Marie Curie

Marie Curie Hospice and Community Services Yorkshire Region

Inspection report

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Date of inspection visit: 9 & 10 January 2024
Date of publication: 22/03/2024

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

Ratings

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

Summary of findings

Overall summary

The service was last inspected in November 2016. At that time, we rated the service as good overall.

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

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, there was comprehensive systems to keep people safe, taking into account current best practice. The whole team was engaged in reviewing and improving safety and safeguarding. Staff understood how to protect patients from abuse, and managed safety well. The service-controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. Medicines were managed safely, stored correctly, and disposed of safely. The service managed safety incidents well and learned lessons from them.
- Staff provided a high standard of care and treatment and gave patients pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care and had access to comprehensive information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs and helped them understand their conditions. People who used the service were active partners in their care. Staff were fully committed to working in partnership with people. They provided emotional support to patients, families and carers.
- The involvement of other organisations and the local community was integral to how services were planned and ensured that services met the needs of the local communities served. The hospice also worked with others in the wider system to plan care. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations.
- Leadership, management, and governance of the organisation assured the delivery of high quality and person-centred care, supported learning and innovation, promoting an open and fair culture. Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values both at local and corporate level 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 to plan and manage services and all staff were committed to continuous service improvement.

Summary of findings

Our judgements about each of the main services

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

Summary of findings

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Summary of this inspection

Background to Marie Curie Hospice and Community Services Yorkshire Region

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

The service offers expert care, guidance and support to help them get the most from the time they have left. All services are free of charge. Patients are referred to the service from the National Health Service (NHS) for symptom control, end of life care and respite. Care is delivered both night and day by Marie Curie Registered Nurses (RGN's) and Healthcare Assistants (HCA's) trained in palliative care.

Marie Curie is a charity working across the UK. Donations pay for 51% of hospice care at home services, and 64% to run nine hospices with the remainder coming from NHS commissioning.

The hospice is situated near the city centre of Bradford, located on a hill with views over the city. Public transport is available part way to the hospice.

The building was purpose-built 23 years ago, the inpatient unit was refurbished in 2014 and the outpatient's unit was refurbished in 2019. The unit includes 12 beds, and all rooms are single person occupancy. Overnight stays can be accommodated for relatives and carers if needed. For those wishing to remain with their loved ones, some patient rooms have a day bed and there are also 2 separate bedrooms with en-suite facilities away from the inpatient area.

From expert nursing and personal care to emotional or bereavement support, hospice care at home provides hands-on care to anyone with an illness they are likely to die from, and those close to them, in the comfort of their own home.

A multi-faith chapel is available with a separate prayer room, including foot washing facilities. The conservatory on the in-patient unit has a supply of toys and books to entertain children. Hot drinks are available via a drinks machine and dining room area. The dining room is open from 7.30am until 6pm, providing a variety of hot and cold meals to staff and visitors.

The inpatient unit is staffed 24 hours a day, seven days a week. The medical team is on site during working hours and a full consultant and junior doctor on-call rota is in operation out of hours.

Diagnostic and screening services are provided by the local hospital which offer biochemistry, haematology, microbiology, radiology, and blood transfusion services.

The Marie Curie Community Service Yorkshire is commissioned to provide services across the local integrated care system and other provider organisations. Services have been developed in conjunction with the NHS commissioners to meet specific needs. These included:

- Planned Hospice Care at Home Service: care is delivered in the patient's home on a single patient per shift basis
- Rapid Response Service: led by registered nurses, providing flexible and responsive palliative nursing care, at short notice to patients at home

Summary of this inspection

- The service offered a hospital admission avoidance service. The Responsive Emergency Assessment and Community Team (REACT) worked closely with emergency department colleagues. The service identified individuals in the last months of life who are medically fit for care at home. They provided care at home for up to 72 hours to enhance patient experience and deliver care, including care homes. The REACT model was unique to Marie Curie Hospice (Yorkshire)

How we carried out this inspection

The team that inspected the service comprised of a CQC lead inspector, supported by 1 inspector and an offsite CQC inspection manager. This inspection was overseen by Sheila Grant (Deputy Director).

This inspection was a short notice announced inspection, staff knew we were coming to observe routine activity.

We spoke with the registered manager who was also the nominated individual. The service employed a team of Registered Nurses (RGN's) and healthcare assistants (HCA's). We spoke with 22 members of staff including clinical and administrative staff.

On the day of inspection there were 10 patients on the inpatient unit receiving care.

We spoke with 7 patients who had used the service and reviewed feedback they had provided on the day of inspection.

We reviewed a range of policies, procedures and other documents relating to the running of the service. After our inspection visit, we reviewed performance information about the service and information provided to us by the service.

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:

- People's individual needs and preferences were central to the delivery of the service. Services were flexible, provided informed choice and continuity of care. The outpatient facility at the service provided a wraparound service for palliative care patients. There was a wide range of differing weekly/monthly outpatient clinics which were supported by specialist consultants, physiotherapists, occupational therapists and clinical nursing staff.
- The service initiated and provided a unique level of support for patients and those close to them with a diagnosis of Motor Neurone disease (MND) and Parkinsons disease. This service ensured joined up care across all agencies involved with an individual from the point a diagnosis was made.
- The service had introduced a garden called the magical garden. This was for children and young people who had or were experiencing bereavement. The magical garden project is to encourage children and young people to use nature and the environment to engage the imagination. Staff told us it created opportunities to open conversations around difficult topics like coping with loss, and feelings around death and dying.

Summary of this inspection

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- The service was working closely with a North East charity called Children North East to undertake the first piece of poverty proofing in a hospice service. This included audit, education and research to ensure that people living in poverty have equal access to services.

Our findings

Overview of ratings

Our ratings for this location are:

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

Outstanding

Hospice services for adults

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

Is the service safe?

Good

Mandatory training

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

Staff received and kept up-to-date with their mandatory training. Training compliance for both on site and community staff was 95.6% against a target compliance rate of 95%

The mandatory training was comprehensive and met the needs of patients and staff.

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

The service had an onsite clinical educator to support staff with training needs. The clinical educator planned monthly face to face training. For example, the next face to face training was scheduled in January 2024. Scheduled training included blood transfusion, syringe drivers, medical gases, level 1 medications, basic life support, catheter care, symptom management, recognising and responding to dying, duty of candour, documentation and record keeping and poverty proofing.

The clinical educator planned to introduce clinical skills with practical sessions for refresher training. Clinical educators across the corporate Marie Curie team collaborated as a group to support and share best practice.

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

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

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

We saw evidence to support that staff were inducted into the service by completing a 1 day course. All staff receive an induction hand book with date of employment and assigned a mentor. On induction staff were allocated 6 hours protected training time to complete mandatory training modules. New staff were rostered for 2 weeks supernumery working with a mentor as shadow experience.

The service recruited volunteer staff and there was a clear induction process. The core and task specific training elements were fire safety, IPC (site specific), manual handling (load only), food hygiene, confidentiality and boundaries, equality and diversity, data protection and health and safety.

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. People were protected by a strong comprehensive safety system with a focus on openness, transparency and learning when things went wrong.

All onsite and community staff received training specific for their role on how to recognise and report abuse. All staff receive mandatory training in safeguarding adults and children (level 2). All clinical leads (band 6 and above) received safeguarding training at level 3. Training compliance data provided showed current compliance for safeguarding adults and children was 98.9% against the organisations target of 95%.

Training was mandatory, all staff were required to complete safeguarding adults and children training every 3 years. Compliance was monitored at the monthly governance and risk meeting. The safeguarding lead completed a monthly check on compliance to ensure compliance met the target range.

Comprehensive systems were in place to keep people safe, which took account of current best practice. The whole team was engaged in reviewing and improving safety and safeguarding systems.

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

The hospice's principle social worker was the named safeguarding lead and was trained to level 3. Regular supportive supervision of the safeguarding lead was provided by the head of safeguarding at corporate level who was trained to level 4.

Other staff also received safeguarding supervision and worked closely with external health care professionals including district nursing colleagues and social care organisations, to share safeguarding concerns.

We reviewed meeting minutes which evidenced regular reflective safeguarding supervision meetings (May 2023). The set agenda included safeguarding management both inpatient and community led. There was a focus on training, an overview of incidents and sharing of safeguarding information.

Hospice services for adults

The local safeguarding lead compiled a monthly safeguarding newsletter for all staff. All staff we spoke with were aware of the newsletter. The January 2024 edition included what is mate crime, types of mate crime, factors that can impact mate crime and what should be done.

The service had a corporate policy in place for adult and children safeguarding concerns. The policy was in date with a review date of October 2024. We saw evidence that the service had a local standard operating procedure (SOP) for adult and children safeguarding concerns. This was in date (November 2023) with a review date of (November 2024)

The policy referenced national guidelines and contained links to local authority safeguarding information and PREVENT. PREVENT is a government led programme which aims to safeguard vulnerable people from being drawn into terrorism. Training compliance provided showed compliance for PREVENT training was 96.6% against a target of 95%.

Face to face courses for clinical and non-clinical staff were facilitated for safeguarding, Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act (MCA). We saw posters on display explaining the 5 principles of MCA.

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

All staff including clinical, non-clinical and volunteers had disclosure and barring service (DBS) checks in place, we saw evidence to support this. The tracker is reviewed quarterly by central HR business partners, and DBS checks renewed within 3 years. This information was stored securely at corporate level and could be accessed locally for assurance and oversight.

Staff we spoke with were able to define safeguarding protocols and understood who to contact with safeguarding alerts. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. We saw examples of safeguarding referrals that had been made at the time of inspection.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. The service provided a safe space for individuals to express themselves without fear of discrimination or harassment. There was a rainbow walkway and rainbow signage at the front of the building identifying the service as a space that was inclusive and recognised diversity.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We saw posters on display in differing areas showing the flow chart of how and who to report safeguarding concerns to.

