St Richard's Hospice Quality Assurance Report 2025-2026

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1.0 Introduction

St Richard's Hospice was established in 1984 and cares for people registered with a South Worcestershire GP. Our In-Patient Unit also cares for patients from the north of the county.

The Clinical Governance and Strategy Committee has been established by the Board of Trustees to ensure the highest standards of care and to provide evidence of compliance with the Care Quality Commission (CQC) and the Integrated Care Board (ICB).

The Clinical Governance and Strategy Committee aims to safeguard and maintain high standards of clinical care by ensuring that systems and processes are in place to continually evaluate outcomes and standards of clinical care. It actively supports the ethos of learning and supportive culture that enables clinical staff to provide high standards of compassionate and dignified care to patients and their families.

1.1 Summary of key findings

St Richard's undertook a significant transformation programme of its clinical services from late 2024 to early 2025. Throughout the entire process quality and assurance have remained a priority, and you will see an improvement in our data capability. As a result of our redesign of clinical services and subsequent development of new processes and recruitment to new roles, we have seen a temporary reduction in the number of people cared for by our services this year. We have already started to see an upturn in these numbers, and we anticipate that this will continue as our new services have been designed to reach and support more patients and their families across Worcestershire

This report meets all the requirements set out in the quality schedule.

1.2 Summary of St Richards Hospice

St Richard's Hospice offers free, expert care and support for adults with an illness that cannot be cured, their loved ones and carers.

1.3 Key clinical achievements

Electronic patient record upgrade

During 2025/26 we have continued to develop our utilisation of the electronic patient record system to take advantage of greater functionality and reporting. This has enabled us to code more accurately and create greater consistency across all our clinical services. We are now able to report on outcome measures for In-Patient services and for Living Well to demonstrate the positive impact of our care. We have established the use of new visualisation dashboards to help clinical staff to navigate the patient record efficiently and

for quality processes such as learning from deaths. St Richard's presented this at Hospice UK conference in 2025, and other hospices are reaching out to us as leaders in this new functionality.

The hospice continues to make use of the Shared Care Record functionality and teams highly value access to timely up to date information about patients under their care.

Service Redesign

The programme of work to transform services continued throughout this year with a focus on

- Improving equity of access
- Enhancing quality care
- Meeting future needs and demands
- Achieving sustainability

In-Patient Unit

A new digitally supported triage and referral system has been launched and is being utilised to support objective decision making on admissions - it has made the process more streamlined and therefore timelier.

New nursing leadership structure has embedded and is supporting the day to day running of the unit as well as delivering several impactful quality improvement projects.

There has been successful recruitment of nursing staff to support the new model of care. Recruitment did take longer than anticipated and we finished the year having recruited to all vacant posts although some staff were yet to be onboarded.

Family Support

A new digitally supported referral system has been successfully launched making it easier for professionals and clients to refer via our website.

The bereavement advice line has been running for most of the year and has evaluated well; people feel it is responsive and helpful.

Hospice at Home

A new cluster structure has been launched in this year and is enabling a timely and supportive response to patients who are referred. This year has been challenging to recruit fully to the new structure, but this has now been achieved for Senior Staff Nurses and Clinical Nurse Specialists. Several new processes have been launched to enable efficient ways of working.

A poster presentation of the successful introduction of the Psychological Care Facilitator to the team was launched at the Hospice UK conference in the Autumn.

Advice and Guidance

A new digitally supported referral system has been developed and is now ready for launch. This is to further enhance the ability of patients and relatives to self-refer to services and to streamline the process for professionals.

Several new processes have been introduced to improve data capture and reporting.

Living Well

A comprehensive review of the Wellbeing Cafe has been carried out in the last 6 months to ensure that the service develops and continues to meet the needs of patients who can self-refer.

