and senior management team.

At a local level the service was led by a senior leadership team consisting of a head of nursing and quality, acting medical director and head of operations. There were further lead posts for the specific clinical teams and services provided.

All leaders we spoke to were experienced and able to clearly articulate the priorities and challenges to the service. We heard that senior leaders and team managers would take part in day-to-day direct patient care at times when this was needed. This demonstrated that leaders had direct experience of the day-to-day challenges and experiences of staff. The senior leadership team had purposefully positioned themselves in office spaces between the reception entrance and changing area for staff. This was to ensure visibility and accessibility of the senior leadership team for all staff and for any visitors to the building.

We saw clear evidence of development of new roles into the hospice over the recent years as leaders had recognised the changing needs and demand for service. For example, the development of a nurse consultant post, a COVID-19 bereavement co-ordinator, children and young person counsellor and paid complementary therapist as a move on from previous voluntary roles.

Staff and patients we spoke to told us that the leadership team were visible and approachable within the service, and they felt comfortable to raise any concerns. Staff within the community teams working as lone workers and at night told us there was always a member of the senior leadership team available through the on-call system. Staff we spoke to told us this system had recently changed from a national to a local on-call system which was more supportive as the managers on-call knew the staff and were familiar with the service.

We heard examples of staff being supported to progress through the organisation, develop skills and take on more senior roles, for example into advanced nurse practitioner and nurse consultant roles. Staff were encouraged to complete the nightingale challenge. This was a nationally recognised leadership and development opportunity.

The service had a nominated corporate Caldicott guardian. The head of nursing and quality was the onsite Caldicott guardian. A Caldicott guardian is a senior person responsible for protecting the confidentiality of people's health and care information and making sure it is used properly.

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.

There was a national overarching Marie Curie Vision and strategy. There was a local five-year strategy for North East and Yorkshire services that had been developed with local needs and provision in mind. This had been launched in December 2023.

The Marie Curie mission was to close the gap in end-of-life care. Between now and 2028 the service intended to design and deliver services providing the best possible care and support to people living with any terminal illness, and those close to them. The mission was to play a leading role in shaping the end-of-life system across the UK; driving research, influencing public policy, campaigning for change, and fighting for better services to ensure everyone has access to the end-of-life care and support they need.

The service's corporate annual report evidenced review of corporate departmental structures, to minimise time spent on administrative tasks by managers and employees at local level. The corporate team had recruited four strategic leaders in newly created roles to drive innovation and nurture talent in people operations, centres of excellence, human resource business partnering and volunteering.

The strategic goals were to grow scale and influence, deliver vital support and build operational and financial resilience.

In developing the strategy, the team had brought together a range of information including national statistics, themes around care provision and local needs, knowledge from collaboration with staff, patients and those close to them. This included projections of numbers of people dying and those living with increasingly complex health difficulties in the years ahead, knowledge of health care inequities, difficulties in navigating and accessing appropriate care systems.

On a local level, managers had thoroughly reviewed feedback from patients and those close to them, sought feedback through volunteer and user forums, spoke to staff groups and other healthcare providers. Staff feedback was sought through team meetings, one to ones and through the 2023 annual staff survey.

The vision was displayed within the hospice and managers told us it had been made available to other local organisations.

Culture

Staff were proud to work for the service and felt truly respected, supported and valued. They were focused on the needs of patients receiving care and those close to them. 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.

During our inspection we heard and observed the culture focussed on putting the needs of patients, and those close to them first. We saw that staff were skilled in meeting the complex needs of patients at end of life, whilst also understanding and meeting the needs of those close to them in a holistic way.

All staff we spoke with consistently told us they felt valued and respected and treated equally regardless of grade or role within the service. This included housekeeping, maintenance and kitchen staff. Staff expressed how much they enjoyed working for the organisation. We saw the pride that staff had in their work and staff survey results evidenced staff were proud to work at the organisation. Staff told us they felt well supported. We heard examples of how the wellbeing of staff was supported, for example, through mindfulness sessions, debrief sessions and regular one to one sessions or group supervision with line managers. All staff and leaders we spoke with recognised that the work could impact individuals in different ways and that unexpected events could happen.

We heard there was a positive culture towards mental wellbeing for staff. We saw evidence that the leadership team had worked to embed this over a number of years, working collaboratively with a local mental health charity to review mental wellbeing across the workplace and ensure appropriate supports were in place. There were staff trained as mental health first aiders and a range of supportive activities available to staff such as complementary therapies, mindfulness sessions and sleep hygiene. Staff had open access to the reflection room. Volunteers told us they felt they had the same support as paid staff.

Staff we spoke with were aware of how to access support from senior managers and felt that all were approachable. Staff felt supported by each other and by senior management. The staff survey results showed the service scored higher than the Marie Curie national average for peer support amongst colleagues. However, we saw the staff survey results scored slightly lower than the national average for 'my manager communicates openly and honestly with me'. In response to this we saw an improvement plan in place for a staff representative open forum and additional support to be provided to managers to develop skills in having open and honest communications.

