Wakefield Hospice

# Wakefield Hospice

**Inspection report**

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

## Ratings

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

# Summary of findings

## Overall summary

Our rating of this location stayed the same. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service managed infection risks well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines and safety incidents well and learned lessons from adverse events.
- 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 service were active partners 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 ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Consultant out of hours cover of the first on-call rota was not evenly shared or sustainable.

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| **Hospice services for adults** | Good  | Our rating of this location stayed the same. We rated it as good because:<br>• 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 managed infection risks well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines and safety incidents well and learned lessons from adverse events.<br>• 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.<br>• 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.<br>• The service were active partners 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.<br>• Leaders ran services well using reliable information systems and supported staff to develop their skills. |

# Summary of findings

Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Consultant out of hours cover was not evenly shared or sustainable.
- The service's incident dashboard had no categorisation for different levels of harm.
- Meeting discussions and learning were not always updated from falls and pressure ulcer incidents to ensure future prevention.

# Summary of findings

## Contents

# Summary of this inspection

## Background to Wakefield Hospice

Wakefield hospice is an independent provider and registered charity committed to providing the highest level of symptom management and care for people who had advanced active, progressing and life-threatening illnesses. They supported anyone with a life-limiting illness such as cancer, dementia, chronic lung and heart conditions, Parkinson's disease, motor neurone disease and other debilitating conditions. The hospice is partially funded by the NHS and has been registered with CQC since 2010. It provides treatment of disease, disorder, and injury, to adults aged 18 to 65.

Wakefield hospice has a registered manager. The hospice is a purpose-built 2-storey building with a 16 bedded in-care patient unit (IPU). It also has a day therapy department and is situated close to Wakefield city centre, in West Yorkshire. The services are provided within the day therapy Seymour suite. This is a large modern building accessible and safe for all service users equipped with appropriate furniture.

The hospice also provides non-regulated services such as complementary therapies and bereavement counselling services to children, adolescents and young adults. It provides support for patients living with dementia through their end of life care (EoLC) admiral nurse. The service was offered grant funding in November 2023 to train volunteers to pilot a Namaste community service. However, these are not within scope of this inspection, as the service does not deliver regulated activities.

Our inspection was unannounced (staff did not know we were coming). We last inspected the service in 2014.

## How we carried out this inspection

During the inspection visit, the inspection team:

- Inspected and rated all 5 key questions
- looked at the quality of the environment and observed how staff cared for service users
- spoke with the Registered Manager (RM) and Nominated Individual
- spoke with 14 other members of staff including nurses, doctors, allied healthcare professionals, reception staff, volunteers, senior leaders, and trustee staff
- reviewed 6 service user records and 7 medication prescription charts
- looked at a range of policies, procedures and other documents relating to the running of the service
- spoke with 6 service users, and 4 carer relatives.

After our inspection visit, we reviewed performance information about the service and information provided to us by the service.

# Summary of this inspection

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

## Outstanding practice

We found the following outstanding practice:

- At the time of our inspection the service had applied for menopause friendly accreditation. The head of people and culture had been trained as a menopause advocate and provided training to other leaders and staff. They had also shared information and updates during staff meetings and clinical away day sessions.
- The hospice was involved in a Hospice UK LINDER foundation project to support staff working in the prison sector by offering an educational programme to improve EoLC and share good practice. This programme improved staff understanding and confidence in specialist areas of EoLC such as dementia.

## Areas for improvement

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

**Action the service SHOULD take to improve:**

- The service should ensure consultant out of hours cover of the first on-call rota is evenly shared between medical staff and is sustainable.
- The service should provide further information for medicines prescribed when required.

# Our findings

## Overview of ratings

Our ratings for this location are:

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

Good

# Hospice services for adults

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

## 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.**

Nursing, medical and voluntary staff received and kept up-to-date with their mandatory training. At the time of our inspection staff's overall completion rate of mandatory training was 98%. This exceeded the provider's 90% compliance target. The remaining 2% of staff were working through their mandatory training. No staff were over 3 months out of date. Training for volunteers was at 95%. and they would achieve 100% training compliance within 3 months.

All clinical staff completed 9 modules which formed their core mandatory training. These were safeguarding children and adults, fire safety, equality and diversity, moving and handling, health and safety level 1, conflict resolution, data security and infection control.

The mandatory training was detailed and met the needs of patients and staff. Staff told us they felt sufficiently competent and supported to fulfil their roles as part of a learning-centred organisation.

Clinical and nursing staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. The admiral nurse had specific specialist knowledge of dementia, supported people living with dementia and their families, and educated and supported other staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. All outstanding training was escalated to the line manager. The service had a clinical staff member seconded to the nurse educator role. They worked to improve staff's mandatory training completion rates. If staff's mandatory training was incomplete, managers added this to their appraisal action plan.

### 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.**

Nursing and medical staff received training specific for their role on how to recognise and report abuse. At the time of our inspection safeguarding training was just above 98% overall, which met provider compliance.

All staff and volunteers were trained in safeguarding to an appropriate level for their role and areas of responsibility. Staff had access to a safeguarding lead trained to level 4 at their local acute NHS hospital.

Staff received training about equality and diversity. Staff understood how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act 2010. The service's safeguarding vulnerable adult's policy outlined their roles and responsibilities, types of abuse and vulnerable groups most at risk, such as those who may lack mental capacity. Staff adhered to this policy. They would routinely raise and consider safeguarding concerns for vulnerable inpatients and service users at risk of abuse.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. All staff and volunteers were aware of different forms of abuse and reported any concerns they had to the director of clinical services, medical director and safeguarding lead or deputy. Concerns were responded to in line with the provider's safeguarding policy and referred to the local authority social care team.

The service's admiral lead dementia nurse and education lead held education sessions with staff and external professionals on how to support people living with dementia when safeguarding concerns were identified.

Staff followed safe procedures for children visiting the service. Staff supervised children visiting the hospice at all times to prevent abuse. All staff and volunteers were enhanced disclosure and barring service (DBS) assessed, and had been checked with the independent safeguarding authority. Disclosure and Barring Service checks provide information including details about convictions and cautions held on the police national computer. The information helps employers make safer recruitment decisions.

The service adhered to West Yorkshire Consortium Safeguarding and Child Protection Procedures guidance. This applied to all practitioners regarding child sexual exploitation (CSE), child criminal exploitation, missing children and female genital mutilation (FGM).

**Cleanliness, infection control and hygiene**

**Staff used infection control measures when visiting patients on the inpatient ward and when transporting patients after death.**

We observed all areas throughout the hospice and noted they were visibly clean and well-maintained. There were suitable furnishings in place.

The service generally performed well for cleanliness. The service completed control of infection audits monthly and quarterly, covering issues such as sharps, clinical waste, and environmental cleaning. The service completed a monthly mortuary audit of 6 questions. October 2023's audit found mould around the fridge door and seal. In response leads had taken action and arranged a weekly cleaning schedule with the relevant cleaning and facilities staff. Nursing team members would attend at cleaning time to ensure any mould was removed.

Cleaning records were up-to-date and demonstrated all areas were cleaned regularly. Staff and volunteers carried out thorough cleaning using checklists.

Facilities staff completed the flushing of taps to prevent Legionella by running them for 2 minutes. They completed checklists weekly instead of monthly for extra assurance and there were no gaps in these records.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff used the handwashing stations appropriately and wore PPE in line with the provider's policy. Staff adhered to hospice uniform policy including bare below the elbows in accordance with National Institute for Health and Care Excellence (NICE) guidance.

The service had an infection control team. This team was responsible for reviewing infection control audits and working with staff to enhance practice and standards. They also attended regular link nurse sessions with the local acute trust and Yorkshire Hospice Forum Group.

The service had a Covid-19 standard operational procedure and guideline summary, usually updated by the medical director and director of clinical services. This confirmed any staff entering the room of a Covid-19 positive or symptomatic patient must wear an FFP3 mask, eye protection, plastic apron and gloves. All staff completed mandatory annual infection control in-service training which included guidance on managing outbreaks of infectious diseases, including Covid-19.

The service had an infection control policy. This outlined staff responsibilities and the hospice's key approaches to help ensure there was a strong framework for the infection prevention and control (IPC).

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. 'I am clean' stickers were on all items of equipment, and on ward beds not in use.

### Environment and equipment

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

Patients could reach call bells and staff responded quickly when called. All patients and carers we asked told us staff never kept them waiting and were often nearby on the inpatient unit (IPU).

The environment was accessible, open plan and had level access throughout the grounds with lifts to the upstairs staff offices. There was extensive outdoor space including a sensory garden developed with a grant in 2021 as a calm, reflective space for patients, their families and other visitors. There were security cameras and door buzzers in all communal areas including outside for optimal safety.

The environment was compliant with fire and health and safety standards. The service's fire officer completed weekly tests. Staff understood how to respond in the event of fire, including how to evacuate people safely. Leads prioritised staff's health and safety. All staff were required to complete a yearly health and safety walk around inspection of the premises before completing a safety checklist log. At the time of our inspection 33 of 61 total staff had completed this with a compliance rate of 61%. This ensured staff were familiar with procedures in case they were called to site out of hours.

Staff carried out daily safety checks of specialist equipment. The service's main automated external defibrillator (AED) was accessibly located near their main reception. We checked the contents and found no equipment was missing or expired. Staff carried out weekly AED checks. IPU staff accessed basic airway management equipment and suction equipment in the dressings room.

The mortuary had a temperature checklist staff checked weekdays to ensure it stayed within the suitable range of 4-8 degrees for cold body storage. This meant cold room storage facilities complied with NHS England guidance for staff responsible for care after death (2011). The guidance stated cold rooms should be below 12°C.

The service had enough suitable equipment to help them to safely care for patients. Equipment was maintained with regular checks and servicing which was completed by an external contractor. All equipment was deemed safe for use. All electrical equipment had passed electrical safety testing within the last year.

Staff could access a cuddle bed, a wide commode on the ward, extra weighted hoists and extra-large slings that all met the needs of bariatric patients. They could weigh patients on the bed accurately with respect to equipment weight limits. Staff could borrow a large amount of other bariatric equipment from a specialist rental service.