Impact

2737 individuals in total supported across all our services:

	Activity	Number of Individuals
ICS Nursing Team	18,075 contacts via face-to-face, telephone, text, email or digital platforms 2,750 patient home visits	Cared for 608 patients
ICS Advice and Guidance	4,121 contacts via face-to-face, telephone, text, email or digital platforms	973 individuals supported 106 individuals supported with no referral opened (unscheduled contacts and no open referral)
ICS Senior Healthcare Assistants	Carried out 587 face-to-face visits Made 403 telephone call to plan support or provide telephone support	Cared for 131 patients

ICS Psychological Support	Carried out 305 face-to-face visits Made 266 telephone call to plan support or provide telephone support	
In-Patient Unit	237 Admissions	235 patients cared for
Family Support, BSSW & Spiritual Care	13,421 Family Support contacts by telephone/virtual/online 717 visits to patients on the IPU 722 group attendances and 124 sessions 718 patient contacts by Spiritual Care 49 funerals held by Spiritual Care	Family Support and Spiritual Care supported 1244 patients and clients 460 adults and children were supported through BSSW
Living Well	172 Living Well Course sessions (Includes Exercise sessions, Living Well and Wellbeing Sessions) 850 Complementary Therapy Treatments 1798 Physiotherapy activities 523 Occupational Therapy activities	542 patients cared for including Physio, Occupational and Complementary Therapies