Staff rarely raised concerns through formal freedom to speak up processes as managers were approachable and accessible. There was a freedom to speak up policy and procedure accessible by all staff. There were five named freedom to speak up champions within the North East and staff were also made aware they could access the national freedom to speak up guardian should they not feel comfortable raising concerns locally. We saw evidence that staff had recently been reminded of these processes following a review of local leadership practices by a national team.

We heard that staff were encouraged to share concerns and raise agenda items for team meetings. The daily walk around on the in-patient unit along with daily review calls to community patients supported a strong culture of raising concerns in a timely way. This also emphasised the culture of respect and value placed on seeking views and feedback from patients and those close to them.

Staff felt there was an open and honest culture to incident reporting and that a recent shift towards adopting the NHS Patient Safety Incident Response Framework (PSIRF) had further supported a no blame culture.

The service promoted equality and diversity in their daily work and recognised when the diversity of people attending the service did not always meet the perceived diversity within the local population. The team actively carried out reviews of the population needs to ensure they were targeting their services in an equitable way across the communities.

We saw that nationally the organisation undertook regular review of equality and diversity across staffing. There was a strong organisational commitment and effective action towards ensuring equality and inclusion across the workforce. We heard examples of how staff with additional needs including learning disabilities, autism and mental health difficulties were supported to maintain roles and progress in careers within the organisation. We also heard examples of volunteers with protected characteristics under the equality act being supported to move into paid roles.

Staff successes were celebrated. The North East team had introduced a staff recognition scheme eight years previously that had then been adopted by several other hospices. Staff, patients and visitors were able to nominate staff when they felt they had gone 'above and beyond'. We saw evidence of recent awards where nominations had been made by patients. Marie Curie had a national staff recognition awards scheme. These awards were divided into categories including values-based awards, clinical innovations and leadership. Managers also supported nominations to external award schemes.

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 executive leadership team and board of trustees maintained oversight of Marie Curie services nationally. There was a board assurance framework that set out clear guidance, timelines and responsibilities for reporting. We saw evidence that some aspects of reporting would be carried out by external agencies, for example, health and safety reports. Responsibility for local governance arrangements was devolved to the local place-based leadership team. The clinical governance framework clearly identified responsibilities and roles throughout the organisation and was available to all staff and volunteers.

We saw evidence of a recent review of local leadership structures that had been carried out by senior members of the national corporate team as part of the wider organisations ongoing commitment to ensuring quality governance structures were in place. We saw multiple areas of good practice reported in the findings along with suggestions for consideration of improvement.

Within the governance structure there was a quarterly people board involving representatives of all staff groups across the North East. This ensured the voice of staff, patients and those close to them were kept central to the work of the hospice as success stories, concerns and hopes could be raised through this forum.

In-patient and community staff meetings were held monthly, staff had the opportunity to attend virtually if not on shift. There was an anonymised suggestions box for topics to discuss at the team meetings.

We reviewed minutes from a range of meetings and saw evidence of systems and processes working across the service. Meetings were regular, staff were aware of the frequency, minutes were available and clear actions were documented.

Management of risk, issues and performance

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

The service had a risk policy and risk register in place. Managers were able to articulate the risks and challenges to the service. We reviewed the risk register and saw evidence that this covered risks that were deemed as constant managed risks such as potential for staffing shortages and financial stability. New risks were also identified on the register. All risks were reviewed at a monthly oversight meeting for the North East and North Yorkshire. This allowed for forward planning should there be known changes to any of the managed risks such as staff leaving.

One local risk area were concerns regarding reduced medical staffing as a result of vacancies. We saw evidence that this risk had been escalated within the organisation at national level and a responsive quality team site visit had been carried out by national senior leaders. We reviewed the report compiled following this visit and saw thorough consideration of risks and mitigations along with appropriate staff support offered. Patient and staff views had been taken into account when reviewing these risk concerns. We did see that not all staff had felt they had been kept fully informed prior to this review and had expressed concern about the impact of reduced medical staffing for both patient care and staff development opportunities. However, we were assured that the national systems and processes allowed for timely review of risk concerns when escalated.

Performance was effectively managed through a range of systems including incident reporting, audits and action plans. The incident reporting system was effective in monitoring all incidents reported at local and national level. This allowed for themes to be shared and quality improvement priorities identified.

The service had highly effective risk management systems in place for lone workers within the community. We heard that community staff used a recognised staff safety system that required staff to enter when they had arrived at a location, expected time of visit and departure from location. An alert would be raised if staff did not log back in within the expected time and processes followed to ensure staff safety. Overnight teams had a process to follow to log in four times throughout the shift and had a closed chat group for support through the night alongside on call managers.