The provider held bi-monthly health and safety maintenance group (HSMG) meetings attended by their senior leadership team (SLT) when possible. The agenda for the latest meeting in November 2023 included training and e-learning, fire safety and departmental health and safety updates.

Staff disposed of clinical waste safely. Waste bins were pedal operated and contained the correct colour coded liners.

### Assessing and responding to patient risk

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

The service had clearly defined and documented eligibility criteria to ensure the safe admission of inpatients and service users. Eligibility for referral into the specialist palliative care service was based on patient need and not a diagnosis. The policy clarified inclusion and exclusion criteria for admission. For example, patients with known or suspected bacterial infections could not be admitted if single rooms were not available.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. At the time of our inspection staff used their own observational chart adapted from the national early warning scores (NEWS). The service was transitioning long-term towards NEWS-type charts over 12-18 months. Clinical leads told us NEWS scores for escalation had been in place for a long time, but they wanted staff to increase observational frequency and review to identify more promptly.

The service had escalation plan NEWS2 guidance for staff. This helped managers provide direction for clinical teams in the use of NEWS2 to facilitate early detection of deterioration in appropriate patients. NEWS charts were kept in patient's personalised supportive care documents. The service planned to rollout further staff training on the scoring system soon after our inspection.

Staff followed all the royal college of physicians (RCP) London guidance around NEWS and had regular meeting updates with a neighbouring hospice who had rolled out NEWS2 10 months before our inspection. Clinical leads felt switching to electronic patient records (EPRs) would also help staff record NEWS scores.

Staff completed risk assessments for each patient on admission or arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff used NEWS scores to monitor patient's baseline observations. One patient had a NEWS score of 10, which would usually trigger escalation and possibly transfer to hospital. The patient had firmly stated they did not wish to go to hospital for treatment. Staff included this preference in the medical notes and respected the patient's wishes.

Good

# Hospice services for adults

At the time of our inspection the service's educational facilitator was planning to rollout simulation training to multidisciplinary team (MDT) meetings around recording NEWS observations and embedding appropriate levels of review. This was in response to recognising their changing patient profile to younger and more acutely unwell patients.

Staff knew about and dealt with any specific risk issues. Staff assessed risks to patients, and understood how to support patient's individual risks, such as those with a risk of falls or pressure ulcers. Staff used the avoiding falls levels of observation assessment tool (AFLOAT). They completed this at least twice daily until there was a significant clinical change. Staff also completed AFLOAT variance recording to ensure the level of observation had been met.

Staff took proactive measures to reduce the risk of inpatients who suffered repeat falls. Staff identified 1 patient's need to smoke was a big falls risk factor, so they supported them to reach the smoke shelter. This reduced their falls and improved their quality of life whilst at the hospice.

Staff discussed falls preventions on behalf of patients at their weekly palliative care MDT meetings. These discussions included consideration of environmental adaptations pre-discharge such as toilet equipment and frequency of nurse or carer visits.

Staff used a pressure ulcer prevention tool with a 5-step approach to protect patients from pressure-related harm. The tool prompted them to review all skin areas at risk from pressure damage at every opportunity, and at least twice daily at morning and night.

The service's ward documentation included a document which staff used to risk assess patient's pressure ulcers. Staff used a booklet to document any patient interventions, and carried out intentional rounding, where they checked on the wellbeing and status of the patient at regular intervals. Managers told us this better evidenced the quality of care patients received.

Staff reported pressure ulcers (PUs) on patients within 24 hours; most were present on admission. Most hospice acquired PUs were associated with actively dying patients who had minimal nutrition. Staff evidenced their repositioning of patients in their records. Where staff could not reposition patients, they considered profiling the bed to help ease pressure.

Staff could refer any patients with grade 3 or above PUs to their local acute trust's tissue viability team who offered advice and support. Staff understood the risks of venous thromboembolism (VTE) and stopped patient's VTE prophylaxis if their baseline observations were normal.

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. Nursing handover documents included relevant prompts, so staff knew all necessary information for patient care. The doctor's handover template was comprehensive and included extra prompts about medication, frequency and important patient priorities.

### Nurse staffing

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

Good

# Hospice services for adults

The service had enough nursing and support staff to keep patients safe. The service was fully staffed. On the day of our inspection the in-care patient unit (IPU) was 1 registered nurse (RN) under establishment of planned numbers due to unplanned sick leave. As a result, the unit was running on 2 registered nurses (RNs) instead of 3. The ward manager told us due to patient's assessed acuity of nursing needs; staff numbers were safe.

There was an out of hours (OOH) on-call rota, which allowed staff to contact senior nursing staff. Records showed no gaps for any OOH on-call cover from September to December 2023. Staff told us they could always contact senior nurses. All contact numbers were accessible to staff in the rota folder.

The number of nurses and healthcare assistants matched the planned numbers at other times. The IPU always had at least 2 RNs on duty within the 24-hour span; 1 of whom was a permanent staff member, senior staff nurse or above. In the event of staff absence, shifts were covered by other staff to maintain safe staffing levels, and the ward manager could step in if required.

Typically, the service's IPU was staffed by 3 RNs and 2 or 3 health care assistants (HCA) on early and late shifts. Nights were covered by 2 RNs and 2 HCAs. Their nurse associate was classed as a HCA when on a night shift. The IPU always had a nurse coordinator on each shift as 1 of the nurses on duty.

The managers could adjust staffing levels daily according to the needs of patients. Managers and leads held planned acuity meetings where they used acuity tools to ensure appropriate staffing levels. Tools considered symptom management, emotional and family or relative factors for each inpatient bed. Their total score was then factored into staffing numbers, additional daily scores around service capacity and that day's occupancy rate.

Service leads used a data-based decision-making tool from an external organisation to provide workforce analysis, benchmarking and planning. The staffing skill mix, beds per nurse ratio and the care hours per patient per day of the models were compared to 50 other hospices in the organisation's benchmarking group, including a local hospice. This meant leads were assured the service was staffed safely and responsively within their region.

The hospice's dementia day care services used a dependency scoring system to determine how many people could be supported by the service. Staff spoke with family and carers and used observations to review the level of support and interventions people needed.

At the time of our inspection leads were reviewing how they could better collect acuity data to inform patient flow.

The service had low and/or reducing vacancy rates. The service's total vacancies in the 6 months before our inspection was 3 clinical staff. Long-term and new staff told us they loved working for the hospice.

The service had low and/or reducing turnover rates. The service's rolling annual turnover was just over 4%. This was lower than their regional average. The latest published figures for their local regional hospice network reported an approximate turnover rate of 5.5% for quarter 1.

The hospice's performance dashboard showed their workforce retention rate had stayed at 96% or above since April 2023. The service had 5 staff who left the hospice in the last quarter.

The service had low and/or reducing sickness rates. The hospice's overall sickness absence rate was 2% for quarter 2. Their latest clinical sickness rate was just over 3%. This was a significant improvement in clinical attendance from the previous quarter 1, and the lowest level of clinical absence. Substantive staff could cover extra shifts in the event of sickness.

The service used a sickness absence ready reckoner which showed the impact of sickness on all full-time IPU nursing staff groups in post.

The service had low and/or reducing rates of bank and agency staff. The service was building their own bank of regular, reliable staff. At the time of our inspection this was 4 HCAs and 1 RN. The service was fully staffed so nursing leads did not need to use this very often.

Managers limited their use of bank and agency staff and requested staff familiar with the service. The service very occasionally used agency nurses but mostly HCAs. Nursing leads told us agency may be used if patients needed one-to-one observations.

Managers made sure all bank and agency staff had a full induction and understood the service. New nursing staff told us they had a robust induction. Their duties were in line with the local NHS trust equivalents.

**Medical staffing**

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

The service had enough medical staff to keep patients safe. The skill mix suited service needs. The service employed 2 consultants, 1 specialty registrar, 1 core medical trainee, 1 foundation year (FY2) 2 doctor and 2 specialty doctors.

The medical staff matched the planned number. All morning, afternoon and on-call shifts were filled on the doctor's planned and actual rotas during November 2023. First on-call contact numbers were given for each date.

The service had at least 2 doctors on all day shifts, and 3 on the day of our inspection. The medical director (MD) led the ward round weekly to ensure a consultant was present. Weekends were covered by 1 doctor which met safety standards.

The service had low and/or reducing rates of bank and locum staff. Only 1 of their 7 core medical staff was a locum.

However, medical bank staff feedback reported a difficult few months, with additional gaps due to strikes and sickness.

Managers did not use more than 1 locum when they needed additional medical staff. The quality of medical cover meant they sometimes had rota gaps. Clinical leads would only fill shifts with doctors they knew from the pool currently working at the hospice, or foundation year 2 (FY2) doctors who had taken a year out and were still on the staff bank.

Managers made sure new and junior medical staff had a full induction to the service before they started work. Medical staff had a comprehensive induction booklet they had to complete and sign. This needed senior sign off before they started work at the hospice. The MD reviewed this pack every 4 months to ensure the practical details were up to date. Junior medical students gave positive feedback about working at the hospice and their level of staff support.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Clinical leads were assured medical staffing was safe and regularly reviewed the rota. All shifts were filled with a small amount of locum cover needed.

The service had 24/7 medical cover and always had a consultant on call during evenings and weekends. They used a first on call rota usually provided by the junior medical team. Daily cover was provided, including by some locums. All shifts were filled on the planned and actual rotas during November 2023. Where the on-call rota could not be covered, the MD came in directly. This included occasions such as rota gaps, long and short-term sickness and cover for periods of industrial action.

However, board of trustee minutes from August 2023 noted this MD cover as not being sustainable for their own work life balance and mental wellbeing. November 2023 board minutes showed the MD had covered 47% of total bank shifts, other consultants 10%, and other medical staff the remaining 43%. This meant consultant cover of the first on-call rota was not evenly shared or sustainable.

The consultants used a separate on call rota for the second on-call rota. This was shared between consultants at 2 local hospital trusts.