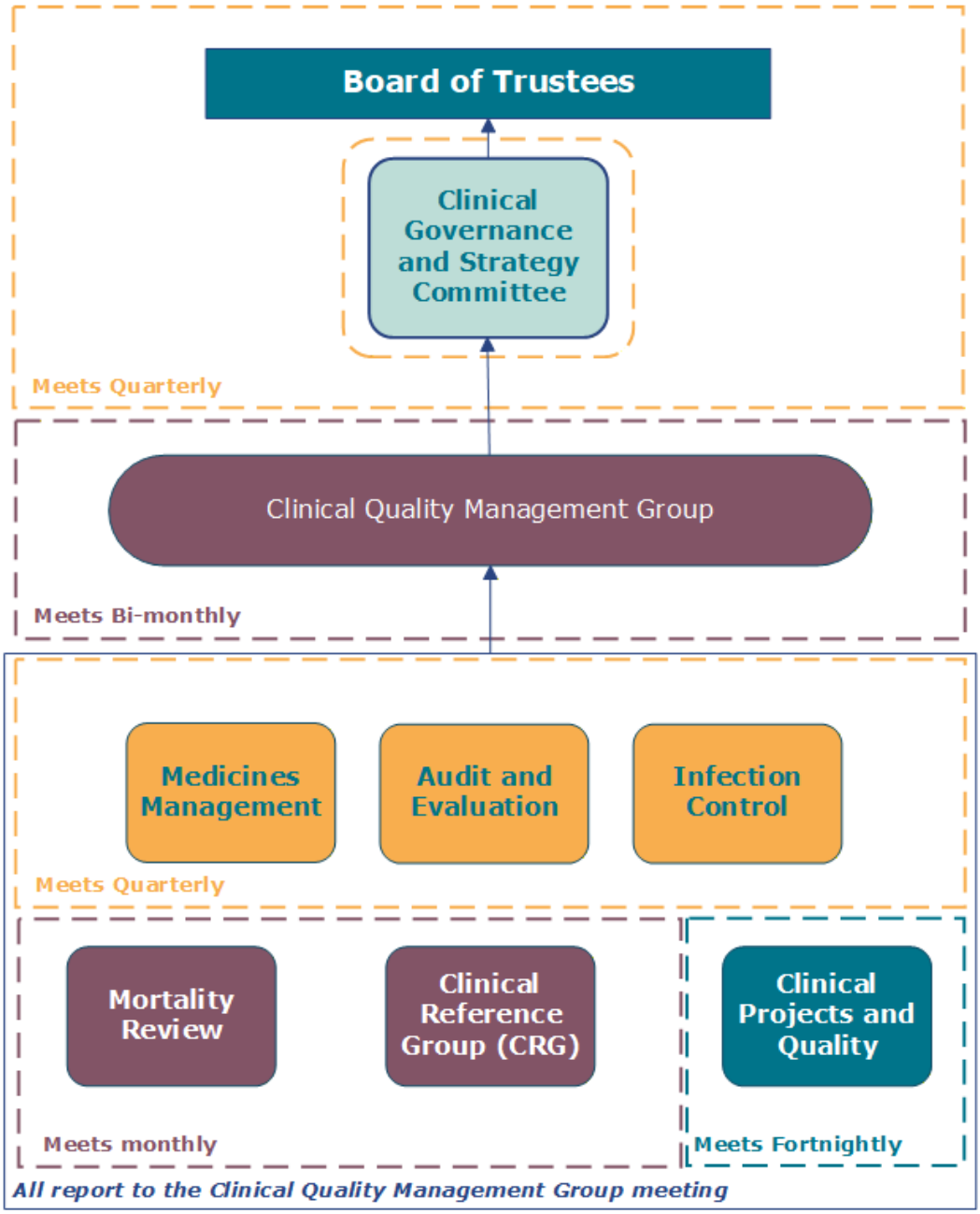
2. Quality Assurance Compliance

2.1 Quality Review Process

Attendance at Clinical Quality and Grant Review Meetings (CQ&GRM) continues and the last meeting was on 8 June 2023.

The submission of the last Hospice Assurance Report to the ICB was on the 5 June 2025.

Internal quality assurance processes, audits, and improvement programs are in place, and an overview of our committee structure is below. Strategic decisions are made by the Board of Trustees in quarterly meetings, delegating operational responsibilities to appropriate standing Committees.



All audits are discussed in relevant meetings and then clear action plans outlined and reviewed within quarterly meetings. Results of audits are shared with teams and within a regular Clinical Governance Newsletter, which all patient/client facing staff receive.

Infection Control Audits completed within this reporting period and discussed at the quarterly Infection Prevention Control meetings have been:

Completed Annually	
• Blood and Body fluids	• Care Equipment
• Healthcare Linen	• Patient Placement
• Safe Disposal of Waste (including sharps)	
Completed Twice a Year	
• Occupational Safety	• Personal Protective Equipment
• Respiratory and Cough Hygiene	
Completed Quarterly	
• Environmental	• Hand Hygiene

Audits and Evaluations completed within this reporting period and discussed at the quarterly Audit and Evaluation meeting:

Completed Every Three Years	
• IPU Admission Clerking	
Completed Every Two Years	
• Notification of Death/Discharge	• Phase of Illness Audit
• ReSPECT/CPR Recommendations	• Circuit Class Evaluation
Completed Annually	
• Counselling – Time Limited Work	• Communication and Protected Characteristics
• Discharge Audit	• EMDR Audit
• FST Referral and Advice Line	• Falls Audit
• Mattress Audit	• Mouthcare Audit
• Next of Kin Audit	• Pressure Ulcer Audit
• Safeguarding Audit	• Wellbeing Cafe
• Wellbeing/Workshop Sessions Evaluation	• Mental Capacity Audit
Completed Twice a Year	
• Consent Audit	
Quarterly Audit	

• Service User Evaluations	
Discontinued	
• FST Referral and Bereavement Line	• Social Drop in Evaluation
• Audit of Unscheduled Contacts	• Lasting Power of Attorney

Audits completed within this reporting period and discussed at the quarterly Medicines Management meeting:

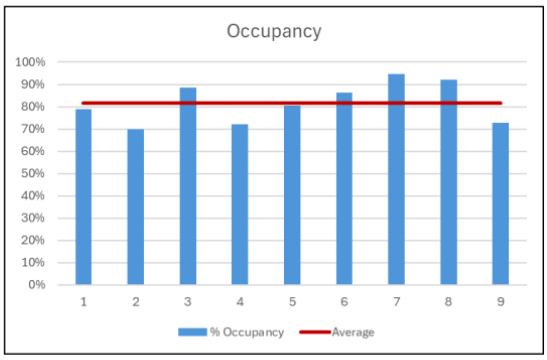
Completed Every Three Years	
• Medicines Administration Audit	• Opioid Toxicity Monitoring
Completed Every Two Years	
• Oxygen Audit	
Completed Annually	
• Anti-Microbial and Antibiotic Stewardship	• Audit of Prescription Stationary
• Blood Transfusions	• Controlled Drugs Self-Assessment
• CQUIMM	• Critical Medicines Audit
• Diabetes Audit	• Emergency Medicines Audit
• Independent Nurse Prescribing	• Medical Prescribing Audit
• Community Medicines Advice Audit	• Subcutaneous Line Audit
Completed Monthly	
• CDAO Audit	• Medication Fridge Records Audit