Staff followed safe procedures for children visiting the ward. Staff were able to give examples of risk assessments completed when children visited patients on the ward.

The service had robust processes in place to ensure that the people who join the organisation through employment or volunteering, were suitable for their roles. Additionally, they had a code of conduct for all staff and volunteers.

Systems and processes were in place to identify and assess potential areas of risk across all activities; and ensure remedial plans were put in place to address these risks. The whistleblowing service included 'speak up champions' in different areas of the charity.

Outstanding ☆

Hospice services for adults

Cleanliness, infection control and hygiene

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

Inpatient areas were clean and had suitable furnishings which were clean and well-maintained.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

We observed public areas had posters which promoted COVID-19 awareness. During inspection the service had highlighted a small cluster of COVID 19 cases. All staff and visitors to the site were mandated to wear face masks in accordance with the services infection control (IPC) policy.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw use of clear signage and appropriate practices where patients were isolated for Infection Prevention Control (IPC) reasons.

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

The service had a local IPC lead in place. There was a hospice IPC policy in place which was in date and next due for review August 2025.

Training compliance for both on site and community staff was 97.2% against a target compliance rate of 95%.

Waste bins were pedal operated and contained the correct colour coded liners.

There were sufficient hand wash basins and hand gel stations. Staff adhered to uniform policy (bare below the elbows) and we observed good hand hygiene compliance.

Environment and equipment

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

The hospice building was purpose built and had suitable and sufficient day and inpatient service facilities.

Access to the site was through electronically operated gates. CCTV was in use at the entrance to the service. The service had a service level agreement with a security company. Security guards were on site seven days a week from 6pm to 8am. Entry to the premises was via automatic doors via a buzzer entry system. Administrative staff had a clear line of sight to the entrance door. There was a sign in and out register and PPE was readily available.

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

The service had suitable facilities to meet the needs of patients' families. There was a dedicated day room for patients and relatives on the inpatient unit. There was an outpatient area where classes were offered for outpatient activities which was suitably equipped. There was dedicated day room/conservatory for outpatient use. All areas were easily accessible. There was a communal kitchen area available for group work.

Hospice services for adults

There was a dedicated area for families, children and young people when accessing children and young person's services. Access to services was via main reception with direct access into therapy rooms. Staff told us this was planned so that young people and children did not need to walk through the rest of the building should they find it emotionally challenging.

The service had a gym which included multiple pieces of gym equipment for inpatient and outpatient use.

There were 3 clinic rooms for outpatient clinics which included a treatment room. The inpatient unit had 12 inpatient beds all with on suite bathroom facilities and patient hoists. There were 2 family rooms available for relatives who wished to stay overnight.

There was multiple office space available for administrative staff/teams and senior leaders who required office space. There was also access to a conference room which was used for larger conference facilities and meetings.

All fire extinguisher appliances inspected were signposted and serviced within an appropriate timescale. Fire exits and corridors were clear of obstructions. The service had a fire evacuation plan and conducted annual fire evacuation drills.

The design of the environment followed national guidance.

There were systems for recording the service and planned preventive maintenance of equipment. The facilities manager had oversight of an electronic central log which indicated when tests were completed and next due. We saw evidence to support this which was stored electronically and managed by the facilities manager. An external provider conducted yearly portable appliance testing of electrical equipment. All clinical equipment we inspected was serviced and fit for use.

Substances hazardous to health were stored safely.

Patients could reach call bells and staff responded quickly when called. Call bells were available at bed sides, patients at risk of falls had access to wrist bands and pendants for wearing around the neck. One patient told us that staff had always responded immediately to the nurse call bell when activated.

Cold room storage facilities complied with NHS England guidance for staff responsible for care after death (2011). We observed mortuary fridge temperatures were in range. Staff monitored and recorded daily fridge temperatures and knew the process to action if there was variation. The cold room had CCTV monitoring with a separate external entrance. The cold fridge was serviced annually and there was an up to date service level agreement in place.

The fridge had capacity of 6 bays. The service had an SLA in place with the local acute NHS trust and funeral director for additional off site cold room storage if and when required.

The service had enough suitable equipment to help them to safely care for patients. Staff had access to specialist equipment for example high/low level beds, pressure relieving mattresses and a nurse call system which included use of a neck pendant or wrist band. All beds had integrated bed rails, split into two on each side of the bed. The upper bed rails were designed to be used as a mobility aid, assisting patients to get in and out of bed. The service also had a range of equipment which could be used to support patients at risk of falls. For example, pressure pads, sound monitors and passive infra-red sensors which alert staff if the patient stands up.

Staff disposed of clinical waste safely.

The housekeeper supervisor had good oversight of the management of linen and laundry services at the hospice. There was an awareness of the requirement for sustainability and staff had a clear system for stock control of linen and other items within the hospice. Cupboards were orderly with a clear and simple rotation system in place.

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 inclusion/exclusion criteria for the safe acceptance of patients. We saw evidence to support this.

The set criteria defined that the patient had active, progressive and usually advanced disease for which the prognosis was limited (although it could be several years) and the focus of care was quality of life. The criteria included a list of symptoms, issues such as uncontrolled or complicated symptoms; specialised nursing/therapy requirements; complex psychological/emotional issues; complex social issues requiring co-ordinated decision making about future care.

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

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

All patients, unless they were actively dying, had observations recorded on admission and then frequency of observations was determined as part of the admission plan. There was a senior decision maker present on the ward at all times. Staff would contact the ward doctor or consultant during working hours if any changes were identified. Staff had access to the 1st on-call doctor outside of normal working hours. If a change was identified by the team, in hours they would speak to the ward doctor or consultant (there was a senior decision maker present on the ward at all times). Out of hours the 1st on-call doctor would be contacted, and their response would be tailored to the patient's treatment escalation plan. The service had implemented the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) model.

The ReSPECT process created a summary of personalised recommendations for a patient's clinical care in a future emergency in which they do not have capacity to make or express choices. Such emergencies may include death or cardiac arrest but are not limited to those events. The process is intended to respect both patient preferences and clinical judgement. The agreed realistic clinical recommendations that are recorded include a recommendation on whether or not CPR should be attempted if the person's heart and breathing stop.

An audit of 30 ReSPECT documentation forms had been completed in September 2023. This had been compared with results from 2021. The audit showed 100% compliance for completing the main areas detailing decisions taken. An area for improvement had been identified to ensure the next of kin (NOK) details or those/names of others involved in discussion were recorded. Results were shared with staff for awareness and action.

Staff were proactive in completing risk assessments for each patient on admission. Within the first six hours of admission a comprehensive range of assessments were completed, and care plans were devised accordingly to manage

the identified risks. A set of risks were reviewed daily for example, skin pressure and nutrition. All risks were reviewed on a weekly basis or sooner if clinical presentation or circumstances indicated a need for review. Assessments included the use of the IPOS (Integrated Palliative care Outcome Scale) which measures symptoms and concerns that matter to individuals in relation to physical, social, psychological and spiritual needs. We heard staff talk about patients in a way that reflected their understanding of changing risks and the needs of those close to patients during the last days or hours of their life.

Staff knew about and dealt with any specific risk issues including falls, moving and handling, bed rails, infection control, skin pressure and wound care, nutrition and hydration. Staff used the Avoiding Falls Level of Observation Assessment Tool (AFLOAT) to determine the recommended level of observation for falls risk according to clinical presentation.

Staff also completed a nationally recognised tool to assess disability and to monitor changes in disability over time. It records indicators of independence in terms of disability caused by impairments. Staff used this tool to ensure risk was minimised whilst promoting independence appropriately for individuals.

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

Staff shared key information to keep patients safe when handing over their care to others. We heard an example of this at a handover to community services in preparation for a patients discharge.

Staff used an SBAR (Situation, Background, Assessment, Recommendations) tool for raising concerns with medical staff out of hours. Staff had recognised that in an emergency concise information needed to be shared. Staff had adopted the use of the SBAR format to support their thinking and clarity in order to be concise with explaining rationale for the need for medical input.

During inspection we observed a daily board round. This was a multi-disciplinary (MDT) meeting including medics, physiotherapists, social worker, nurse, pharmacist and reception staff. Each patient was discussed in detail. Nursing staff were familiar with each patient and used a detailed printed handover sheet to focus discussion. Any required updates and plans were recorded in real time on the patient notes during the meeting. During this meeting we observed evidence of risk discussion, medicines management including use of as required medication (PRN), pain review, family needs, emotional needs and discharge planning.

Shift changes and handovers were thorough and included all necessary key information to keep patients safe.

Nurse staffing

The service had enough nursing and allied healthcare professional staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

On the day of inspection, the inpatient unit was fully staffed with a dedicated clinical nurse in charge. Each shift was covered with the correct ratio of registered nurses and healthcare assistants according to planned verses actual staffing records. We saw evidence to support that staffing met the planned numbers.

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

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

The service had stable vacancy and turnover rates. We saw that vacancies were filled as staff left. The service used bank staff if and when required to cover annual leave and short-term sickness. The service had a standard operating procedure (SOP) in place if staffing levels fell below certain levels. We reviewed the safe staffing policy which was in date and next due for review October 2026.

Managers could adjust staffing levels daily according to the needs of patients. Staff told us they felt able to raise any staffing concerns on a daily basis through handovers.

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 medical team had honorary contracts with Marie Curie and the local acute NHS Trust. The body of consultants rotated every three years in palliative care in the community, onsite at the service and within the acute trust. The medical staff supporting first on call cover were dedicated to the service. Second on call is always provided by a consultant, who supported the service, plus another hospice, two acute hospitals, regional community teams and a local advisory service for telephone advice.

There was a service level agreement (SLA) in place with the local trust for the supply of medical services which was in date (April 2021 to March 2024). The service had a standard operating procedure for the palliative care consultant on call covering the Bradford District and Craven 24 hours a day, 7 days a week. Senior leaders were sighted on the need to ensure the SLA agreement was updated and agreed before the agreement lapsed.