## 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 detailed, and all staff could access them easily. We reviewed 6 sets of patient and service user records. All sets of patient notes had 7 standard care plans and staff could add further care plans based on individual need. There were 'other' care plans, where the nurse could write an individual plan for areas not covered in the standard care plans. Patient notes also included assessments about family care, chaplaincy or religious and cultural needs, therapy, complementary therapy, and medical assessments.

In March 2022 the service rolled out new ward documentation. The service had trialled this documentation and gained positive feedback from staff that it worked well. The service completed an inpatients records audit after implementing their new documentation. The roll out was commenced on the in-patient unit in April 2023 with a view to auditing both the bedside and ward notes in October. After feedback from all MDT staff, numerous 'tweaks' to the notes were made. The audit programme would commence in November 2023.

When patients transferred to a new team, there were no delays in staff accessing their records. Staff kept their person-centred files at the patient bedsides to aid patient-centred care. Staff removed files on the night shift, so they did not disturb the patient and returned them at the start of the day shift.

Records were stored securely. Patient notes were kept in the ward office. The service used an electronic healthcare record which enabled information sharing between healthcare organisations involving each individual patient's care.

The service had a record retention and destruction policy which helped employees and volunteers through the process in accordance with relevant legislation such as general data protection regulations (GDPR).

## 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. We looked at 7 treatment charts and 3 patient records on the inpatient unit. We spoke to the pharmacist who supported the service, a mix of medical and nursing staff, volunteers, patients and carers and 1 trustee about medicines.

When people were prescribed a medicine to be taken 'when required' the maximum dose staff could administer was recorded. However, staff missed further information for the indication and minimum gap between doses. We raised this with nursing staff who said staff were involved in discussions around patient's treatments. The service planned to implement a protocol for as required medicines.

Staff stored, handled, and recorded controlled drugs in line with requirements. The stock balances of the 6 controlled drugs we checked were correct. Nurses regularly checked stocks of controlled drugs and additional checks and audits were carried out by the pharmacist supporting the service. The service had a controlled drugs accountable officer (the person who has a legal responsibility to ensure controlled drugs are properly managed). They participated in local meetings and submitted reports to the controlled drugs local intelligence network.

The service had a clearly written medicine policy covering the different aspects of medicines management including the safe administration of controlled drugs. The director of clinical services had responsibility for the legal compliance in all matters related to controlled drugs.

Staff completed medicines records accurately and kept them up-to-date. Staff recorded patient's allergies and accurately recorded their administration of medicines. They ensured any patients with known allergies wore red wristbands with their identifiable information. Administrations of medicines were accurately recorded with very few gaps. Where medicines were not given the reason was noted on the medicine administration record. All medicines and patient records were reviewed, dated and signed by the pharmacist.

At the time of our inspection the service was starting to implement the electronic prescribing of medicines as part of a collaborative with another local hospice. The ward manager updated and shared minutes from these collaborative meetings and distributed to staff. The medical director planned to roll out E-prescribing by November 2024.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Staff adjusted patient's medicines to ease and better respond to their symptoms from a holistic perspective. For example, if patients had headaches, hallucinations, considering their fears of any side effects.

Staff stored and managed all medicines and prescribing documents safely. All medicines were stored securely in cupboard or fridges which staff used keys to access. The inpatient unit had locked cupboards and trolleys. Checks on temperatures were completed and logged by staff daily.

There was limited provision for patients who wanted to self-administer their medicines as only one room had a lockable cupboard for storing medicines. The service had a plan to address this. Their director of clinical services (DCS) had sourced quotes for patient's own drugs lockers for each bed space and 2 computers on wheels for when they progressed to E-prescribing.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Any patients admitted for inpatient care were asked to bring a list of their medicines with them. Doctors checked and confirmed people's medicines on first admission to the hospice (a process called medicines reconciliation). When people were discharged, they were given detailed written information about their medicines.

The service had a service level agreement (SLA) with their local acute trust for a weekly 9 hours' service to provide clinical pharmacy input and medicine supply service. Staff also held quarterly meetings with the pharmacy contract manager. Staff told us they were able to obtain medicines promptly.

Staff learned from safety alerts and incidents to improve practice. Staff heard about medicine incidents, errors and learning from incidents which was widely shared. The service had systems to ensure staff knew about safety alerts and incidents. The service completed medicines audits. Incidents involving medicines were investigated and actions to improve practice were monitored to prevent a recurrence of the incident.

The in-care patient unit (IPU) ward manager compiled a monthly medicines incident reporting newsletter with shared best practice distributed to all staff. The service's bi-monthly care learning newsletter also included a medication update. The latest quarterly newsletter from October 2023 mentioned 2 recent documentation errors in the CD book, which they attributed to human error. The clinical lead and ward manager took action to reduce CD book errors. For example, they maintained a calm quiet treatment room environment to aid prescribing staff's concentration.

However, 3 nursing staff told us they heard about medicines incidents but could not always give examples or elaborate on these.

Managers had put learning in place from incident investigations. For example, the service had implemented a medicines management group, checked staff's medicines competencies such as syringe driver training and assessments, and carried out preventable work around any future medicine incidents.

Staff reported 36 medicine error incidents from October 2022 to September 2023. The most common category of error involved controlled drugs (CDs) which comprised 21 of these 36 incidents. The most common CDs related incident was documentation errors in the CD book or during a CD audit. Learning was in place with meeting discussions recorded for all these incidents, except for 1 CD incident in September 2023 still in progress. At the time of our inspection, 3 of the last 4 reported incidents related to syringe drivers.

### 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 actions from patient safety alerts were implemented and monitored.**

Staff knew what incidents to report and how to report them. Service leads ensured all incidents were reported promptly. The hospice IT manager had developed an electronic reporting system that was being rolled out at the time of our inspection. The hospice planned to fully implement their new electronic reporting system by January 2024.

Incident management training had been provided for all staff providing managers and staff with the appropriate information they needed to use the system, log incidents and near misses.

Staff raised concerns and reported incidents and near misses in line with the service's policy. The service had a process for drug error reporting which staff followed. All medicine error investigations were fully completed within 20 days. Staff alerted the medical team if there was an immediate need or requirement for assessment of a patient's condition after medication errors. The in-care patient unit (IPU) sister or nurse in charge was informed.

Clinical leads felt the service's incident reporting culture had improved in the few years before our inspection. Staff were less afraid of any perceived blame culture after lots of related work on 'just learning'. Staff had reported more near misses in the 6 months before our inspection. Clinical and reporting staff had helped some trustees understand and recognise the benefits of over-reporting incidents as part of an improved safety culture. For example, 1 trustee received reports on ward incidents to review any falls analysis, pressure ulcers and how they were acquired.

The service's IT lead had developed a training session on their new electronic incident reporting system. All staff both clinical and non-clinical could report incidents and were encouraged by the practice educator.

Staff reported serious incidents clearly and in line with the service's policy. Staff we asked understood the service's incidents policy. The service's clinical dashboard contained all incidents. Incidents were divided into separate tabs for drug errors, pressure sores, falls or other. Their total incidents from October 2022 to September 2023; the year before our inspection numbered 104. Their most common incident category reported was drug errors.

There were 31 incidents relating to falls staff reported from October 2022 to September 2023. All incidents included learning, which was shared with staff. This meant we could ensure staff were able to debrief or fully process learning from these incidents to prevent future reoccurrence.

For 21 of these 31 falls the patient was either in an observation room, had a falls sensor, or a pressure mat. 13 of these patients had more than one precaution in place. For 9 of the other 10 falls, staff had documented the full context on the dashboard as to why patients had none of these precautions in place. For example, if a patient was later assessed as being safe to mobilise independently with help from a physiotherapist.

The clinical dashboard had categorised incidents for different levels of harm to the patient, including for falls. This meant leads could accurately assess or determine the impact of incidents upon patient safety.

The service's falls incidents were summarised with an occupational therapist and physiotherapist at monthly clinical governance meetings. The quality and audit lead also completed a quarterly falls audit where key learning points were shared with staff verbally, electronically, and in writing.

We reviewed all 27 incidents relating to PUs from October 2022 to September 2023 and found staff reported 6 grade 3 pressure sores, 5 were present on admissions and one was hospice-acquired. The service completed a root cause analysis to identify any learning from this hospice-acquired grade 3 pressure ulcer. During this 12-month period, the service reported 6 unstageable pressure ulcers. All were present on admission, not hospice acquired and were reported to CQC at the time. This meant staff had taken action to prevent future reoccurrence of patients suffering grade 3 or above skin damage.

All actions taken arising from incidents such as falls and pressure ulcers were on the clinical dashboard. There was detailed evidence of the action taken. Any incident learning identified was updated on the dashboard and summarised in the care learning newsletter. All falls and pressure ulcers were summarised at monthly operational governance meetings. Incident learning was also shared quarterly with the board of trustees at the clinical governance and quality committee.

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. The duty of candour (DoC) is a general duty for registered providers and RMs to act in an

open and transparent way with people receiving care or treatment from them. The service had a DoC policy and leaflet service users and visitors could take away or with details of how to make a complaint. Patients or carers could request a written outcome of their investigation, which the service provided within 10 operational days of the incident being closed.

Patients and their families were involved in incident investigations. The provider sent 3 examples where staff had followed DoC in response to drug, a fall and pressure ulcer-related incidents raised on the incident platform. Staff kept families informed and updated regularly.

Staff received feedback from investigation of incidents, both internal and external to the service. Clinical leads established an incident dashboard in 2021 to identify and monitor trends and numbers with clearly documented learning. Staff were encouraged to approach members of the management team for supportive reflection following incidents, concerns or challenges.

There was evidence changes had been made as a result of feedback. Clinical leads noticed 1 incident trend was staff being interrupted whilst collecting medicines from the drug cupboard. As a result, they installed closed circuit television (CCTV) to easier identify any medicines errors and lessons learnt. This helped reduce drug error incidents in a supportive way.

Managers investigated incidents thoroughly. Incidents were shared with staff through the bi-monthly care learning newsletter as well as identified key learning points from audits. The 2 latest newsletters from July and October 2023 gave staff updates on falls, pressure ulcers and medicine with support and education contacts.