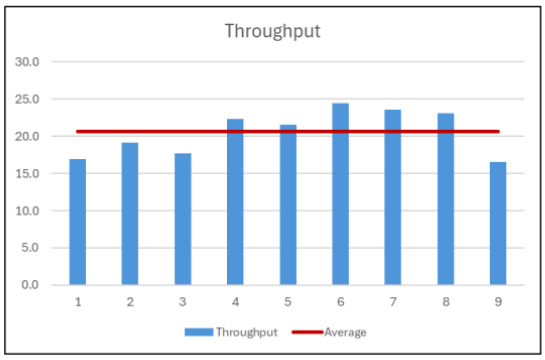
The West Midlands Executive Clinical Leads in Palliative Hospices (Hospice and Palliative Care) have agreed to submit their clinical data each quarter to be benchmarked against other hospices in the region.

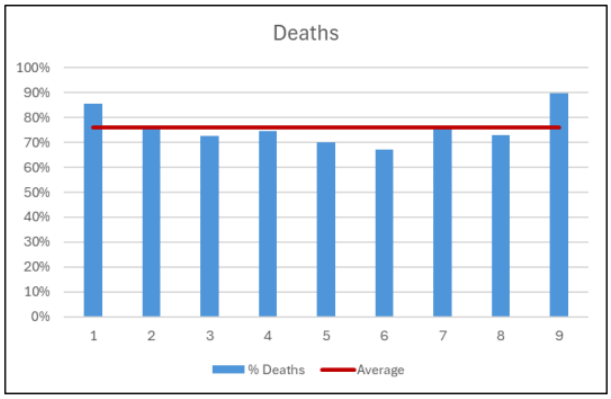
Below are a summary of St Richard's figures and the benchmarking results for Q1 – Q4 for 2025/2026. St Richard's Hospice is number 9.

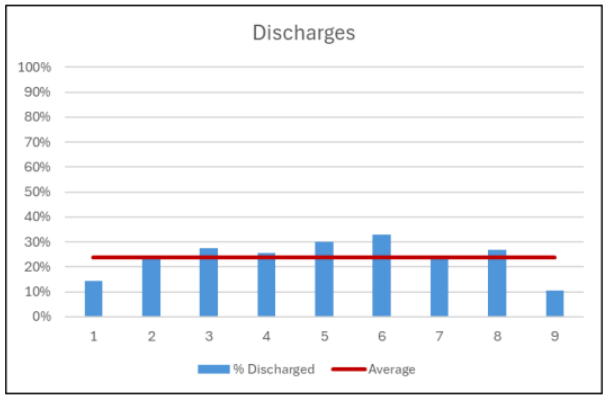
YTD Q1 – Q4

		Bed Data										
Hospice	Quarter	No Beds (Size of Bedded Unit)	Number of Available beds	Available bed days	Occupied bed days	% Occupancy	No of deaths	No of discharges	Total deaths and discharges	% Deaths	% Discharged	Throughput
1	YTD	28	28	9770	7710	78.9%	407	68	475	85.7%	14.3%	17.0
2	YTD	15	15	5475	3826	69.9%	217	70	287	75.6%	24.4%	19.1
3	YTD	16	16	5840	5163	88.4%	206	78	284	72.5%	27.5%	17.8
4	YTD	39	25	9125	6569	72.0%	416	143	559	74.4%	25.6%	22.4
5	YTD	21	15	4775	3839	80.4%	227	97	324	70.1%	29.9%	21.6
6	YTD	19	12	4653	4011	86.2%	197	97	294	67.0%	33.0%	24.5
7	YTD	7	8	2917	2761	94.7%	145	44	189	76.7%	23.3%	23.6
8	YTD	8	9	3192	2936	92.0%	152	56	208	73.1%	26.9%	23.1
9	YTD	14	14	4012	2923	72.9%	208	24	232	89.7%	10.3%	16.6