The consultant was assisted on a daily basis by 2 medical staff, consisting of a registrar/speciality doctor and foundation year doctor/GP trainee. During the inspection we observed medical students working alongside the consultant of the day. The service had strong links with the local university.

Medical Staff led daily clinical rounds, including weekends, a consultant was always available for advise 24/7 and for face to face reviews if clinically indicate. The medical staff matched the planned number. We reviewed the medical duty roster for December 2023 which evidenced this.

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

The service always had a consultant on call during evenings and weekends.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. The service used a recognised electronic patient record system and were working towards a paper light model. Paper records were kept securely and included information such as drug charts and cannula checks.

The e-record system was comprehensive, easily accessible and had clearly identifiable flags to highlight risk and concerns. Electronic records were accessed by a secure smart card system. Some warnings were set to flash up on accessing a patient notes, for example, when there was a lasting power of attorney in place. We saw evidence of protected characteristics recorded. We reviewed risk assessments that had been completed and saw care plans that were determined following completion of risk assessments. We saw evidence of spiritual and psychological needs recorded within the notes.

We saw that visiting healthcare professionals from other organisations were able to include details in the notes and contact details for all external multi-disciplinary team (MDT) members were recorded.

The community team used the same system to record information. The team could access community colleague's electronic records. This enabled them to work together effectively to to benefit their patients. We reviewed the core care plan document which included but was not limited to symptom management, oral intake and oral hygiene, skin integrity, personal care, continence and mobility.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely. There was a clinical records policy which was in date and due for renewal January 2024.

Record keeping audits were routinely carried out with a focus on specific areas of record keeping, for example, the use of bed rails. A recent audit that had been completed and found inconsistencies of the recording of a rationale. There was a piece of work underway to look at how best to support staff to ensure consistency.

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. All staff members we spoke with were aware of how to report medicine incidents. All reported incidents had been investigated and actions put in place to reduce the risk and prevent re-occurrence. Themes were discussed at weekly clinical review meetings and at the quarterly medicines management group meeting.

Medicine management training compliance for both on site and community staff was 93.8% against a target compliance rate of 95%.

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

Staff stored and managed all medicines and prescribing documents safely.

The service had a full-time pharmacist. There was a service level agreement in place with the local NHS trust to provide this service. There was a vacancy for a part time pharmacy technician, plans were in place to recruit to this role. Local standard operating procedures (SOPs) were in place covering the medicines management process. A national Marie Curie medicines management policy was in place and adhered to.

Patients had paper prescription charts for medicines that needed to be administered. We reviewed three prescription charts and found staff had completed them correctly. The service was yet to adopt electronic prescribing. There was a plan to adopt this moving forward to be in line with other Marie Curie units nationally.

Staff reviewed each patient's medicines on admission and recorded this on the patient record. Staff provided advice to patients and carers about their medicines. The onsite pharmacist also gave advice and support to patients.

Staff monitored and recorded medicines fridge temperatures and knew the process to action if there was variation.

Medical gases were piped to each bed space. Cylinder gases were stored securely. All cylinders we checked were in date.

Staff learned from safety alerts and incidents to improve practice. There was a system to receive and act upon MHRA alerts. The Medicines and Healthcare products Regulatory Agency (MHRA) is now an accredited issuer of National Patient Safety Alerts (NPSA). All safety-critical alerts for medicines and medical devices that require a system wide response will be issued as National Patient Safety Alerts. Drug alerts are actioned and logged locally as well as responding to Marie Curie centrally. Staff were able to give examples of NPSA alerts which were shared at clinical hand over to ensure staff oversight.

The services controlled drugs accountable officer (CDAO) attended the controlled drug (CD) Local Intelligence Network (LIN) meetings and completed regular quarterly occurrence reports. A review of the CDAO was last completed January 2023. This review was completed annually in line with national guidance. The CDAO were responsible for all aspects of controlled drugs management. The roles and responsibilities of CDAO's are governed by the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

Controlled drugs were checked and administered using the single nurse administration process. This was in line with the service's medicines management policy.

Staff told us they completed medicines management training and competency assessment in line with the service's mandatory training schedule. Nurses administering controlled drugs via the single nurse administration process had to have been in post onsite for a minimum of 12 months before competency assessment and sign off is approved by a clinical lead.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Patient's medicines and medicines management at home prior to admission was assessed when the patient is admitted to the service and throughout their stay. The service completed weekly in-patient unit (IPU) reviews which were discussed at the IPU clinical review meeting to discuss medicines management issues and other clinical risks. The pharmacist also attended daily handovers.

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

Outstanding ☆

Hospice services for adults

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

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

All staff had access to the electronic incident data base and could upload live incidents. The service was a high reporter of incidents; however, most incidents reported were low and no harm. Higher levels of incident reporting allowed managers to review trends and themes. Medium harm incidents reported were escalated directly with the corporate team for oversight organisationally alongside local management of such incidents.

Staff raised concerns and reported incidents and near misses in line with the service's policy.

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

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

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

Staff told us incident panel meetings were open for any staff to attend. The service instigated weekly inpatient and community incident meetings. Weekly incidents were reviewed highlighting themes, trends and required actions.

The service had a tissue viability link nurse who supported patients and staff surrounding pressure damage and management. The safeguarding lead jointly reviewed suspected pressure damage with local unit managers to ensure appropriate actions had been taken. For example, risk assessments, care planning and equipment needs were in place to safeguard patients.

The service had a falls champion who was the lead physiotherapist. Patient falls were investigated, lessons learnt were shared with staff and actions taken to prevent recurrence were clearly documented. All fall's incidents were reviewed by the falls lead to determine any changes required to systems or processes. After each fall the fall's lead would also review the patient concerned individually ensuring timely and responsive review of such incidents. Over the past year one falls incident had been classed as moderate harm with all others recorded as low or no harm.

The service completed quarterly patient falls meetings; we reviewed the last meeting minutes completed in December 2023. The objective of the meeting was to review reports on all falls related incidents within the hospice, and the hospice care at home service and undertake quarterly analysis. There was an action plan in place to address theme and trends.

The registered manager produced a weekly newsletter for inpatient and the hospice care at home staff by way of an update regarding the number of inpatient admissions, average length of stay and incidents. In the month of December 2023, the inpatient unit had 13 admissions, the average length of stay was 17 days. There were 20 incidents reported which was below average for the unit. There were 5 inpatient falls (low or no harm and 2 near miss falls). Staff had reported 4 medication incidents (no harm, 1 missed dose, 1 storage issue, 1 under dose on syringe driver and 1 wrong syringe type on syringe driver.

In December 2023 the hospice care at home service reported 37 incidents with 32 reported as no harm and 5 reported as low harm. There were 4 patient falls (low or no harm) and 2 reported safeguarding concerns. Between April & November 2023 there had been 216 reported incidents of missing documentation averaging 27 incident reports per month. The registered manager clarified that the incident investigation had highlighted missing documentation from the external district nursing community team. The risk was minimised as the hospice care at home service complete their own individual risk assessments and care planning documents. This was being monitored by the hospice care at home management team to identify ongoing themes and trends. The service would feed back to external agencies where such concerns were raised.

Staff understood the duty of candour (DoC). They were open and transparent and gave patients and families a full explanation if and when things went wrong. We saw posters on display in differing areas clearly explaining the process surrounding DoC. We reviewed the DoC policy which was in date and next due for review January 2026.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made as a result of feedback. For example, we saw feedback on display surrounding availability of a bariatric bed (December 2023). A patient scheduled for admission required a bariatric bed. The bariatric bed normally in service was found to be faulty. This impacted on the patient admission which was delayed by 36 hours. The patient remained at home with support of the REACT team until a replacement was sourced. A replacement bed was sourced via a planned service level agreement with a specialist equipment hire company, ensuring ongoing timely access.

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

Managers debriefed and supported staff after any serious incident.

Outstanding ☆

Hospice services for adults

Is the service effective?

Good

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff 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. Clinical practice was audited, and findings were positive. We were assured that the service's processes ensured staff followed national guidance and evidence-based practice. The service had a tracker showing all clinical and non-clinical policies which evidenced policy by type, who was responsible for review, date of issue and date of next review. All policies we reviewed were in date, version controlled with a named author.

The corporate brand had a national process in place for review of National Institute for Health and Care Excellence (NICE) guidance. All guidance was stratified. Review of Local NICE guidance was completed by the clinical leads group at local level.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We attended a handover meeting and heard staff referring to patients psychological and emotional needs.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs. They used special feeding and hydration techniques when necessary. The service made adjustments for patient's 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 we saw menus with broad options of meal choices and foods with modified textures were available. The service offered halal and vegetarian options. Kitchen staff were aware of patient's dietary needs and any food allergies and intolerances.

We saw patients had water provided within reach and staff offered drinks to patients and their visitors throughout the day.

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

There was evidence in the patient records we checked that staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs.

Specialist support from staff such as dietitians and speech and language therapists were available from the local acute NHS trust for patients who needed it. Staff we spoke to were aware of how to make referrals.

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

Hospice services for adults

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 pain using tools appropriate to each individual. Staff felt that there was a lack of appropriate pain relief tools available nationally for use in palliative care. Staff were able to identify a range of pain tools available to them such as the Numerical Rating Scale (NRS) and Verbal Descriptor Scale (VDS).

Staff explained individualised pain assessments would be carried out at a point when the patient was not experiencing pain in order for a baseline to be recorded and an individualised discussion around what intervention had been best used to manage pain. Main sites of pain were also recorded.

We observed pain management was discussed for all patients at daily handover meetings. Emotional, psychological and spiritual support was a key focus on managing pain.