In future incidents would be shared with staff through group governance meetings around medicine management, tissue viability and falls. Leads also planned to discuss incidents during the rollout of daily safety huddles and at routine team meetings to aid learning. Key themes would also be identified, and thematic reviews carried out.

Managers debriefed and supported staff after any serious incident. The hospice ward manager and quality and audit nurse were working with 3 other hospices on the patient safety incident response framework (PSIRF). They planned to help develop the service's incident reporting systems and culture adopting a 'just learn culture'. The IPU ward manager had taken a lead on PSIRF.

## Is the service effective?

Good

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

### 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 review the evidence base regularly. Staff protected the rights of patients subject to the Mental Health Act 1983.**

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Care and treatment was incorporated into patient's records and staff completed ReSPECT documentation for all patients. The ReSPECT process creates personalised recommendations for a person's clinical care and treatment in a future emergency in which they are unable to make or express choices.

Staff followed national institute for health and care excellence (NICE) guidance such as the Karnofsky performance scale. This determined patient's ability to tolerate therapies in serious illness. For example, at their weekly palliative care multidisciplinary team (MDT) meeting staff considered patient's mobility and how much they were in bed.

Staff also used the British Geriatrics Society's Barthel index of activities of daily living (ADL). This was an ordinal scale used to measure performance in activities of daily living to assess inpatient's functional independence. Staff used both during the MDT.

Staff were developed into link practitioner roles which maintained an overview of specific aspects of clinical practice, and ensure it was evidence based.

At huddles and team meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Staff outlined and discussed the wishes and needs of the patient and their family relatives frequently, including at MDT meetings. These discussions could include property decisions, the patient's will and financial situation.

### 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 made sure patients had enough to eat and drink, particularly those with specialist nutrition and hydration needs. Meals were prepared in house, and menus had a wide range of meal choices and foods with modified textures were available. For example, 1 carer told us their patient relative was on a normal diet, but was risk assessed by staff and switched onto a soft pureed diet after choking on a roast dinner. Carers informed us staff were aware of patient's food allergies and told them everything the patient had eaten to ensure their needs were met.

Kitchen and catering staff were aware of and could accommodate any specialist dietary needs or intolerances patients had. If there was something particular a patient wanted, they did their very best to make it available.

Patient food and drink was appropriately stored and labelled with their room and date in a separate fridge to any staff stock. Patients had water provided within reach and staff offered drinks to patients and their visitors throughout the day.

Appropriate staff were level 2 food safety trained for handling and assisting patients with their nutritional needs. Staff reviewed and discussed any nutrition and hydration issues for patients and the best approach. For example, if patients were nauseous or if they managed more intake in certain environments.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff completed continence charts for patients as often as needed.

The service undertook a nutrition audit in August 2023. An audit of 10 sets of patient notes scored 83% overall. Key learning points and actions included both ward and facilities teams undertaking dysphagia (difficulty in swallowing) training, provided by their local acute trust. The nutritional catering sheet would be updated and piloted to highlight swallowing issues and food allergies. Staff would also revise care plans to aid recording of oral care issues. The service had planned a re-audit in 6 months' time to re-review the findings.

In September 2023 after staff feedback, the service piloted a food and fluid recording chart amendment. This gave volunteers the opportunity to document any drinks or snacks provided and highlight earlier opportunities to help with nutritional intake if a patient had not eaten.

Staff used a nationally recognised screening tool to monitor patients swallowing abilities and risk of choking. Staff used the international dysphagia diet standardisation initiative (IDDSI) food classification and testing for adult patients.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. Staff could access several shared resources from speech and language therapists (SALTs) to support patients, such as coughing diaries and care plans. The community SALT team had organised dysphagia training for staff.

### Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff used a pain assessment tool for use with family and carers of people with cognitive impairment, people with dementia who were non-verbal or had communication difficulties. Pain scores were based on the family carers observations of the patient's behaviours. Information collated from both family carers and staff were then rated as red, amber, or green (RAG). This helped staff monitor and manage patient's pain appropriately.

Patients received pain relief soon after requesting it. Patients assessed as appropriate could self-administer pain relief medication. Staff supported and monitored those in chronic or debilitating pain using syringe drivers.

Staff prescribed, administered and recorded pain relief accurately. Symptomatic relief policy was followed in 1 patient's notes. Staff had completed risk assessments for blood clots, but had not prescribed treatment to avoid this risk to the patient as they were also at risk of bleeding.

Staff discussed pain management for all patients at daily handover meetings. They offered patients alternatives to medicines for pain relief such as activity groups and complementary therapies. For example, the lead dementia nurse had completed Namaste sensory training originally developed for people with dementia. This included hand massage, and music or aromatic activities which stimulated the senses.

### 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 had been accredited under relevant clinical accreditation schemes.**

The service participated in relevant national clinical audits. For example, staff used the Hospice UK toolkit audits.

There was a systematic programme of clinical and internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken. The service had an annual schedule of clinical audits. These included audits covering the avoiding falls levels of observation assessment tool (AFLOAT), bed rails, EoLC documentation and crib sheets, falls package, falls risk reduction care plan, mouth and oral healthcare, nutrition, post falls checklist, syringe driver, and use of movement sensors spot check.

Outcomes for patients were positive, consistent and met expectations, such as national standards.

Managers and staff used the results to improve patients' outcomes. For example, audit leads re-introduced an oral health care plan as part of patient records, after the service scored poorly in the related audit. The service had devised a monthly tissue viability audit and planned to share findings with staff.

Managers and staff carried out a programme of repeated audits to check improvement over time. The audit leads maintained an action log based on audit findings. Audits were split into medical and clinical categories. There were more actions still in progress for clinical audits than medical ones. However, 1 outstanding medical audit action was overdue from April 2023. This was delayed due to clinical pressures from industrial action, and winter pressures.

The service's infection prevention link nurses completed annual and monthly IPC audits. They devised action plans from these and displayed the results. Bare below the elbow and hand hygiene monthly audits had both achieved 100% in October 2023. All monthly hand hygiene audits were forwarded to the director of clinical services. The audits were emailed to the CEO and facilities manager.

The service completed a syringe driver audit in September 2023 against 28 criteria to reflect staff's edited prescription chart. The audit scored 93% overall. This was an improvement on their previous syringe driver audit in February 2023 which scored 86.8%.

As a result, themes were identified, and key actions taken to support staff feedback. For example, staff were reminded that completing all sections of the syringe driver prescription chart at every entry was a legal requirement and adhered to standards set by the nursing and midwifery council (NMC) code of practice. The lead planned to re-audit in 6 months to review findings.

Managers used information from the audits to improve care and treatment. Improvement was checked and monitored. The service undertook a quality improvement programme (QIP) paper drug chart audit in March 2023. The audit noted areas for improvement and paper prescribing pitfalls. It also assessed the advantages and pitfalls of e-prescribing and found there were more advantages so planned to rollout e-prescribing in 2024.

Managers shared and made sure staff understood information from the audits. Audit leads emailed audit findings to all ward staff and made copies available in the ward diary and ward office for shared learning and awareness. All audit results were fed back to the relevant management structures and disseminated to all areas and staff for learning. Any changes to practice were fed back to the staff and volunteers and included in training.

### 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.**

Good

# Hospice services for adults

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. All nursing staff were experienced practitioners, including their hospice admiral nurse. All medical staff were up to date with their competencies and had educational or clinical supervision relevant for their roles.

All staff clinical and non-clinical had to complete competency assessment criteria for monitoring patient's observations. This helped managers demonstrate staff's safe practice for obtaining patient observations, ensuring they always obtained privacy, dignity and consent, clear documentation of observations and immediately reported any significant changes to a health professional.

Managers gave all new staff a full induction tailored to their role before they started work. The service had a full induction programme for new staff which included a comprehensive induction day agenda. Attendees feedback was positive.

The service's probation period for all new staff was 3 months. Director-level staff probation lasted 6 months. All staff files were kept up to date.

Managers supported staff to develop through yearly, constructive appraisals of their work. The hospice's overall appraisal rate for their first appraisal season was 88%. Staff feedback was positive for the new appraisal process and timescales. The 12% incomplete appraisals were due to staff's sickness-related absence and part-time working. All medical staff's appraisal with last and next revalidation dates were up to date.

From 2023 the service had adopted an appraisal season approach for all their employed staff from January to March. The service evidenced appraisals. These used the specific, measurable, relevant, reasonable, timebound (SMART) objectives tool and measured staff against their values, behaviours and challenges or issues they faced.

Managers supported nursing and medical staff to develop through regular, constructive clinical supervision of their work. The service had 10 clinical supervisors, 3 of which had updated their training in September 2023.

Clinical leads emailed staff in June 2023 to explain clinical supervision and the benefits for staff's practice and development. Staff confirmed who they wanted their clinical supervisors to be. In response to low uptake of new staff accessing clinical supervision, leads had devised an action plan.

Trainee doctors had to complete assessments, one of which was observe consultations, then give feedback. Specialty doctors received additional competency support dependent on their individual needs. Some junior medical staff preferred to follow a less formal structure.

The hospice's consultant in palliative medicine had completed specialty training in various locations across Yorkshire and was also the motor neurone disease (MND) lead for Mid Yorkshire.

The clinical educators supported the learning and development needs of staff. The service had a education lead and practice educator to facilitate training and sessions based on staff feedback. For example, the practice educator worked alongside leads to deliver staff training on areas relating to CD medicines used such as syringe drivers. Leads aimed to embed best practice around medicines administration with staff, whilst taking human factors into account. The service's clinical educator lead gave external training to other organisations.

The hospice offered training to other partner organisations in their integrated care board (ICB). They sought to assist these organisations to develop their own learning and development resources for a wider sense of ownership.

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

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers encouraged staff to discuss their career aspirations and added annual actions to staff's development plan.

The hospice's infection control team devised annual training for clinical and non-clinical staff and developed training tools to stimulate their areas of interest for further development. One of the hospice's board members had personally provided training and information updates for both senior clinical staff and other trustees in clinical governance and regulatory quality assurance.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. There was evidence of extensive staff training. For example, 1 non-clinical staff member's file had 73 different relevant training courses completed.