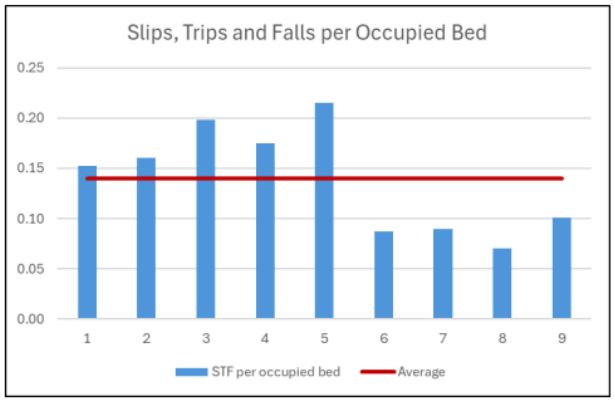


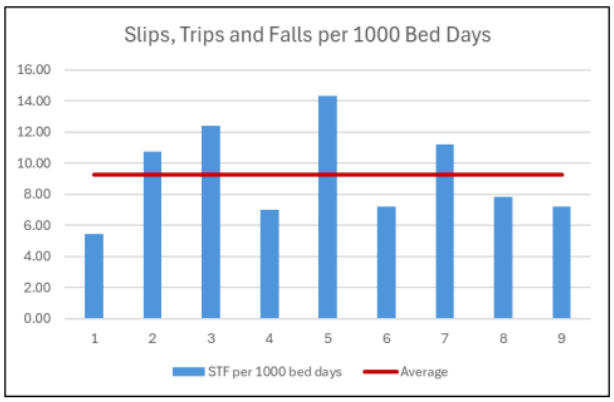




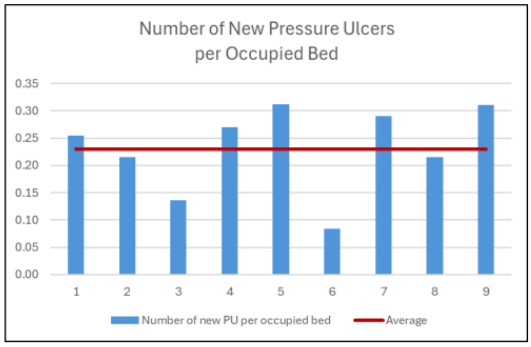


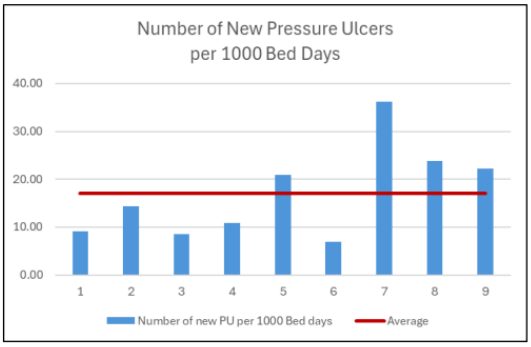
	Slips trips and falls				
Hospice	All Slips Trips & Falls	STF per occupied bed	STF per 1000 bed days	Severe Harm (Level 4)	Fatal (Level 5)
1	42	0.15	5.45	0	0
2	41	0.16	10.72	0	0
3	64	0.20	12.40	0	0
4	46	0.18	7.00	0	0
5	55	0.21	14.33	0	0
6	29	0.09	7.23	0	0
7	31	0.09	11.23	0	0
8	23	0.07	7.83	0	0
9	21	0.10	7.18	0	0