Patients were asked how their pain levels were, following administration of analgesia and this was recorded. Staff told us each patient was treated as an individual, pain levels were closely assessed, monitored and recorded. Staff were clear that each patient was an individual and that pain management was aided by the building of relationships with patients. Staff also demonstrated an understanding of the emotional and psychosocial impact upon pain. For example, staff valued the use of meaningful occupation in helping to manage pain.

Patients we spoke with told us they received pain relief soon after requesting it.

Staff prescribed, administered, and recorded pain relief accurately. The service used differing specialist equipment to manage pain. Differing options included but were not limited to transcutaneous electrical nerve stimulation (TENS). This is a method of pain relief involving the use of a mild electrical current. A TENS machine is a small, battery-operated device that has leads connected to sticky pads called electrodes.

Pain relief medications were prescribed following initial assessment and could be administered orally, via skin patches or transfusion pumps. Syringe drivers were used within the unit to administer some pain medication. A syringe driver (or syringe pump) is a small battery-powered pump. It delivers a steady stream of medication through a small plastic tube under the patient's skin. Syringe drivers were used for medicines that help with pain, sickness, fits, agitation and breathing problems. Information leaflets were available for patient's offering advice on syringe drivers and managing pain.

Staff told us patients also had access to single patient use wheat bags which could be pre warmed and placed in cotton bags to protect skin integrity.

Patient outcomes

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

The service participated in clinical national and local level audits. We reviewed the national annual schedule of clinical audits 2023/2024 for both the hospice and home nursing service. Scheduled audits covered; International Dysphagia Diet Standardisation Initiative (IDDSI), mouth care, duty of candour, safeguarding, tissue viability, falls, controlled drugs, accountable officer, electronic patient record, bed rails assessment and documentation audit.

The audit schedule evidenced audits undertaken nationally and locally, frequency and staff responsible for collation. Audit data was submitted locally. The central team analysed the data set and reported the findings re trends & themes. Individual services are given 2 months to develop an action plan to address non-compliance using a RAG (Red-Amber-Green) rated tool. RAG ratings, also known as 'traffic lighting,' are used to summarise indicator values, where green denotes a 'favourable' value, red an 'unfavourable' value and amber a 'neutral' value. Teams had a 2 month timeframe to implement required actions.

We reviewed the national audit tracker which evidenced compliance rates and clear action plans to address non-compliance. For example, an accessible information audit completed in June 2023 showed a compliance rate of 92.31%. There was evidence of clear actions and updates.

The service completed audit at local level for example but not limited to, wrist bands, controlled drugs registers and admission audits.

Managers and staff used audit results to improve patients' outcomes. There was a local and national action log in place identifying additional training needs.

We reviewed the most recent clinical effectiveness meeting minutes (December 2023). Minutes evidence discussion of audit, recommendations and actions taken.

Information was used to benchmark against peers in other hospices for example, length of stay, number of admissions etc. Staff told us they monitored admission and discharge planning. The average length of stay was currently 14 days. The number of patients admitted and treated in December 2023 was 13. Data showed some extended length of stay. The service explained this could be due to gaps in community service and differing patient comorbidity impacting on treatment.

The service audited the patient's preferred place of death and accommodated this as far as possible. The service collated this information, we saw data from January 2023 to December 2023 which evidenced 74% of patients had died at their preferred place of death. The service instigated post death meetings with families.

Outcome Assessment and Complexity Collaborative (OACC) was in place and embedded. OACC is a suite of measures designed to assess patient related clinical outcomes. It guides service development of virtually all palliative care services in the UK. Information was discussed daily at board round and weekly in clinical review meetings. Staff told us there was an annual corporate district wide data collection of this information.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work. We spoke to three staff members who were on induction or recently had an induction. They all felt the induction was beneficial and met their needs. Managers told us that inductions were implemented over a two-week period as a minimum and tailored according to staff experience. Following induction there was a set of competencies identified for staff to work through. The service had an induction framework check list covering expected roles and responsibilities. We saw evidence to support this.

Managers supported staff to develop through yearly, constructive appraisals of their work. Appraisal compliance was 100% across both the inpatient unit and the community services.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Medical staff had honorary contracts with both the local acute NHS Trust and Marie Curie. The service ensured that medical staff completed mandatory training in line with their employing trusts policy. This was tracked and managed by HR business partners and the dedicated senior consultant who is the named responsible officer (RO) for the service. Additional training specific to the role was mandated by the service, for example but not limited to, completion of the ReSPECT tool and mortuary training. The RO managed medic appraisals for permanent medical staff and those connected to NHS trusts. Senior managers and trustees have oversight of this.

NHS England had completed a visit to Marie Curie Charity in October 2023 to review medical staff requiring appraisal and revalidation process. The visit was conducted on behalf of the Higher-Level Responsible Officer (HLRO). The review was to provide assurance that the responsible officer (RO) and designated body had appraisal and revalidation systems and processes in keeping with 'The Medical Profession (Responsible Officers) Regulations 2010, Amendments 2013'. The purpose of the visit was to identify and disseminate good practice, maintaining and improving standards of quality and performance, and to provide the RO with support and advice on any appraisal and revalidation issues.

Findings stated that Marie Curie had good policies and procedures; the appraisal policy, HR procedure, and the RO's oversight of non-connected doctors were highlighted as areas of good practice. The report highlighted that the RO required administrative support during the appraisal and revalidation process to ensure independence between themselves and the connected doctors thus protecting the decision-making process for revalidation. It was recommended that Marie Curie formalise a managing concerns process and transition from the Medical Appraisal Guide Model Appraisal Form to an electronic appraisal platform. An action plan was in place to address this with clear timescales.

People received care and treatment from a team of well-trained, competent and confident staff.

The service had recently launched a preceptorship program for newly registered nurses. The course was a flexible 18–24-month program offering support, guidance, and advice to newly registered nurses. It offered a structured program of learning, allowing newly registered nurses to develop their skills and build confidence in a safe learning environment. The program included monthly education sessions, monthly drop-in sessions with the preceptorship lead and regular resilience-based supervision.

Student placements were available for doctors, nurses, physiotherapy, occupational therapy and social work staff.

Staff files were stored centrally and managed by central human resource business partners (HRBP). Individual staff files contained details of recruitment which were managed by the talent acquisition and onboarding team. Staff training was managed locally; training compliance data was shared with the corporate team for assurance and discussed at the monthly governance oversight meeting. The service had support from a dedicated HR business partner.

Clinical nurse managers ensured all staff in community services were clear about their roles and responsibilities and had appropriate support. They were responsible for regularly reviewing performance and identifying on-going training and development needs through Marie Curie's 'my plan' and review process. Individual training plans ensured that required skills and competency levels were maintained and developed. Clinical nurse managers were also supported by senior registered nurses who had delegated line management responsibilities and were utilised to monitor staff performance in the community.

The clinical educator supported the learning and development needs of staff. Registered nursing staff received specific clinical skills training relating to syringe drivers, tracheostomy, non-invasive ventilation, nasogastric tubes (NGT) and percutaneous endoscopic gastrostomy (PEG) feeding tubes. The service had a tracker in place to evidence individual staff completion and next review date. Nursing staff had a defined competency training pack which nurses had to complete when they met the competency criteria. Training was assessed and signed off by clinical leads.

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

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Team meetings were held monthly. Staff were able to attend in person or online if not on shift and wished to attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. We heard examples from staff who had been supported to progress within their careers, for example to complete training nursing associate courses, registered nurse training and physiotherapy training. Staff told us that they had been able to map out clear plans for development. For example, one member of staff had started as a volunteer and worked towards employment as bank staff before becoming a permanent healthcare assistant and then on to complete nurse training and being retained as a member of the nursing team. We also heard the leadership team had been proactive in seeking out an appropriate route to physiotherapy training for a therapist assistant.

Managers made sure staff received any specialist training for their role. Staff told us they felt able to ask for additional training and that they were supported to attend training to meet additional needs.

Managers identified poor staff performance promptly and supported staff to improve.

Managers recruited, trained and supported volunteers to support patients in the service. The service recruited volunteer staff, there was a clear induction process. We reviewed the volunteer managers handbook which evidenced a robust process surrounding recruitment, induction, core training and on-going supervision. The service had 31 volunteer staff who supported the service in differing roles.

Multidisciplinary working

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

Staff were committed to working collaboratively and held regular and effective multidisciplinary meetings to discuss patients and improve their care. During inspection we saw evidence of a daily system wide hospice multi-disciplinary team admissions meeting. This was attended by all palliative care services to ensure appropriate clinical triage of patients waiting for admission and ensuring those with the greatest need were prioritised. This enhanced working relationships ensuring transparency of bed availability.

The MDT also extended to administration staff, kitchen and housekeeping staff who would work to meet the needs of patients and those close to them.

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

Hospice services for adults

Staff worked consistently across health care disciplines and with other agencies to care for patients. During the inspection we saw evidence of a monthly multiagency meeting for patients with motor neurone disease (MND) and Parkinson's disease.

The clinical team participate in the locality wide MDT, held fortnightly involving all palliative care services in the local area to discuss patients with complex issues, or who may be crossing boundaries.

The service participated in the palliative care network. This was a longstanding managed clinical network in place across Bradford, Airedale, Wharfdale and Craven, which Marie Curie Yorkshire, have always been partners in. This helps drive strategic improvements in palliative care across the patch, and also champions improving inequity in access to services. Through this the service also contribute to other strategic groups, for example but not limited to the integrated care system (ICS) and urgent and end of life (EoL) care workstream.

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

Housekeeping and estates staff had close working relationships with the care team and were kept updated daily about unplanned or urgent admissions. This allowed for sensitivity when working in areas of the building and ensured the care team could continue to focus on providing good, safe care.

Seven-day services

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

Consultants led daily clinical rounds, including weekends.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic testing, 24 hours a day, seven days a week. The service made sure staff on call were able to reach the service within thirty minutes of being called.