All staff had received Maguire communication skills training internally. This was a workshop to improve communication skills which all healthcare professionals could access. It kept effective communication at the heart of patient-centred care.

Staff had access to monthly reflections. These were an opportunity to reflect in confidence, with peers about their role and lived experiences at the hospice. Leads and staff felt the sessions had several benefits; opportunities to share good practice, challenges, identify strategies or further support and training needs, and discuss both personal and professional issues in a safe space.

Managers made sure staff received any specialist training for their role. Inpatient ward nursing staff were encouraged to attend numerous online webinars relating to tissue viability. One webinar in October 2023 covered skin changes at life's end and addressing skin tone bias.

The admiral nurse was about to finish their clinically led workforce and activity redesign (CLEAR) training. This aimed to solve complex health and care problems by simultaneously providing workforce and service redesign, and training clinicians to deliver it. After this they planned to rollout levels 1 and 2 to other organisations across Wakefield with 3 other course trainers on challenging behaviour.

The head of people and culture (HoPaC) delivered coaching training to the operational management group (OMG) in July 2023 as well as mental health awareness and stress sessions in September 2023.

Managers identified poor staff performance promptly and supported staff to improve. The service had a performance management procedure which outlined their structured approach to handling poor performance. Manager's aim was to help employees improve and reach to standards required.

Managers recruited, trained and supported volunteers to support patients in the service. Volunteers received structured training for their role. They also had to read through and complete a volunteer induction handbook. Volunteers had to sign a confirmation of understanding and return this to the hospice before starting shifts. Voluntary registered nurses had to be currently registered with the NMC and have a PIN number.

The service recognised the challenging and emotive nature of hospice work so volunteers were encouraged to use support available to help them maintain a professional and objective approach to all service users and their families.

The service collected volunteer feedback through a survey. The latest survey had a 30% return rate. 100% of respondents would recommend the hospice as a place to volunteer. Leads implemented 'you said we did' examples.

### Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. During our inspection we observed a hospice palliative care weekly multidisciplinary team (MDT) meeting. This was chaired by a physiotherapist using an outcome form with all relevant prompts. MDT discussions included symptom control, safeguarding, escalation plans, falls risk, nutritional risk, skin risk, and do not attempt cardiopulmonary resuscitation (DNACPR) choices. Discussion also covered approaches to family inclusion and patient involvement. We observed symptom control discussions included patient feedback.

Staff considered patient's accessibility needs at every stage of discharge, including their home environment and any reasonable adjustments or adaptations which should be made.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff worked with other agencies when required to care for patients and sought information from national organisations such as Hospice UK.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. Social work staff provided support and advice to patients and those close to them. This included (but was not limited to) advice and support in writing wills, obtaining benefits, and organising applications for power of attorney.

### Seven-day services

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

There were daily medical ward rounds, including at the weekend. Consultant ward rounds were 4 days a week, with consultant advice available 24/7. Doctors were onsite during the day and on-call 24 hours. Patients were reviewed by consultants depending on their care and treatment. The hospice's medical director was a specialist consultant in palliative care and responsible for the overall running of the hospice. The service had an on-call arrangements policy to ensure staff knew the on-call process and who they may need to contact. Clinical staff were supported by other essential services which kept the hospice running.

The hospice did not meet NHS England's 7-day services priority standards around time to first consultant review. This was because the service very rarely considered new patients as emergency admissions. All patients admitted to the hospice out of hours must be accepted by the on-call palliative care consultant to ensure they are appropriate for admission to the hospice, rather than to a more acute environment. This meant consultant reviews were not always initially face to face if the consultant on-call was non-resident.

However, the service had appropriate mitigations to ensure patients were safely admitted under their care in line with hospices across the region. Staff admitted patients both for symptom management and end of life care as a specialist palliative care inpatient unit, and only considered them emergency admissions very rarely. The service had their own policy for medical review of all patients within 14 hours of admission anytime of the week. However, this was usually within the first 1 or 2 hours. This standard was confirmed in the service's medical induction policy.

However, hospice leads felt there were appropriate mitigations to ensure the safety of patients admitted under their care. This was in line with all other hospices across the Yorkshire region.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, 7 days a week. The hospice was open 24 hours a day, 365 days a year. Staff could support people at any time, day or night with their specific needs. Their services tailored to the needs of users, carers and their families. For example, they planned to maintain the dementia day therapy sessions between Christmas and new year as a respite service for carers who needed support at that time of year. The hospice only provided respite care for patients in an emergency.

Healthcare professionals (HCPs) were on duty around the clock, including nurses, care assistants and other staff. Other HCPs across all therapies, a social worker and family care nurse were accessible to help support families.

### Health promotion

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

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

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

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Patients admitted to the in-patient unit needed to provide consent to receiving care.

Staff clearly recorded consent in the patients' records. The service rolled out personalised supportive care documents in March 2023. This included an updated consent to care document which staff informed patients of on admission and gained their consent.

Staff made sure patients consented to treatment based on all the information available. The service used a consent to care at the hospice form patients had to sign and date to confirm their admission for care and assessment. Staff discussed this document with the patient and/or their carer during admission on their day of arrival. Staff then gave all inpatients white identity wristbands stating their full name, date of birth and NHS number.

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. Staff could give implied consent if a patient was unable to provide signed consent. If the patient could not give either signed or implied consent, their nominated advocate could do so.

The service planned to audit their new consent to care document within the upcoming in-patient records audit in November 2023. The verification and care after death form would also be audited during the service's next end of life care (EOLC) plan audit.

Good

# Hospice services for adults

Staff we spoke with understood how and when to assess whether a patient had the capacity to make decisions about their care and knew who to contact for advice. Staff made sure patients consented to treatment based on all the information available and clearly recorded their decision.

Staff we spoke with described the best interest decision making processes and how they would be applied. Do not attempt cardiopulmonary resuscitation (DNACPR) forms in patient records were up to date, fully completed and stored securely. In addition to DNACPR, staff completed a recommended summary plans for emergency care and treatment (ReSPECT) form for all patients admitted to the service. They considered the patient's mental capacity for involvement and fully involved them in plans when they had capacity. Staff completed ReSPECT forms fully and printed them for easier review. This meant staff understood and adhered to patient's wishes around resuscitation.

Nursing and clinical staff received and kept up to date with training in the mental capacity act (MCA) and Deprivation of Liberty Safeguards (DoLS). The service's annual safeguarding report identified quarterly summaries including any recommendations, actions or updates around training and education including MCA and DoLS.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and Mental Capacity Act (MCA) 2005. They knew who to contact for advice. Staff used mental capacity alerts for any service users who seemed confused around decision making and completed assessment when needed. The service's mental capacity or DoLS policy had been updated in July 2023 with information on how to contact an independent mental capacity advocate (IMCA).

Staff could describe and knew how to access policy and get accurate advice on MCA and DoLS. The service had an assessment of mental capacity policy, including DoLS. This clarified best interest decisions staff could make under the MCA's relevant sections, and how to pursue urgent, standard and DoLS for patients approaching the end of life.

Managers monitored how well the service followed the MCA and made changes to practice when necessary. The service undertook a mental capacity or best interest decision making audit from July to September 2023. Leads addressed the audit's key learning points. For example, the MDT sheet had been redesigned with a section to record capacity to evidence staff discussed this at the MDT weekly meetings.

Managers monitored the use of DoLS and made sure staff knew how to complete them. Staff implemented DoLS in line with approved documentation. The service applied for an urgent deprivation of liberty between July and September 2023 for a service user requesting to leave. It was in the service user's best interest to remain at the hospice as they were undergoing treatment for an infection. The DoLS allowed staff to keep the service user safe at the hospice. Staff rescinded the DoLS once their infection had been treated, as they regained capacity to consent to being at the hospice.

## Is the service caring?

Good

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

### Compassionate care

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

Good

# Hospice services for adults

Staff were discreet and responsive when caring for patients. We spoke to 6 service users and 4 carer relatives. Carers told us staff always provided appropriate and attentive personal care to patients, and updated them upon their return to the service.

Staff took time to interact with patients and those close to them in a respectful and considerate way. The service was patient-centred and staff based their care on the patient's needs. The hospice accepted referrals for patients out of area as soon as possible when they had the capacity.

The medical director was responsible for the patient's care, together with a team of medical assistants and a second consultant. The patient's own general practitioner had the right to all documents and information on the patient and was informed of admission to the hospice.

Patients said staff treated them well and with kindness. Patients, carers and family members were full of praise for staff and emphasised they could never do enough to ask how they were and support them. Dementia nursing staff platted a service user's hair in the style they liked each week. One carer told us the drive home with their spouse from the dementia day service was the happiest moment of their day.

Staff followed policy to keep patient care and treatment confidential. Patients and carers told us staff would respect their privacy and take them to one side for any sensitive conversations. Staff made separate space in other rooms or available areas to maintain privacy and dignity for patients who shared bays with others.

The ward sisters ensured all aspects of the patient's nursing care was holistic in focus. The team liaised with specialists of other disciplines when required. The sisters were responsible for ensuring there was effective communication with the patient's primary healthcare worker.

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. The MD outlined all their current inpatient's wishes and preferences at multidisciplinary team (MDT) meetings. Staff discussed bereavement support options for patients, including referral, their mental and psychological health needs.

Staff considered where patients would be ideally placed, for example if they wished to be around others. Staff offered patients a preference such as moving to a shared bay nearer the family activities room. Staff managed last days and hours of life for patients with due consideration and according to their needs whilst meeting their family's holistic needs.

Staff understood if and when patients did not want to be over-medicalised or admitted into hospital. For example, if a patient's nephrostomy bag or tube kept blocking staff would treat them in-house.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. For example, staff encouraged patients to reflect on what they most wanted. At MDT we heard how a patient requested whisky and lemonade with a film.