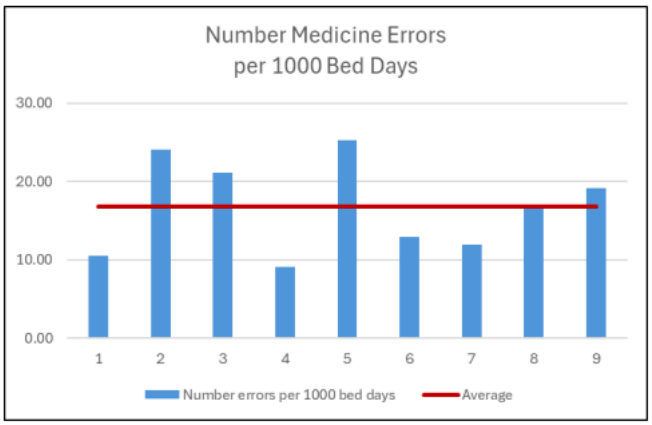


		Pressure Ulcers															
Hospice	Quarter	PUoA Cat 2	PUoA Cat 3	PUoA Cat 4	PUoA DTI	PUoA Unstageable	Total PU on Admission	NEW Cat 2	NEW Cat 3	NEW Cat 4	NEW Medical Device Associate	NEW DTI	NEW Unstageable	Number of patients with new PU	NEW Total PU	Number of new PU per occupied bed	Number of new PU per 1000 Bed days
1	YTD	74	7	3	41	61	186	27	0	0	1	28	14	53	70.0	0.25	9.08
2	YTD	39	3	2	33	17	94	21	0	0	0	28	6	33	55.0	0.22	14.38
3	YTD	32	8	3	15	4	62	25	7	1	0	11	0	38	44.0	0.14	8.52
4	YTD	57	21	3	8	6	95	41	2	1	0	22	5	72	71.0	0.27	10.81
5	YTD	70	38	5	0	0	113	54	18	0	8	0	0	52	80.0	0.31	20.84
6	YTD	53	21	0	0	2	76	22	4	0	0	0	2	24	28.0	0.08	6.98
7	YTD	50	6	0	24	8	88	51	3	0	6	32	8	51	100.0	0.29	36.22
8	YTD	32	0	0	31	16	79	20	1	0	0	41	8	38	70.0	0.21	23.84
9	YTD	44	9	3	16	10	82	25	1	0	1	36	2	54	65.0	0.31	22.24





		Medication errors			
Hospice	Quarter	All Medication errors	Level 4 (Severe harm)	Level 5 (Fatal)	Number errors per 1000 bed days
1	YTD	81	0	0	10.51
2	YTD	92	0	0	24.05
3	YTD	109	0	0	21.11
4	YTD	60	0	0	9.13
5	YTD	97	0	0	25.27
6	YTD	52	0	0	12.96
7	YTD	33	0	0	11.95
8	YTD	49	0	0	16.69
9	YTD	56	0	0	19.16



2.2 Care Quality Commission (CQC) Compliance

An unannounced CQC inspection took place on the 18 March 2025 where all five domains were inspected. St Richard's Hospice was awarded outstanding.

There have been no notifications of any issued conditions and action plans during this reporting period.

St Richard's Hospice HTML report for assessment AP10335 - Care Quality Commission

3. Mortality and Preferred Place of Care

3.1 Unexpected Deaths Reporting on the In-Patient Unit

For compliance with Patient Safety Incident Response Framework (PSIRF) - see section 7.1.

There is an established process for reporting any unexpected deaths on our Electronic Patient Record system. In the last year we have recorded one unexpected death which was secondary to an interventional procedure at the Acute Trust and the ensuing complication was a known risk of the procedure, therefore not entirely unexpected. Our reflection is that we have a lower threshold for identifying unexpected deaths than other ICS providers, but we prefer to review deaths in this way for learning purposes.

1	Unexpected Death
29	Expected Death but Sudden
236	Expected Death

3.2 Learning from Death Reviews

We perform monthly multi-disciplinary team Learning from Death Reviews for patients who have died on our In-Patient Unit. Cases are either escalated following identified incidents, complaints or concerns by families or staff, or are randomly selected. Both paper and electronic patient records (using our new dashboard functionality) are reviewed, and a mortality review template is completed to help us identify any themes. See appendix 1.