Health promotion

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

Staff assessed each patient's health when admitted and provided support and advice. The outpatient service facilitated a wellbeing group. This provided individuals with wellbeing tools according to their own identified needs. We heard that hospice staff held a strong view that there was 'life left to live' and therefore it was extremely important to find different ways of living life.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care and knew who to contact for advice. All staff we spoke with told us that the doctors and the patient family support team were involved in capacity assessments and concerns regarding capacity would be raised with a doctor at the time of identifying concerns.

Outstanding ☆

Hospice services for adults

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff and patients told us consent was gained and re-checked at every appropriate opportunity during care.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. We heard multidisciplinary discussions that took into account individual patients and family members circumstances.

Staff made sure patients consented to treatment based on all the information available and clearly recorded their decision. One patient told us that all information had been clearly explained and sufficient information had been given to allow decision making.

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

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and they knew who to contact for advice. Staff understood the relevant consent and decision-making frameworks and the changing implications during a person's last days of life.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. All urgent DoLS were reported through the incident reporting system. All urgent DoLS would be reviewed by the safeguarding lead and registered manager to ensure correct processes were followed.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). All staff we spoke to were clear that the safeguard lead and the family support team were experts regarding the mental capacity act and DoLs and were always available for advice and support. The patient and family support team attended the daily MDT's and would identify tasks for completion or share information at the meetings in a timely way.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. We were unable to review any DoLS documentation during our inspection, however we heard from staff that detailed descriptions of evidence and discussions used to determine capacity would be recorded appropriately and thoroughly within a capacity assessment before determining the DoLS.

Is the service caring?

Good

Compassionate care

People are truly respected and valued as individuals and are empowered as partners in their care, practically and emotionally, by an exceptional and distinctive service.

Outstanding ☆

Hospice services for adults

We saw on inspection that patients were involved with decisions about their health and care from the start of their admission. Treatment options were discussed with them, which could include acute transfer to hospital, management in the hospice or a focus on symptom management and comfort. This was recorded on admission as part of the treatment escalation plan and as part of the ReSPECT form.

Staff were empowered to treat patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff regularly took time to interact with patients and those close to them, in a respectful and considerate way.

Feedback from people who used the service, family, friends, carers and stakeholders was continuously positive. There was a strong visible person-centred culture. Staff were highly motivated and able to recognise and respect the totality of people's needs. Staff took time to interact with patients and those close to them in a respectful and considerate way.

A common feedback theme was that 'staff could not do enough for me'. Staff followed policy to keep patient care and treatment confidential. Patients said staff treated them well and with kindness.

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

During our inspection we saw that staff were discreet and responsive when caring for patients and their families. We observed all staff across the organisation took time to interact with patients and those close to them in a respectful and considerate way. We spoke to families and carers who told us they had received excellent care from the service. One patient explained how staff treated them as an individual offering support and assistance. The patient's family, friends and carers were also included in care and planning options.

We heard an example of a patient supported to be fast tracked home from hospital and support put in place for them to be able to visit home. An inpatient had expressed the wish to go bowling which staff facilitated and supported. Staff had recently facilitated and supported an inpatient wedding. Family and friends were involved in the planning of the ceremony.

Staff told us 'The service is about how we bring life back to people'.

We heard another example of compassionate care demonstrated by staff. An inpatient expressed a love of theatre and pantomime. Staff facilitated the signing of a programme from the local theatre where a pantomime was currently running. Stars from the cast signed a programme, this was presented to the family as a small token of support.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. For example, following the passing away of patients from certain cultures, staff organised compliance with post death practices.

Staff across the service had an understanding of the needs of the local population. The service employed a spiritual liaison lead specifically to work with and support staff.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. This was through a referral to the onsite therapeutic and holistic service. Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. 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.

Staff were aware of the changing emotional demands on patients and those close to them. Staff demonstrated their awareness of the changing psycho-spiritual distress to patients as health conditions changed. The staff team worked together to find ways to be ready to manage and support individuals in such circumstances.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

An importance on bereavement counselling was prevalent within the service. 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. For example, the service had the facility for family members to stay overnight within the hospice to provide continual support to a loved one and not be disadvantaged by living a large distance away.

The hospice counsellors were specialists in providing bereavement counselling and support for those experiencing grief after someone dies. They provided both pre- and post- bereavement support for both patients, families and carers.

The bereavement team were experienced in helping children aged 5-18 who had lost a parent or relative at the hospice work through their grief and the feelings and thoughts they had relating to their loss.

The service held memory events throughout the year. These take place in the hospice every quarter which was an opportunity for loved ones to come back to remember the person who has passed.

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.

People who use services and those close to them were active partners in their care. Staff were fully committed to working in partnership with people and making this a reality for each person. Staff empowered people who used the service to have a voice about their care and treatment and to realise their potential by encouraging small daily achievements.

Patients told us staff took the time to make sure they were cared for in the way that they wanted. A common theme with patients we spoke with, was how quickly staff responded to call bells being pressed. We heard from family members and those close to patients that they had been involved in all information sharing and decision making appropriately.

We heard examples of staffs understanding of anxiety provoking situations and heard how staff would manage these. For example, supporting somebody who was anxious to be hoisted for the first time or anxious to wear a mask for non-invasive ventilation.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. We heard that white boards or picture boards would be used to support communication. Staff were aware of how to refer into the local assisted technology team to support patients with communication needs. Staff also told us they would work with speech and language therapy colleagues. We noted that a translation service was available for staff to use in supporting patients.

Outstanding ☆

Hospice services for adults

The service had a patient and family support team to help with practical, emotional and spiritual support.

Patients and families had access to use the family lounge, conservatory, multi-faith chapel, prayer room and gardens to relax as well as to spend time with their loved ones in individual private rooms. The service also had two en-suite bedrooms available for families and loved ones to stay the night if required. Within the chapel we saw a table to support mindful colouring in a quiet safe space. The table had paper and differing choices of coloured pens/pencils for people to use. Staff had displayed some of the colouring completed by patients and children and young people.

Wi-Fi was available allowing unlimited Wi-Fi calls/ face to face calls with families.

The service had completed carers drop ins and bereavement drop in which could be accessed virtually or face to face.

Staff told us the team were available to help with making decisions and planning for the future. This might include for example advice about getting benefits and planning for care at home, signposting to free will-writing services, sharing information about funeral planning and making memory boxes.

The service offered a range of emotional support including:

- one-to-one support sessions for adults
- one-to-one counselling for adults/children
- therapeutic support, such as making memory jars, memory boxes or writing letters for adults/children
- art therapy with adults or children

Staff supported patients to make advanced decisions about their care. Staff supported patients to make advanced decisions about their care, through talking about advanced care planning, what they wanted for the end of their life and where it was important for them to pass away.

Patients gave positive feedback about the service. Staff told us the service monitored and evaluated feedback received through patient and carer experience questionnaires.

Patients were supported to give feedback by completing a survey. Feedback could be given in a variety of ways. For example, comments cards, inpatient information packs or iPads using QR codes. QR codes direct the patient to an experience of care questionnaire. Patients were also encouraged to speak to staff if they were unsure how to give feedback.

The service also instigated ad hoc interviews and focus groups with patients and carers about their experiences. The corporate service has a national voices group of service users from England, Wales, Scotland, and Northern Ireland, sharing information to improve the quality of hospice care, nursing services and support. Changes made as a result of feedback from patients and their families are put on the “You Said, We Did” part of the Marie Curie website and displayed in the hospice.

The service implemented a ‘Friends and Family Test’ from which data was gathered via postcards and patient questionnaires and analysed on a quarterly basis by the clinical governance group.

Patients gave positive feedback about the service. We noted that comments about the service were overwhelmingly positive. The most recent friends and family test feedback evidenced that 100% of patients agreed that they were treated with care and compassion.

Outstanding ☆

Hospice services for adults

Is the service responsive?

Outstanding ☆

Service delivery to meet the needs of local people.

The involvement of other organisations and the local community was integral to how services were planned and ensured that services met the needs of local people and the communities it served. It also worked with others in the wider system and local and national organisations to plan care.

The services incorporated a day hospice, inpatient unit, outpatient unit and community services. The purpose was to promote and maintain the best quality of life and offer high quality end of life care.

The service specialised in providing individual holistic care for people with terminal illnesses, offering care and support to patients requiring symptom control, psychological support, rehabilitation, and end of life care. We saw examples of individualised holistic care plans produced by the nursing team. There was a named nurse process to ensure continuity in care. Care plans focussed on goals within documentation from all teams to ensure the patient's wishes were catered for.

In addition to a team of highly experienced doctors and nurses, the service had specialists in a wide range of roles, including physiotherapy, occupational therapy, social work, bereavement support and pastoral care.

Managers planned and organised services, so they met the needs of the local population. The outpatient and day therapy unit provides a therapeutic environment for assessment, monitoring and control of symptoms, as well as providing peer support, respite for carers and rehabilitation.

Facilities and premises were appropriate for the services being delivered. The outpatient facility at the service provided a wraparound service for palliative care patients. There was a number of differing weekly/monthly outpatient clinics which were supported by specialist consultants, physiotherapists, occupational therapists and clinical nursing staff.

The service offered a weekly baking class for patients. On the day of inspection, we spoke with 5 patients who had attended the class. Feedback was consistently positive, all patients told us they felt included, welcomed by staff and listened to. Staff supported patients to make differing dishes each week. The class was set up in the day unit where there was ample space and cooking facilities.

The service offered a monthly MND outpatient clinic. This service was funded by the hospice, there was no external funding in place for this service. This had been initiated by the service approximately ten years earlier in recognition of a need for more local joined up MND care. The meetings brought the neuro rehabilitation and palliative care services together along with social care in order to manage boundaries between the services. The provision continues to be driven by the service. It allows multiagency meetings for all individuals diagnosed with MND in the local integrated care system.