### Emotional support

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

Good

# Hospice services for adults

Staff gave patients and those close to them help, emotional support and advice when they needed it. The family care and support staff in conjunction with the inpatient unit team provided bereavement services, including anticipatory grief support, links to faith and spiritual organisations and future planning support. A bereavement support team were available for counselling. Staff knew grief was long-lasting and would support people who were bereaved with face-to-face specialist counselling.

Patients had access to complementary therapies and staff helped them develop effective self-help techniques to manage symptoms such as breathlessness and anxiety.

Staff also understood the needs of carers; they gave them advice and asked about their welfare. Some carers said their mental health or depression had improved as a result. Staff listened and reassured carers who had bad experiences caring for other family members at local hospital services. Carers described staff as 'a godsend' and told us staff gave them as much time and space as they needed to talk openly.

Staff offered support to all children visiting their loved ones in the hospice. Ward staff ensured children were supported and the bereavement team provided counselling when required. The family care team ensured children had access to transitional teddy bears used to support with the natural grieving process where patients could leave messages as a memento for their children or young relatives.

The service offered children bereavement support. This could be direct or indirect and include funeral attendance advice, support and steer for difficult conversations, or reassurance around the right behaviours.

Staff encouraged patient's families and close friends to visit as much as they liked. The service also allowed well-behaved pets. One patient living with dementia was emotionally supported and engaged by an animatronic cat which staff allowed them to take home.

Staff supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity. Nursing staff told us they put aside their personal beliefs to reassure people with dementia who became distressed or upset. One service user became very upset while they attended the day therapy session. Staff comforted and consoled them by explaining they were safe, held their hands and gave appropriate responses.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Nursing, medical and allied healthcare professionals, together with volunteers had undergone training in advanced communication to help patients express their emotional needs and reactions to their illness. This care extended to the patient's family.

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. Family carers of day and therapy service users told us they had confidence and peace of mind when leaving their relative or loved one with staff. Carers told us the hospice services were a godsend and gave them vital respite each week.

Staff considered the complex family dynamics of some patients, and the impact on all relatives they wanted to be involved towards the end of their lives. Staff could speak to relatives on the patient's behalf if they requested and consented at all times.

Good

# Hospice services for adults

## Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Dementia nursing staff held sensitive private conversations with the carers and families of people with dementia around how advanced or progressive their dementia had become. They helped them transition between day therapy sessions for different stages of dementia, and could offer both short-term to best meet their needs.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff supported carers to complete contingency plans. These helped carers plan in the event they were not well and unable to care for their patient loved one. Staff would support families and carers who needed help finding other social care services that could provide support. Staff guided everyone through the decision-making processes as much as possible, and signposted places for further help.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The hospice constantly sought ways to improve the service it provided for both patient and carers. Feedback was extremely positive and divided into staff groups and services for easier dissemination.

Staff supported patients to make advance decisions about their care. Staff supported patients to make advance care plans. This was an arrangement to stay in the hospice when patients became very unwell, and wanted to spend their remaining time onsite. Staff had delivered advance care planning (ACP) training to the integrated care board (ICB). This included training and bereavement for black and minority ethnic (BAME) and disabilities communities as well as patients who were hearing-impaired.

The service had also completed and evaluated a collaborative project on ACP and bereavement which helped them devise a toolkit. This enabled staff to develop improved bereavement and advance care planning training programmes in the future.

Staff supported patients to make informed decisions about their care. Staff gave patients a support needs assessment tool (SNAP - version 2) to tick their box(es) of choice before discussing with them any wishes they had. This completed form was then added to patient's medical notes and care plans. This form asked 'how are you?' and what support patients needed.

The family care nurse ensured patient's next of kin or relatives knew to inform their GP after death, even if the death had been expected but was quite sudden.

Patients gave positive feedback about the service. We read the hospice's messages of thanks board covered in handwritten praise from patients, carers and families.

The service received positive EOLC feedback. For example, 1 patient relative in November 2023 said staff were kind, caring and very thoughtful. They added in writing staff were always there to help and comfort the family and were sympathetic towards the end.

## Is the service responsive?

Good

# Hospice services for adults

Good

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

## Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the needs of the local population. The hospice had an outreach nurse whose role was to reach out to communities and share their messages in unique ways. They were mental health first aider trained with qualifications in wellbeing.

The hospice's dementia service team extended the reach of their services, targeting an under-served population within their local community. The service could accept referrals and admissions for patients from other health districts outside Wakefield and Mid-Yorkshire. These patients were assessed by the appropriate community nursing team in the referring district before being accepted by the hospice. Staff could also accept admissions out of hours (OOH).

Staff linked up with their local NHS acute trust to support patient's earlier discharge from hospital, and had links to mental health services to offer joined-up care for patients with dementia.

The hospice was involved in a Hospice UK LINDER foundation project to support staff working in the prison sector by offering an educational programme to improve EoLC and share good practice. This programme improved staff understanding and confidence in specialist areas of EoLC such as dementia.

Facilities and premises were appropriate for the services being delivered. The service had suitable facilities to meet the needs of patients' families. The service had quiet rooms and a family room called Verbena equipped with play toys, games and other provision. The family room had a bed for patient carers or family members to stay overnight.

At the time of our inspection the activities coordinator of a dementia day therapy service was helping the service users engage in autumnal craft activities.

The service's lead dementia nurse had agreed a strategy and appropriate responses with other staff for 1 service user who regularly used inappropriate language. This entailed staff using standard phrases which aimed to quickly de-escalate this language. Staff reported any inappropriate behaviour back to the service user's wife at her request, whilst also supporting her needs as a carer.

Managers monitored and took action to minimise missed appointments. Staff could access their regional ambulance trust to transfer any patients unable to make their own way to the hospice.

The hospice had strong working relationships with the local and regional system, through their regional West Yorkshire integrated care board (ICB).

Good

# Hospice services for adults

## 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. At the time of our inspection the hospice held a dementia day care therapy service for people with more advanced or severe dementia. This was a respite service for family carers open 2 days a week. At the time of our inspection staff planned to offer carers a third day. This was well attended and supported by an admiral nurse, staff nurse, activity coordinator and volunteers. They hosted another weekly session on Mondays for people with milder forms of dementia.

Each full-day session focused on an aspect of dementia care, to which both the carer and their family member were invited. The service was led by the hospice admiral nurse who had knowledge and expertise in this area of care.

Areas were designed to meet the needs of patients living with dementia. The service had been awarded in recognition of their 'dementia friendly environment' from the Alzheimer's Society.

Hospice staff had developed a dementia services team who held weekly sessions. This team could offer education and support to carers, visitors, other staff and volunteers.

The dementia team provided structured provision to patients through their daytime respite care. Team staff also supported patient's continued independence through structured occupation, education and rehabilitation activities. They also supported carers to maintain their role, avoiding or prolonging the need for institutionalised care for the person living with dementia.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. The service tailored their care and support to people living with dementia and their family carers. Their admiral nurse was based on site, but also worked in the community and supported local care homes. The dementia team could offer carers, and other service users access to the day therapy unit (DTU) for someone to share feelings with, emotional support, advice and complimentary therapies.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff could order pendant alarms for patients with cognitive impairment called dementia buddy devices as part of the service's safer communities bid. In the event patients went missing, this helped whoever found them to contact their relatives, the regional police's missing persons lead, local authority and a radio representative.

The service had information leaflets available in languages spoken by the patients and local community. The Tuesday wellbeing services leaflet outlined the service's activities and sessions and what they offered. Staff had access to specific documentation in alternative languages and easy read versions from their local DoLS team.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff could access translators and interpreters when needed. The service had a related policy with their contact details. Staff could also access British sign language (BSL) interpreters and professional lip speakers.

The service provided spiritual care and religious support according to patient needs. Staff could contact faith and spiritual leaders in the local area to ensure patients had access to their chosen person. They also had access to a chaplaincy volunteer religious and spiritual support team who visited the hospice. The trustees valued the engagement from chaplains and spiritual support.

Patients were given a choice of food and drink to meet their cultural and religious preferences. During our inspection the service was celebrating multifaith week with a range of dishes from different ethnic and cultural backgrounds.

Staff had access to communication aids to help patients become partners in their care and treatment. The service had completed a clinical audit in April 2023 to support patients with hearing loss in palliative care. A hospice and palliative care practitioner had checked documentation, given staff a teaching session, and planned to reaudit with an amended multidisciplinary team proforma. This proforma would include hearing loss and communication needs to their initial medical assessment. As a result of the audit, the service's reception desk had a loop system for hearing aid users installed. Patients with hearing impairment could also access pocket talkers and vibrating pagers. This meant staff better understood and documented the needs of these patients.

### Access and flow

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

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The hospice generally always had spare beds available on the inpatient unit. Bed occupancy for the 6 months from April to September 2023 varied between 68-82% of their total beds.

We also reviewed the hospice's total monthly admissions to in-care for the last 12 months from October 2022 to October 2023. This totalled 373 admissions ranging between 24 and 34 each month.

Managers and staff worked to make sure patients did not stay longer than they needed to. Staff offered people support to help get their symptoms under control before returning home or to their preferred place of care after a few days or weeks of assessment and support.

The service had completed a quality improvement audit project in the year before our inspection. Patient's written discharge letters with all their medicines were reaching their GP late, so ward staff switched to their clinical computer system to send these out more promptly.

Managers monitored that patient moves between services were kept to a minimum. The service had remote access to their local acute trust systems to access pathology results immediately.

Staff did not move patients at night. The service moved patients only when there was a clear medical reason or in their best interest.

Managers and staff started planning each patient's discharge as early as possible. The hospice did not provide long-term care so staff would facilitate early discharge planning into nursing homes for people who needed 24-hour care. Staff held discharge planning conversations for patients frequently, considering specialist and therapies input, family support and welfare calls.

Good

# Hospice services for adults

Staff provided specialist care to people with life-threatening illnesses, some of whom stayed at the hospice at the very end of their lives. Many of the hospice's patients stayed for just a few weeks until their symptoms were better managed. They were then supported to be discharged from the hospice, transferring their care to their, or a relative's home.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. The family care team could offer patients domiciliary or home visits at their preferred place of care. The physiotherapy team were instrumental in this process and ensured patients had the required intervention they needed.