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.

The service used secure systems and stored records according to guidance. The service used an electronic patient record system and electronic prescribing. These were effectively embedded into use in practice and under constant

review to ensure the systems supported staff in being able to find data they needed it when they needed it. Managers supported a clinical member of staff with a particular working expertise of the records system to work innovatively and creatively with the information technology team to ensure the electronic recording system was as efficient and as user friendly as it could be to ensure safe patient care.

Data was regularly submitted to the national corporate teams for scrutiny and review. Staff surveys and audits were completed electronically using a recognised system. We saw evidence of data presented back to staff in helpful graph format. We saw clear evidence of action plans completed to improve performance based on data collection. We saw evidence of narratives and interpretation behind the figures, for example the staff survey results also provided supporting information.

Engagement

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

The service had consistently high levels of engagement with patients and those close to them to help develop and improve services. We saw 'you said we did' feedback that evidenced ongoing changes made to services based on patient and family views. Examples of changes demonstrated a dedicated commitment to acting on feedback.

The staff within the wellbeing hub had been proactive in seeking out the views of patients, public, health professional groups and community groups. Staff told us feedback had been phenomenal in identifying needs and shortfalls. The chaplain had previously engaged with a range of multi-faith groups and planned to revisit this piece of work to ensure services met the needs of the wider community.

The team were actively engaged with an equality and engagement group at a local hospital trust. The aims of this group were to engage with services, groups and communities to identify areas of unmet need including in under-represented groups. Staff and managers told us about partnership working with teams in other organisations such as the interstitial lung disease team and Newcastle heart failure MDT.

We saw evidence of the service taking on an active role with the local Integrated Care Boards (ICB's). As part of ICB working there was a focus on health inequalities and local needs. Through meeting minutes we saw evidence of constructive challenge to support the provision of safe and effective services.

We heard of a nurse led initiative to ensure staff and patients on the in-patient unit were engaged in improvement work. This initiative was the 'patient safety walk round'. On a daily basis the nurse in charge would introduce themselves to all patients and families, making themselves visible should there be any concerns anyone wished to raise. On a monthly basis a nurse in charge would engage with staff, patients and visitors to seek views about safety and care provided, exploring concerns and positive areas of practice in order to plan improvements. This initiative was based on evidence of such practices supporting patient safety.

Staff were involved in joint meetings with a local NHS trust re IPC and involved in training ambulance services in relation to end of life care.

Outstanding ☆

Hospice services for adults

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.

Leaders were committed to encouraging improvement work and were keen to support staff to develop expertise in areas of clinical practice. There was a national support for improvement work from the wider organisation and opportunities to learn and share throughout the organisation and from other hospice collaboratives.

We saw locally that staff were empowered to be creative and determine the learning opportunities and service improvements that best met the needs of patients, those close to them, the local communities and staff working within the service.

The team at Newcastle had been proactive in setting up the Nightingale Leadership challenge for hospice staff. This had begun during the pandemic of 2020 and despite challenges to the original plans for teaching the team had adapted the programme to continue safely without delay. Staff are now recruited onto this programme on a regular basis. We saw evidence of quality improvements made as a result of this, for example the improvements to the management of hyperkalaemia that then prevented the need for transfer back to hospital. This in turn reduced distress for patients and reduced pressure on other services.

There was an organisation wide commitment to sharing work locally and nationally. We saw examples of this commitment on a local level.

We saw that staff had led the way nationally in carrying out research and a project into improved pressure ulcer care for end-of-life patients. We saw evidence of published articles, presentation at the national Patient Safety congress and contributions to NICE guideline development for pressure care. The team had also contributed to publications relating to nutritional screening work and early support for carers of people with motor neurone disease as collaborative work with colleagues from other local organisations.

The team had presented posters at national nursing and hospice conferences on multiple topics including but not limited to cultural diversity, psychological services within palliative care, withdrawal of PEG feeding in MND care.

We also heard that occupational therapy staff had been involved in trialling the use of virtual reality (VR) to allow patients to access experiences that they would not otherwise be able to do. For example, one patient who had previously been a deep-sea diver was able to access this through VR. At the time of inspection VR was not available as the trial had ended, however, the team planned to be able to reintroduce this as a longer-term opportunity due to its success.

We heard of future plans to be involved in the Marie Curie research team regarding clinically assisted hydration.

Staff told us managers were very supportive of improvement ideas. This view was shared across those who had service level agreements in place and worked only a small amount of time within the hospice. We heard that students would often attend with staff such as the dietician for the learning opportunities provided.

There were links with a number of local universities to support ongoing development including offering student placements, practice development posts, non-medical prescribing.

Outstanding ☆

Hospice services for adults

The service had a library on site and a librarian who was skilled in carrying out literature searches and finding journal articles for staff to support the ongoing learning, development and provision of evidence-based practice.