Team working consisted of a consultant neurologist, community speech and language therapist (SALT), dietician, neuro-rehabilitation team as well as on site staff (consultant palliative care physician, MND coordinator, nursing and AHP professional). Immediate referral of all patients to the service at the point of diagnosis was available. Every patient with MND registered with a Bradford GP, was able to access palliative care from diagnosis (in line with NICE guidance) and had a minimum of 3 monthly monitoring, meeting the NICE requirement for 3 monthly respiratory testing.

Patients were seen in a one-stop clinic, which meant they tell their story only once to reduce time and effort. This was more efficient and productive for staff and patients. If, when patients were no longer able to attend clinic, the service had access to extend support to them in the community.

We saw evidence of this initiative enabling care provision to be provided in a smooth and joined up way without patients having to struggle to navigate systems. The service was aware that some patients were missing out on this support due to geographical location. The service was taking a lead on working with the Integrated Care Board (ICB) locally to consider funding for this service to ensure equal access for all.

Through partnership with services in Calderdale the service had secured access to psychology resources specifically to support patients with MND. The service had identified a pocket of unmet need in another local area and had commenced work with commissioners and the national MND Association to work towards equitable access to care.

We spoke with a patient and their relatives on the day of inspection. Feedback was overwhelmingly positive, they felt supported and cared for by the multi-disciplinary team.

Patients had access to an advanced Parkinson's syndrome monthly outpatient clinic. The service had a funding agreement and SLA in place with the local acute NHS trust. The clinics alternated monthly. The clinic was supported by a specialist Parkinson's nurse from the local acute NHS trust for advice and support. The clinic was adapted in response to patient need to hold both a face-to-face clinic in the hospice, but also a 'home visit clinic' for those patients on the caseload who are no longer well enough to attend clinic.

A neuro-dance group meet at the hospice on a weekly basis, providing peer to peer support, social interaction, and exercise, promoting independence and maintenance of current abilities, in a friendly, supportive, positive, and purpose-built environment.

The service had systems to help care for patients in need of additional support or specialist intervention. The service offered an anaemia/ transfusion service. Funding was currently under review with commissioners to provide a wrap around service. The service had specialist equipment (phlebotomy chairs available). Patients who attended other clinics (in patient or outpatient) could access this service relieving pressure on external services within the community.

The service had a multifaith chapel and patients had access to multifaith chaplaincy services. Patient's spiritual needs were explored during the admission process and during their stay and were recorded. There was a dedicated spiritual liaison lead and wellbeing champion who was available to support patients, family and staff emotionally and spiritually.

The spiritual lead facilitated and supported 4 events a year to support and promote spiritual healing. For example, families who had lost a family member were encouraged to attend the unit to participate in group work. The most recent event had encouraged visitors to plant tulip bulbs by way of remembrance of their loved one. Children were encouraged to attend this event and participate.

There was a separate multifaith prayer room available for both patients and staff.

Breakout rooms were available for staff for quiet reflection and break times. Staff were aware of the wellbeing champion and how they could offer support. There was clear focus on what the role of the wellbeing champion could offer to staff, this included:

- to ensure the hospice maintains a focus on wellbeing initiatives

- to be a contact point for staff who may be struggling
- to promote the importance of staff wellbeing
- to gather and disseminate resources relating to wellbeing
- establish staff expectations and needs to maintain and improve staff wellbeing.
- promote awareness of the wellbeing strategy within teams and the whole hospice.
- promote awareness events such as mental health awareness week
- signpost staff struggling to maintain their mental wellbeing and assist in sourcing solutions

The spiritual liaison lead was completing resilience-based supervision training, joining other resilience-based supervisors in the service. This was a confidential service for support and wellbeing. The service was confidential and staff were aware conversations were confidential.

The lead was also working to develop support for members of the Muslim community. Offering open access to the multi faith chapel, informing members of the local community what the service could provide to make Marie Curie more visible and share the work within the local community settings.

The lead was also working with a local 'womenszone group' which was a Muslim organisation working from a local community centre in a low socio-economic area. The service was looking to instigate a bereavement group within the community. It was a monthly group designed to create a safe space for discussion around grief and loss. It is also a safety net allowing for confidential discussions around wellbeing and an access route to community counselling via referral.

The spiritual care lead and bereavement coordinator were providing peer to peer bereavement training to help the group transition into independently running bereavement support. The service was also providing an educational workshop about palliative care and resources to support community palliative care engagement.

The spiritual care lead, alongside members of the patient and family support team supported families and carers with after death meetings. This was to assist with the legal framework surrounding after death, emotional support and financial steps they would need to take.

The service worked with an Islamic charity and funeral directors in the local area who offer advice and support to integrate with the local Muslim community to ensure services are culturally appropriate and accessible to all. They complete regular visits to the hospice to understand more about what the service offer. Both parties had discussed culturally sensitive end of life care including prayer room, accommodating large visiting groups, halal meals and interpreter services with the aim of educating and informing the local Muslim community to reduce perceived barriers to access hospice care.

The service worked with local businesses to encourage charitable funding to encourage acceptance of the hospice by the influential people within the Muslim community.

Meeting people's individual needs

People's individual needs and preferences were central to the planning and delivery of tailored services. The service was inclusive and took account of patients' individual needs and preferences. They coordinated care with other services and providers.

There was a strong visible person-centred culture with staff delivering exceptional and personalised emotional care. Services were tailored to meet the needs of individuals and delivered in a way to ensure differing options, choice and continuity of care.

Outstanding ☆

Hospice services for adults

Staff supported patients, families and carers living with complex health care needs. The service was able to provide the necessary care to meet all of their needs. Each care record we reviewed demonstrated an overview of the individual needs and preferences of patients and family members. We saw evidence of social needs, physical health needs, communication aids and adjustments.

There was clear evidence of family involvement. For example, one care record demonstrated the service had allowed a child to visit after school during the week. The service did not usually allow children to visit without adult supervision under the age of 16. Some family members were unable to visit Monday to Friday due to work/school commitments. Staff arranged for the eldest sibling to visit after school, which was local to the service. Risk assessments were completed, and staff supported the after school visits.

We heard an example of how staff had worked with a family prior to the patient's death to consider how best to support an autistic family member following the death.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. For example, there was a hearing loop system installed in differing areas of the unit.

The service had information leaflets available in languages spoken by the patients and local community. Signage was clear on site and was in differing local languages.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

The service had clear visiting arrangements which were in accordance with patient's physical and emotional needs.

Information leaflets were available for patient's offering advice on what to expect at the end of someone's life for patients, family, friends and carers.

There was a dedicated children and young person's coordinator. The service offered therapeutic therapy and 1:1 wrap around family support. Referral criteria was for any child or young person with contact with an inpatient or community family member known to the service. The service was currently supporting 12 families. Assessment was undertaken to evaluate children and young person's individual needs. Primary needs are reviewed to support individual bereavement needs and activities planned. There was a dedicated bereavement suite for families with a separate play/therapy room for children and young people. The therapy play room had immediate access to the magical garden.

The service had introduced a garden called the magical garden. The maintenance team and the patient and family support team had worked together closely on this project which took 2 years of planning. The team consulted with children during the planning stages and used this feedback to design a bespoke garden area. Visiting children had been encouraged to draw things they wished to see in the hospice garden.

The primary function of the garden was to support children who may have experienced bereavement, or who may be spending time with a poorly relative in the hospice. Staff told us it created opportunities to open up conversations around difficult topics like coping with loss, and feelings around death and dying. There was a dedicated children's and young person's counsellor available for support to assist and better understand children and young people's needs. This service was funded by the hospice.

An accompanying magical garden workbook had also been created for children to use either when they come to the hospice or in their own garden or in a park with their families. The workbook acted as a guide and prompt for parents but was also something the child could complete independently and then show their family members. The workbook was full of ideas and activities to explore feelings which are all focused on the theme of the garden (e.g., the life cycle of a flower, animals in the garden, seasons etc).

Staff told us the service had introduced the Oscar bear initiative. This was available for any child or young person with an inpatient or community family member known to the service. Oscar the bear was offered to children and young people to enable them to maintain connections during the end of life process and after the death of a loved one. Oscar can help children talk about their feelings, support attachment difficulties, and help with sleep. He can go out and about with the child, so they are never far away from their special person. An additional Oscar bear is frequently given to the patient also, so children feel they have a constant connection to that person.

The service networked with differing faith leaders across the local area creating a religious leaders contact list. This includes representatives from Buddhist, Hindu, Muslim, Sikh, Roman Catholic, Church of England, Christian Science, and other Christian Denominations (Quaker, Jehovah Witness, Baptist.) The spiritual care lead kept this list up to date.

Individual patient's spiritual needs were checked as part of their initial patient and family support team assessment, and if they identified as having a religious need the service would offer to contact a faith leader. The service had also called upon support from Bradford Cathedral with requests for weddings and blessings, this was in addition to the support the service give for civil services from Bradford registrar's office.

As well as a spiritual care lead the service had a volunteer chaplain who offered support as needed. The service was currently exploring developing the volunteer chaplaincy team further and had interviews scheduled in January 2024.

There were 37 companion volunteers currently supporting the service, with more currently going through onboarding. The service provided a companion at home service. This was managed by a designated coordinator based at the hospice. Most referrals to the companion at home service were through healthcare professionals. The service was non-clinical, each client was risk assessed, and the coordinator ensured that working smoke alarms were in place in the home before volunteers were allowed to visit. Additional checks included who lives at the property and who visits on a frequent basis, what animals were in the home and if anyone smokes.

Once a volunteer was matched with a service user the coordinator attended an introduction visit with the volunteer at the service user's home. This was to ensure that the volunteer was aware where they were going and who they were meeting.

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. The service had developed innovative ways to improve the access people had to the service.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The service continuously monitored patient outcome data; for example, they collated patient length of stay, number of patients treated, incidents and audit results. In December 2023, the inpatient unit had 13 admissions, the average length of stay was 17 days. Average length of stay was variable depending on complexity and comorbidities of patients. Staff told us the unit was not an outlier.