Staff supported patients when they were referred or transferred between services. Staff did all they could with the resources available to achieve patient's preferred place of care including a safe, effective and timely discharge involving them and their family as plans progressed.

The service's practicing privileges service level agreement (SLA) helped the service complete rapid end of life patient transfers from the trust's emergency departments and surgery, mental health liaison or crisis teams.

### Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. The service had a raising concerns leaflet outlining the hospice's complaints procedure patients and visitors could take away.

The service clearly displayed information about how to raise a concern in patient areas. If service users or their families were not satisfied with their complaint response, the service displayed details on how they could escalate further, both internally and to external organisations such as the Parliamentary and Health Service Ombudsman.

Staff understood the policy on complaints and knew how to handle them. The service had a complains policy available to which staff could refer. There was always a senior staff member available onsite who staff could ring for any advice or reassurance.

Managers investigated complaints and identified themes. The director of clinical services and senior leadership team oversaw the complaints process. Operational managers were responsible for investigating complaints in their areas.

Leads discussed complaints during the rollout of daily safety huddles and at routine team meetings to aid learning.

## Is the service well-led?

Good

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

Good

# Hospice services for adults

## Leadership

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

Leaders had the skills, knowledge, experience and integrity they needed, both when they were appointed and on an ongoing basis. The hospice had a stable, highly skilled and experienced senior team. The CEO and consultant had been in post for over 7 years.

All staff throughout the service told us leaders were visible and approachable. The senior leadership team (SLT) maintained weekly rotas for where they worked. At least 2 SLT members were based at the service every weekday during November 2023.

There were clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership. There was a leadership strategy or development programme, which included succession planning. The hospice appointed a new in-care patient unit (IPU) ward manager on 18 July 2022. They took on a developmental role to become deputy director of clinical services (DCS) under the DCS. They loved the developmental role, felt the hospice had the right fundamentals and managers were keen to listen. They had made some achievements 3 months into the role. For example, writing and distributing a monthly medicines incident reporting newsletter with shared best practice.

Trustees had strong links to Wakefield and were very active in their local communities, and in charity or community sectors.

The hospice had appointed a pharmacist and an experienced physiotherapist to their board of trustees in 2021 who led their end of life care personalised workstream. Trustees felt this resulted in a diversity of clinical roles on the board. Trustees joined the ward rounds with the MD/consultant.

The trustees chair held surgeries with all staff on any topics they wanted to discuss. Trustee assurance visits were valued by patients, and their framework was modelled around this, such as first impressions. The ward manager joined the DCS for visits periodically.

Senior leaders including the registered manager and CEO/nominated individual had a close, effective and supportive relationship with the clinical staff and trustees. Conversations were wide-ranging and open to challenge. Trustees engaged with staff at different levels of seniority and proactively got to know the senior clinicians and attended ward rounds with the medical lead as helpful for clinical oversight role but doesn't intervene. Different trustees reacted with other staff members.

Leaders understood the challenges to quality and sustainability, and could identify the actions needed to address them. Leaders told us the COVID-19 pandemic and related challenges helped them work and pull together even closer with their staff, trustees and local communities.

## Vision and Strategy

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

The hospice endorsed a holistic approach in promoting quality of life for patients, as well as providing the continuing support offered to families and carers.

There was a clear vision and a set of values, with quality and sustainability as the top priorities. The hospice's vision was for the needs of people living with life-limiting illness, and those close to them, to be met with skill, compassion and care.

Their values were; Professional; Caring; Aspirational and strong and skilful leadership at all levels.

They also had a mission statement, an aim and a philosophy of care with 6 statements.

The vision, values and strategy had been developed using a structured planning process in collaboration with staff, people who used services, and external partners. Leads had undertaken staff engagement on devising their values, and at the time of our inspection were about to add 'inclusive' as a fourth value.

Staff knew and understood what the vision, values and strategy were, and their role in achieving them. These values had been developed on consultation, through all operational meetings and through their staff survey. As a result, the values were well owned, lived and shared by staff. Senior leads received feedback to reflect this in the latest staff survey. Ninety six percent of volunteer survey respondents said they saw the hospice's values being lived out in the workplace where they volunteered.

There was a robust, realistic strategy for achieving the priorities and delivering good quality sustainable care. At the time of our inspection the hospice was working on a new clinical strategy 2023-2026. This had just been approved by the board and set out 4 actions for delivery. Lead members planned redesigned models of care for more patient privacy and dignity such as single room accommodation.

The strategy was aligned to local plans in the wider health and social care economy. Services had been planned to meet the needs of the relevant population. The strategy's consultation period started in August 2023 as the result of a previous strategy session at their annual board day.

Progress against delivery of the strategy and local plans were monitored and reviewed, and there was evidence to show this. The board considered and reviewed their priorities and weighed up how to balance them. They were constrained by their financial environment and reduced donations due to/fundraising from the cost-of-living crisis. Members recognised a growing depth between statutory income and rising operational costs.

### Culture

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

All staff we spoke to felt supported, respected and valued. They were proud to work in the organisation.

The culture encouraged openness and honesty at all levels within the organisation, including with people who use services, in response to incidents. The service had a current freedom to speak up (FTSU) whistleblowing policy. In the first instance staff raised concerns with their manager, then if dissatisfied with their response, someone more senior. Staff could escalate concerns to various authorities if they felt appropriate remedial action was not taken. They could gain independent advice and support from Protect; formerly known as 'public concern at work'.

Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution. Leads encouraged all staff to speak up reasonably if they suspected wrongdoing or misconduct so concerns could be dealt with properly. Appropriate learning and actions were taken as a result of concerns raised. The head of people and culture had completed freedom to speak up guardian (FTSUG) training. They had also trained operations managers on various modules such as freedom to speak up and managing stress.

There were mechanisms for providing all staff at every level with the development they needed, including high-quality appraisal and career development conversations. Any staff issues or challenges raised on appraisal would be escalated into senior management team (SMT) meetings. The head of people and culture was also a mental health first aider who would tailor staff support depending on need.

There was a strong emphasis on the safety and well-being of staff. Leads prioritised staff's health and safety. All staff were required to complete a health and safety walk around inspection of the premises before completing a safety checklist log. At the time of our inspection 33 of 61 total staff had completed this with a compliance rate of 61.1%.

There were cooperative, supportive and appreciative relationships among staff. Staff and teams worked collaboratively, shared responsibility and resolved conflict quickly and constructively. Hospice and service leads attended a conflict resolution training day in November 2023. Agenda content focused on positive approaches to behaviour, safer de-escalation and personal safety and disengagement. Conflict resolution was part of all staff's mandatory training. The service engaged in several collaborative projects across their region to meet shared outcomes. For example, in advance care planning and bereavement.

The culture was centred on the needs and experience of people who used services. Leads had made new and positive clinical appointments such as audit and clinical education leads as they could not keep reducing their overall spend. These posts boosted wider morale, generated more staff confidence, and expanded some services and commissioner support.

Action was taken to address behaviour and performance inconsistent with the vison and values, regardless of seniority. Manager's monthly one-to-one conversations with staff assessed their answers against the service's values to prompt aligned behaviours. The service had a disciplinary policy and procedure. This applied if employee's performance was not meeting acceptable standards due to misconduct.

Equality and diversity were promoted within and beyond the organisation. All staff, including those with particular protected characteristics under the equality act 2010, felt they were treated equitably. The hospice respected equality and diversity. For example, they launched an equality diversity and inclusion (EDI) focus group in October 2023. The service also ran their first hospice training day shortly before our inspection, where a senior manager delivered a session on cultural humility. Staff understood the equality act's protected characteristics and challenged inappropriate behaviours in people who did not adhere to them. All the hospice's policies and procedures included an equality impact summary.

### Governance

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

There were effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. These were regularly reviewed and improved. The hospice's board of trustees meeting minutes from August 2023 showed attendees reframed the strategic risk register around their 4 strategic pillars. The revised version was shared at November's board meeting.

Staff at all levels were clear about their roles and understood what they were accountable for, and to whom. There was a service level agreement (SLA) with the local trust around consultants and their practising privileges. An SLA sets out the service to be provided, expected standards, monitoring and review arrangements, usually between an independent provider and NHS services. Both consultants had practising privileges who worked cross-site between the trust and hospice.

All levels of governance and management functioned effectively and interacted with each other appropriately. The service had a clinical governance and quality committee chaired by a trustee with clinical knowledge and experience. The trustee also had extensive knowledge of regulatory and governance processes. The executive team regularly reviewed their performance against the health and social care act 2012 requirements with presentations for quality assurance.

The service's MD had a significant background in clinical governance prior to working at the hospice. They felt the service's clinical governance was now more clearly structured and documented. The service set up an operational clinical governance meeting in 2021 whilst putting more governance structures in place.

Clinical leads outlined future governance plans. For example, the creation of a clinical dashboard including length of stay, waiting times, and other metrics to help staff better understand facilitate service improvement.

Arrangements with partners and third-party providers were governed and managed effectively to encourage appropriate interaction and promote coordinated, person-centred care. The service was part of a West Yorkshire hospices collaborative. They had worked hard at integrated care system (ICS) level for a 5-year sustainable funding model. At the time of our inspection this was still progressing with regional ICS lead affirmation.

### 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.**

Potential risks were considered when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities. The hospice had developed a full risk management and monitoring process over time. The board demonstrated their understanding of and assurance of risk management through a comprehensive register of strategic risk and issues.

There were robust arrangements for identifying, recording and managing risks, issues and mitigating actions. The service's risk registers were operational and highlighted issues escalated for board attention. The respective committee chairs gave updates to the hospice's board about their 3 key risk areas of finance, clinical and business improvement and development. At the time of our inspection long and short-term sustainability remained the highest risk on the financial risk register. This risk had controls in place to give sufficient levels of assurance. The service's second highest financial risk was the recruitment and retention of staff to enable provision of effective management. There were no examples where financial pressures had compromised care.