Hospice services for adults

The service had a hospice services access and discharge policy which was next due for review July 2026.

There was a daily bed meeting at 08.30am. Bed meetings were attended by a multidisciplinary team. The service discussed bed availability at this meeting. Referrals were sent to the hospice via email or in urgent cases by telephone. Patients were referred from the local acute NHS hospital trust, GP's, registered nurses, MacMillan nurses, palliative care teams, day hospice consultants and community hubs. Priority was given to patients with complex clinical needs dependant on bed availability. Senior leaders informed us there were no incidents relating to bed availability. If the service had no bed availability, then the REACT service would intervene and manage the patient until a bed became available.

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

The service offered a hospital admission avoidance service. The REACT model was unique to Marie Curie Hospice (Yorkshire). REACT is an innovative collaboration between Marie Curie and Bradford Teaching Hospitals Foundation Trust (BTHFT) and community providers of palliative care across Bradford. The service model had been developed in recognition of local challenges, from unwarranted clinical variation, health inequalities and system pressures. As part of this service 4 virtual beds were offered, under the care of a medical practitioner. This was in addition to admission to the REACT caseload. Care was extended to family, friends and carers during a patient's stay and carried on into bereavement. The emphasis of care was community focused, enabling patients to be cared for and die at home.

The service aimed to provide high quality, well-coordinated, flexible and responsive palliative care and advice in the community at short notice. The service was able to provide care for patients in their usual place of residence, whose needs can be met by rapid, short-term intervention in the palliative phase of their illness.

The model was a three-year funded project commissioned by the local NHS trust in October 2022 and was due to end May 2025. The model was commenced to evidence how the service could prevent patient admission into hospital and care for patients at home. Staff monitored the number of patients who received this. The service was reviewing a business case to seek funding to continue with this service.

The team consisted of a clinical nurse manager, an advanced clinical nurse specialist (CNS), 3 additional CNS practitioners, 4 RGN, 4 healthcare assistants, 1 senior physiotherapist who was the falls lead for the service and 3 speciality doctors. The service had managed 58 referrals in December 2023. An advanced clinical nurse specialist (CNS) working in the REACT team supported medical staff as a non-medical prescriber (NMP).

The access to this network of specialists within palliative care demonstrated collaborative working. Palliative care patients in the final year of life both in the community and inpatients had access to a dedicated gold line telephone advice service. This unique service was first instigated by Airedale General Hospital NHS trust. The call hub was staffed by experienced registered palliative care nurses. Patients could use the service to ask questions, support and advice when in crisis. District nurses routinely referred patients at end of life and signpost patients to this service.

The service also offered a hospice care at home service. This hospice care at home service is a community-based service managed by the hospice. From expert nursing and personal care to emotional or bereavement support, hospice care at home provides expert, hands-on care to anyone with an illness they're likely to die from, and those close to them, in the comfort of their own home.

Healthcare assistants and registered nurses managed patient symptoms providing vital emotional and practical support. Patients were predominantly referred into the service by the district nursing service.

The hospice care at home service was managed by the deputy head of operations and was divided into 3 communities based on contract specification and geography. Each of the 3 communities had band 7 clinical nurse managers (CMN). Each CNM had a small team of band 6 senior registered nurses (RGN's) who supported the CNM with caseload management, supervision and line management of the community RGN's and HCA's.

The service contracted across Marie Curie regionally are of 3 different types:

Planned Variable: A set number of contracted hours are delivered over the year and were responsive to the needs of the patients on the caseload and the staff rostered to work. Staff support patients in their own home overnight 10pm to 7am.

Planned Guaranteed: A set number of night shifts must be delivered each day. Staff support patients in their own home overnight 10pm to 7am. Staff are rostered to work every night.

Rapid Response: The end of life multi visit domiciliary care service provided a locally coordinated fast track service for patients in the last 12 weeks of life. (This service was terminated in Bradford in June 2023 as covered by the REACT model)

All staff have a work travel radius of 25 miles from home. Gaps in rota's were managed by moving staff across service boundaries within their milage or if agreed in advance with the individual by extending milage range slightly. The planned guaranteed and rapid response services were prioritised.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns.

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

Staff understood the policy on complaints and knew how to handle them. The service aimed to respond to formal complaints within 20 working days. If this is not possible, a revised timeframe was agreed with the complainant.

Managers investigated complaints and identified themes. We reviewed 3 complaint responses and found the concerns raised were thoroughly investigated. Service users and families were involved in investigation, responses from the provider were timely, and final response letters were written sensitively.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We heard all complaints would be investigated and a rapid review carried out and managers would speak to all staff, patients and those close to them.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff told us they felt there had been a shift from a blame culture to a learning culture.

Outstanding ☆

Hospice services for adults

Staff could give examples of how they used patient feedback to improve daily practice. For example, staff had introduced the use of passive infrared falls sensors following a patient fall. Sensors were readily available and used as part of ongoing falls risk assessment falls management.

Is the service well-led?

Outstanding ☆

Leadership

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

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

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

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

At corporate level for 2023-2024 financial year the service set 5 metrics against which they would measure work. Workstreams included equality, diversity and inclusion, absence reduction, diversity of leavers (within 12 months) and new recruits, customer satisfaction and volunteering volumes. The metric review would assist the service corporately to review recruitment, attraction and retention strategies.

At local level the service was led by a senior leadership team which consisted of a head of nursing and quality (CQC Registered Manager) interim head of operations, interim associate director, deputy head of operations, medical director, fundraising integration lead, deputy head of quality and governance, head of facilities, OPU manager, patient and family support team manager, IPU manager, React manager, clinical nurse managers.

Staff and patient's, we spoke to told us that the leadership team were visible and approachable within the service, and they felt comfortable to raise concerns. Staff within the community teams working as lone workers and at night told us there was always a member of the senior leadership team available through the on-call system.

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

Outstanding ☆

Hospice services for adults

Vision and Strategy

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

The service's vision statement was 'Everyone will be affected by dying, death and bereavement. That cannot be changed; but the end-of-life experience can. Everyone deserves the best possible care and support, reflecting what's most important to them. We want a better end of life for all'.

The service had a North East and Yorkshire 5 year place based strategic plan. This was designed to map the course of future growth and success. The service had recently completed a summary of the 5 year strategy and vision bringing in all elements of what and how the plan would work at local level. This was to ensure that staff understood the strategy and vision.

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

The strategy included transforming direct care and support, delivering more practical information and support and leading in shaping the end of life system. Each priority included clear actions on how the service intended to address this.

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

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

Culture

There was a strong organisational commitment of equality and inclusion across the service. Staff were proud to work for the service and felt truly respected, supported, and valued. There was strong collaboration and team-working across the organisation, and all were focused on the needs of patients receiving care. The service encouraged openness and proactively developed a culture where patients, their families and staff could raise concerns without fear.

Staff mandatory training included equality, diversity, and human rights training. Training compliance for both on site and community staff was 100% against a target compliance rate of 95%

All staff we spoke with told us they felt valued and respected. Staff expressed how much they enjoyed working for the organisation. The staff survey results (March 2023) showed staff were proud to work at the organisation. Staff told us

they felt well supported. We heard examples of how the wellbeing of staff was supported, for example, through resilience sessions, debrief sessions and regular one to one session's with line managers. There were several wellbeing champions onsite offering wellbeing and extra support or advice to staff as needed. All staff and leaders we spoke to recognised that the work could impact individuals in different ways.

Staff were encouraged to speak up and discuss concerns with 'speak up champions'. Staff told us they felt supported if and when they raised concerns with senior leaders.

Staff told us there is a communications book which staff can use, and this works well. There is also a comment/ suggestions box outside the ward managers office that staff can use. The ward manager ensures that the feedback from comments/suggestions is included in the ward team meeting, the feedback includes if actions have been taken and what they are or an explanation as to why if the suggestion could not be taken forward or implemented.

The service offered a free and confidential employee assistance programme. The programme offered unlimited access to advice, information, coaching and counselling where appropriate. The service was available 24 hours a day, 365 days a year. Support was offered by telephone, on line and face to face.

Senior leaders told us the service had a team Yorkshire wellbeing and resilience framework in place. The goal of the framework is to contribute to and improve the health, safety and wellbeing of Marie Curie staff and to prevent work-related ill-health to benefit individual staff and the charity.

The framework includes the physical, mental, spiritual and social health of staff and recognises that employees' values, personal development and work contribute to their overall wellbeing and resilience at work, and beyond.

We saw evidence to support that the service had a wellbeing and resilience framework. The wellbeing and resilience framework aimed to support the charities vision, mission and values and recognition that staff are its greatest asset.

The service's corporate equality, diversity and inclusion (EDI) lead was proactively driving internal research around the impact of EDI on recruitment and retention. In the first phase the service intends to run a series of anti-racism workshops organisation wide.

The EDI strategic lead intends to use feedback from specialised forum groups to learn and proactively pursue dignity and fairness in the workplace. The service promotes a culture which celebrates diversity, acceptance, and inclusion. It provides an environment where LGBTQ+ people feel acknowledged, welcome, and safe.

Staff were supported and encouraged to be part of the wider staff LGBTQ+ network making links across the national organisation. The service actively monitored demographics in line with 'If we're not counted, we don't count' project to ensure the service serve as many people from the community. The service has all gender facilities to make people from all gender identities and background feel safe and welcome. This was developed in partnership with members of the LGBTQ+ community and local LGBTQ+ organisations.

The wording of the services literature (Men's shed and Ladybirds information for example is inclusive of non-binary and trans individuals. As a wider organisation, Marie Curie has a rainbow badge scheme and was one of the first palliative care organisations to introduce it, this helps reduce disclosure anxiety and anticipatory discrimination.

The IPU consultant was involved in ongoing research around what is missing from the current literature for LGBTQ+ people. The service was actively involved with Hospice UKs project 'I just want to be me' to improve the lives of trans and gender diverse patients, this is entering phase II. The IPU consultant continues to be a part of the work along with some members from the Marie Curie central team.

The service had installed a pride walkway at the entrance to the main building. The service had placed a wall plaque stating: Marie Curie is proud to support the LGBTQ+ community. We promote a culture which celebrates diversity, acceptance and inclusion. We provide an environment where LGBTQ+ people feel acknowledged, welcome and safe. Staff told us they felt proud to support this statement.

Launched in February 2022, a weekly staff newsletter spanning the 'Yorkshire place' has consistently been produced. The newsletter has evolved significantly over the last 2 years, with regular content including safety updates, examples of good practice, good news stories, survey and audit results, joiners and leavers. Staff are encouraged to share items they would like to include.

The service instigated a monthly team player award. Staff had the opportunity to vote for staff who they felt deserved recognition. We saw the award poster on display. Staff told us they took great pride in their work and recognised the importance of positive feedback for all staff.

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 governance structures, processes and systems of accountability and a clear governance framework to support the delivery of the strategy and vision.

The senior leadership team were accountable to the board of trustees. Service leads reported to the board of trustees through board papers, including a regular care service report. Quarterly board agenda items included progress reports against the strategy, minutes of committee meetings, risk management, policy ratification, safeguarding and the quality of services.

The service held a quarterly integrated performance meeting as well as monthly/quarterly place-based meetings to address for example but limited to clinical effectiveness, incident and risk, infection control, finance, estates, serious incidents and other organisational issues at a local level.

The service had moved into a place-based model of care with support from the central corporate quality team. The rationale of place-based systems of care is to bring services together around the population they serve. The inpatient unit and the community teams used the same governance structures and held joint meetings. Staff told us the model of care was more integrated. The joint meetings ensured a clear oversight of the two services.

Agreed terms of reference were in place which includes details on purpose, membership, chair, secretary, quoracy, frequency, duration, aims, and reporting. An annual self-assessment of effectiveness is undertaken in quarter 4, with a review of the terms of reference.

We reviewed the Marie Curie quality account 2022/2023 which reflected the three quality priorities are:

- patient safety, improving and increasing the safety of care and the services we provide
- patient, carer and staff experience, ensuring that people are treated with compassion, dignity and respect, and that services are person-centred and respond to people's individual needs
- clinical effectiveness, making sure that the care and treatment provided achieve good outcomes, promote a good quality of life, and are based on the best available evidence

In March 2023 senior members of the national corporate team completed a quality site visit. The visit was undertaken by the deputy director of quality and nursing (DDQN), associate director of nursing and quality (ADNQ) and a quality improvement facilitator (QIF). A report was submitted to the board. This showed key findings evidencing suggestions to consider and good practice. Good practice examples listed but not limited to were:

- the leadership team are seen to be visible within the hospice
- all training is recorded on the Learning and Development system. Competencies are completed on paper and then scanned into the record with the original document given to the member of staff for their own record
- staff spoke positively about equality, identifying measures undertaken to ensure that rota requests were considered fairly, and in a way that supported people to undertake carer responsibilities
- the senior leadership team have clear SLAs in place with the local ICBs and commissioning teams and showed evidence of working with commissioners to ensure SLAs are reflective of services delivered. Commissioner meetings are held every 3 months where evidence of activity and quality are shared via reports
- there is a good structure in place to address all governance related topics and issues. The meetings are well attended which is evidenced by the minutes and the terms of reference (TOR) are in date

Recommendations for consideration examples listed but not limited to were:

- it may be helpful for the Senior leadership team to articulate the reasons why they need to attend specific meetings
- consider how community staff could be felt to be more included, by the senior

  leadership team

- review staffs understanding of place-based working
- review the content of the notice boards in the hospice to ensure that the material

  presented is accessible to the intended audience

We were assured by senior leaders that recommendations had been actioned.

We reviewed the meeting minutes for the contract review meeting minutes completed in October 2023. The provider held 3 monthly contract review meetings with North Yorkshire commissioners. There was a set agenda and evidence of quality reports showing for example but not limited to never events, duty of candour, serious incidents, staff training compliance, appraisal/sickness levels, RESPeCT process and complaints.

Management of risk, issues and performance

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

The service had a business continuity plan with actions, roles and responsibilities for managers to refer to.

There was an electronic incident reporting system in place.

The service had a board assurance framework which was in date with a review date of October 2026. This clearly demonstrated annual and non-regulatory items for example but not limited to safeguarding (annual report and policy review), annual health and safety report and infection prevention annual report.

The service had a risk register which demonstrated appropriate identification and recording of risks associated with clinical areas and corporate issues across Marie Curie (Yorkshire and Marie Curie (North East). The risk register evidenced clear ownership of mitigating actions and dates that risk registers were reviewed.

The service had a risk policy in place which was in date with a review date of December 2026.

Senior managers clarified the top three risks relevant to the service locally. These included the REACT model (financial modelling and sustainability), medical honorary contracts which were due to be reviewed with the local NHS trust and site security due to the recent instigation of the pride walkway and security due to site location.

We reviewed the incident and risk monthly meeting minutes (December 2023). Clear objectives of the meeting were evident.

The service had commenced using the Patient Safety Incident Response Framework (PSIRF). The PSIRF policy supported the requirement of PSIRF & the Marie Curie approach to developing, maintaining, effective, compassionate systems and processes. One of the principles of the PSIRF is to do fewer “investigations” but to do them better. Better means taking the time to conduct systems-based investigations by people that have been trained to do them.

Local training had been rolled out incorporating the Health Safety Investigation Branch (HSIB). Investigations included a rapid review (timeframe 2 days), Concise (timeframe 30 days) and comprehensive (timeframe 60 days). Quality improvement (QI) priorities relating to PSIRF review included pressure damage/ patient falls & medication Incidents. Action plans were planned to be monitored via governance groups.

The service had a lone working policy, lone working procedures had been enacted and the “buddy system/safe system of working” had been stress tested. Lone working risk assessments were completed by staff to ensure personal safety in the community setting.

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.

Data protection training compliance for both on site and community staff was 96.1% against a target compliance rate of 95%.

The service used secure systems and stored records according to guidance. We saw evidence of audit demonstrating records were accessed for the intended purposes only.

We saw that data had been collected and analysed, for example, through the staff survey and through incident reporting.

Outstanding ☆

Hospice services for adults

Engagement

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

The service was proactive in improving staff health and wellbeing. For example, the service had in place a wellbeing and resilience framework. The wellbeing and resilience framework aims were to support the charities vision, mission and values and recognition that staff are its greatest asset.

Managers carried out periodic staff surveys, which staff completed anonymously via an online platform. In the most recent survey (March 2023), 27 responses were received, which equated to 55%. The provider developed an action plan and gave specific examples of changes made in response to staff feedback. The overall engagement score was 8.2 which was above the benchmark of 7.8 evidencing engagement levels were above average.

The registered manager completed a monthly summary of news and events at the hospice, which was posted on the intranet and e-mailed to all staff.

Staff and service users were encouraged to contribute ideas to make service improvements.

At the time of inspection, we heard the service was engaging with service users and working on building relationships with harder to reach groups through the outpatient unit to continually understand changing local needs.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

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

The service work closely with Children North East (charity) to undertake the first piece of poverty proofing in a hospice service. This included audit, education and research to ensure that people living in poverty have equal access to services. Children North East deliver services, support and initiatives that provide a platform for children, young people and families to work through issues, take action and provide them with the tools to reach their full potential. These included therapeutic services, mental health support, youth work, family support, domestic abuse services, community-based support, consultations with young people and Poverty Proofing.

The hospice was involved in the West Yorkshire Hospice collaborative. This is attended by the services head of operations and hospice collaborative, consisting of all 10 hospices in West Yorkshire. The collaborative was formed in response to COVID 19 in a bid to ensure the hospices had visibility and a voice. The members continue to meet, with the shared objective of sustainability to enhance quality for patients and their loved ones. The collaborative was awarded provider collaborative status by the Integrated Care Board (ICB) and members have a seat at the system leadership executive group. Current work is looking at sustainable commissioning models and distribution of funding and needs assessment/integrated pathways in partnership with the ICB.

Outstanding ☆

Hospice services for adults

The 15 Step challenge was completed in October 2023. This provided the service with an opportunity to listen further to patients, carers, and visitors, to understand their first impressions of the hospice environment through their eyes. It was a collaborative process to hear their thoughts by providing the opportunity to listen, share ideas, and to identify improvements that can be made to enhance the patient family, carer or visitors experience. An action plan was ongoing, and progress was being monitored.

One of the specialty doctors in the services developed an e-learning induction package for junior doctors which has been used nationally by other Marie Curie hospices, not replacing face to face induction, but reducing duplication, increasing consistency, and allowing staff to focus their time face to face on individual's specific needs.

Another speciality doctor worked closely with University of Cambridge / The University of Manchester/ University of East Anglia to convert a paper-based carer support needs assessment tool (CSNAT -1) into an electronic template, this tool is embedded in many teams' templates (inpatient, outpatient, Patient and Family Support Team and AHP teams). This tool is used nationally and CSNAT creators can distribute the template to new users across the UK.

The hospice participated in research studies. We saw examples of differing research programmes which included research in MND study, advanced clinical nurse practice and Men's Shed (The role of the Men's Shed in a hospice day service).

An anaemia assessment clinic is currently underway as an outpatient clinic. This project is ongoing. Patients receive anaemia assessment from the community with palliative care needs, following palliative care criteria for blood transfusion or iron infusion. It takes referrals from GPs or community palliative care teams, and occasionally from hospital teams. The project was developed following recommendations from an audit undertaken by a specialty registrar based on guidelines for anaemia management in hospices regionally.