The service's clinical risk register from October 2023 showed their joint 5 top risks were all scored 12 out of a possible 25. These related to patients being given the wrong drugs, patients falling out of bed or whilst mobilising, managing confusion, safeguarding vulnerable adults and children, and staff absence leading to shortages. Risk leads reviewed this register monthly. They had considered potential impacts of all risks, with a probability raw risk total calculated. Mitigations were also in place for each risk, and the status showed each risk's previous score for comparison. This gave risk reviewers greater understanding of risks' direction of travel each month.

There was alignment between the recorded risks and what staff said was 'on their worry list'. Leads and managers had comprehensive knowledge and oversight of their cross-divisional risks. Clinical leads we asked felt the service's biggest risk was their need for medical e-prescribing. They were aware this risk was not included on their clinical risk register at the time of our inspection. They had arranged a session to add this, and the lack of a clinical IT systems update to the register in November 2023. This meant we could ensure their amended register would fully capture and reflect the service's clinical risks. The latest board meeting had feedback that after long-term discussions, it was time for action on this risk.

In the autumn 2023 the board agreed a new risk register format, to be restructured around the 4 pillars of their emerging new strategic intentions. This was based on a new reporting template, similar to the NHS' board assurance format. The first draft was shared at the November 2023 board meeting, and trustees agreed further work should be done to populate the template in full before agreeing the final format. The new risk register had assigned leads for all risks and any gaps in control or assurance clearly outlined.

When considering developments to services or efficiency changes, the impact on quality and sustainability was assessed and monitored. The service had a business continuity plan to help ensure business processes could continue during a time of emergency or disaster. The plan was audited and reviewed yearly and outlined their key personnel without whom the business could not function. The service also had a crisis communication action plan and crisis response team with responsibilities in the event of a crisis. Resilience training sessions had been hosted for managers and after staff survey feedback, leads planned to roll this out to all staff.

There were comprehensive assurance systems, and performance issues were escalated appropriately through clear structures and processes. These were regularly reviewed and improved. The hospice's committee structure had regular updates on notifications, incidents and audits from their full programme on different activities at meetings. As a result, the service's governance committee received assurance their care met CQC's 5 key lines of enquiry (KLOE).

There were processes to manage current and future performance. These were regularly reviewed and improved. The hospice ensured performance was reported to operational clinical governance and audit committee meetings, and leads discussed all incidents at the monthly operational clinical governance meetings. The service did not need practicing privileges as the MD assigned the hospice as a dual role on their SLA contracts. All doctors who worked at the service were signed off by the deputy director at the local acute trust.

The service's clinical governance and documentation was becoming more embedded through IT and system developments. For example, their new incidents reporting system and the E-prescribing leads planned to rollout within a year of our inspection. The latter had been postponed due to COVID-19 related service disruptions.

Good

# Hospice services for adults

## Information Management

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

IT systems were used effectively to monitor and improve the quality of care. At the time of our inspection the service was undergoing digital transformation of their electronic patient records, electronic prescribing, as well as audit and other data.

The service had also improved e-connectivity between their hardware and training program. This established much better links between staff and senior team members who could maintain internal communications easily. Leads understood the benefits of connectivity which they planned to feature in their next staff survey around Easter 2024.

There were effective arrangements to ensure data or notifications were submitted to external bodies as required. For example, the service had an inter-agency information sharing protocol with their local hospital trust. This considered confidentiality, consent and helped them work together to share effective data about services and service users.

There were good arrangements (including internal and external validation) to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards. The service had prepared a data protection compliant document as part of a new ward documentation rollout in March 2023. This ensured staff had measured the risk of keeping information in the patient room. Staff files could only be edited or updated by the appropriate senior manager or HR administrator. In line with the service's digital transformation, senior managers were trying to move away from paper files and encourage more staff to go 'paperlight'.

The hospice's policies adhered to general data protection regulations (GDPR) which were also outlined on their website. They had a designated data protection officer people could email to query how the hospice used their personal data. The service also had a privacy policy. The multidisciplinary team considered any potential confidentiality breaches of patient's data.

The service had an information governance and records management policy approved by the SLT. They had a designated information governance lead, and a hospice senior information risk officer. The service's RM was their designated Caldicott guardian. The medical director had discussed becoming deputy Caldicott guardian with them. However, at the time of our inspection this was on hold until a new consultant had completed induction.

Lessons were learned when there were data security breaches. The service had an information governance breach in June 2023. This involved tablets to take home (TTOs) being sent to a local neighbouring hospice by mistake resulting in a delayed discharge. Relevant staff had escalated to the pharmacist, but not early enough to advise staff around escalation plan for problems as advised by the pharmacy lead. Work was ongoing to streamline joined up working systems between the service, other local hospices and their local NHS hospital. More staff education was planned and required when the new process was in place.

## 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.**

Good

# Hospice services for adults

People's views and experiences were gathered and acted on to shape and improve the services and culture. This included people in a range of equality groups. The hospice helped their local NHS acute trust with medically optimised patients for discharge. They ran a test supporting a person into a care home with enhanced skills. The aim was this helped staff better understand what patients were trying to say.

There were positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs. Their medical director; a consultant in palliative medicine undertook lots of education to junior medical staff and had links with other hospices and palliative care teams. She also worked with the community palliative care team ensuring consistency of care. The hospice did lots of work with care homes as leads felt their remit was wider than just providing end of life care to people on their premises.

There was transparency and openness with all stakeholders about performance. The hospice had undertaken a workpiece on access to care; this was a 10 hospices group collaborative in West Yorkshire around sharing best examples. The collaborative began early during the COVID-19 pandemic but had continued since. They had met weekly but at the time of our inspection met less frequently with a structured agenda. There was a dedicated group with close working relationships and gave a voice for hospice care to carry more influence and support from their ICB with strong links for better representation at this level.

Staff were actively engaged so their views were reflected in the planning and delivery of services and in shaping the culture. This included those with a protected characteristic. The hospice's admiral nurse and director of clinical services provided clinically-led workforce and activity redesign (CLEAR) training for their local NHS hospital nurses on medical inpatient wards and the care team. They wanted to work towards simulation modelling in other areas such as frailty and respiratory. This added a more intensive care approach into the care home.

The service had refreshed their staff survey delivery, and now used 'you said we did' examples. Staff could also propose new beneficial ways of working. Trustees were more engaged in hearing different survey's focus and findings. In the latest staff survey 92% of staff and volunteer respondents said they would recommend working there. Senior leads said this survey demonstrated real improvement around staff morale since the height of the COVID-19 pandemic which had a dramatic impact on staff and service continuity. The service launched a 3-month flexible working pilot in September 2023 after the latest staff survey feedback. This pilot was available to teams who were not on the rota or working in premises with specific opening times.

The service launched a staff forum 2 years before our inspection. This had representation from all departments, discussed various topics, and let staff suggest ways forward so they felt they had a widespread voice. The hospice had developed a staff newsletter with their communications officer's input. An operations management group was initiated in 2022 alongside the hospice's head of people and culture.

The hospice had a wide range of employee benefits such as an employee assistance programme all staff could access. Staff could self-refer or be signposted to their employee assistance programme for psychological support and counselling in full confidence. Some staff used this service after the external wall collapse incident. Staff had access to an extensive resource library on a wide range of subjects, work life support and health promotional 4-week programmes designed to support staff with structured, achievable targets. On the day of our inspection the service was undertaking health checks for staff onsite including all their vital observations as part of Wakefield PLACE.

This programme included a healthcare cash plan, access to a benefits hub, and onsite support from a mental health first aiders (MHFA) support team. The service had 15 MHFAs in different departments including 3 clinical staff and 4 men.

Good

# Hospice services for adults

People who used services, those close to them and their representatives were actively engaged and involved in decision-making to shape services and culture. This included people in a range of equality groups. The service marked relevant and local events such as national suicide day. Staff celebrated Wakefield Pride in August 2023, attending the event with a neighbouring local hospice. Staff introduced pronouns for their email footers and displayed the hospice logo with a rainbow to express their support.

Staff had access to a wellbeing room with a reclining couch and massage chair. The room contained a personal computer if staff wanted to complete cash plan claims or review employee assistance programme (EAP) wellbeing information. There was also a staff wellbeing board with helpful information on groups and courses including safe spaces and men's mental health clubs.

The service held a sound bath in September 2023, ran by an external practitioner. This was a relaxation wellbeing session concentrating on sound vibrations. Over 40 staff and volunteers attended across 2 sessions. Staff could access complementary therapy sessions with a qualified therapist. These were holistic so treated the whole person rather than one particular problem, which helped staff to alleviate stress and anxiety.

## 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 and staff strived for continuous learning, improvement, striand innovation. This included participating in appropriate research projects and recognised accreditation schemes. For example, in July 2023 the service completed 1 project with a neighbouring hospice to improve the quality and accessibility of information on advance care planning and bereavement for disadvantaged communities. They co-produced resources with relevant organisations which supported these communities to ensure they were relevant, appropriate, and user-friendly. The service's end of life care admiral nurse had completed a Covid oximetry project from August to December 2021 to deliver education and training to staff at 14 local care homes covering 4 modules.

At the time of our inspection the service had applied for menopause friendly accreditation. The head of people and culture had been trained as a menopause advocate, and then trained the SLT, operational management group (OMG) and the MHFA group. They had also presented at staff meetings and attended clinical away day sessions. The service held its first menopause case in September 2023 and had a menopause page with resources and signposting links on their staff intranet.

There were standardised improvement tools and methods, and staff had the skills to use them.

The service completed audits around their quality improvement project relating to patient's written discharge letters and paper drug charts.

The hospice supported students on placement from the local university.

Participation in and learning from internal and external reviews was effective, including those related to mortality or the death of a service user. Learning was shared effectively and used to make improvements. For example, the service had set up a patient safety incident response framework (PSIRF) working group with other local and regional hospices for mutual support and collaborative working.

Good

# Hospice services for adults

All staff regularly took time out to work together to resolve problems and to review individual and team objectives, processes and performance. This led to improvements and innovation.

There were systems to support improvement and innovation work, including objectives and rewards for staff, data systems, and processes for evaluating and sharing the results of improvement work.