Within this reporting year, 21 patient Learning from Death Reviews took place. Actions are generated and logged to support learning and improvement.

Themes are outlined below:

What we have done well:

Celebrating best practice — Teams and individuals have been consistently recognised for excellent documentation, compassionate care, and high-quality communication with patients and families.

Embedding SystmOne learning — Insights from the upgrade programme are being actively incorporated into practice, improving usability, data integrity, and use of visualisation tools.

Sharing positive communication examples — Strong examples of written and verbal communication have been shared to reinforce good practice.

Routine discussion of templates and data quality — Regular review has supported more consistent use of templates and improved data quality across services.

What we can improve upon:

Falls processes and care planning — Staff need a simpler, more standardised pre- and post-falls process, along with improved use of falls templates.

Communication with Coroners — Documentation of Coroner discussions need to be clearer and more reliably recorded.

Referral acceptance and late admission processes — Reviews highlighted the need for clearer steps around referral acceptance, late admissions, and transport arrangements.

Use of communication templates — Teams need to consistently complete communication templates for patients with identified communication needs.

MCA assessment reminders — Staff require ongoing reinforcement of when MCA assessments are required.

Accuracy in written correspondence — Some reviews identified the need for improved terminology, clarity, and accuracy in written communication.

Where we are provided with the patient's preferred place of death, we record this in SystmOne and when the patient dies, compare this against their actual place of death.

| Apr - Sep | Actual Place of Death | | |

The staff, students and volunteers are encouraged to talk through any concerns with a Safeguarding Lead, Advocate, their Line Manager or a Social Worker. If the concern is in relation to a patient and client, these conversations are always noted on SystmOne.

Not every safeguarding conversation becomes a safeguarding incident. This year there have been 173 safeguarding discussions, 147 of these turned into safeguarding incidents which were investigated by one of the Safeguarding Leads, 26 discussions were not serious enough to warrant an investigation.

This is a way of supporting staff and monitoring trends.

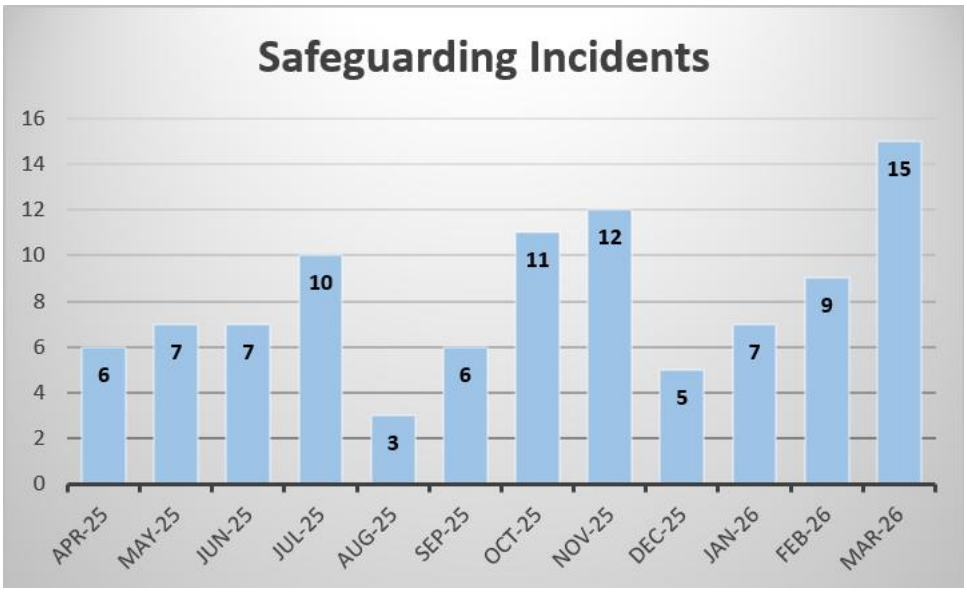
Safeguarding Advocates:

The Safeguarding Advocates have supported streamlining safeguarding practice to ensure consistency, up-to-date competency and confidence in providing support across the organisation.

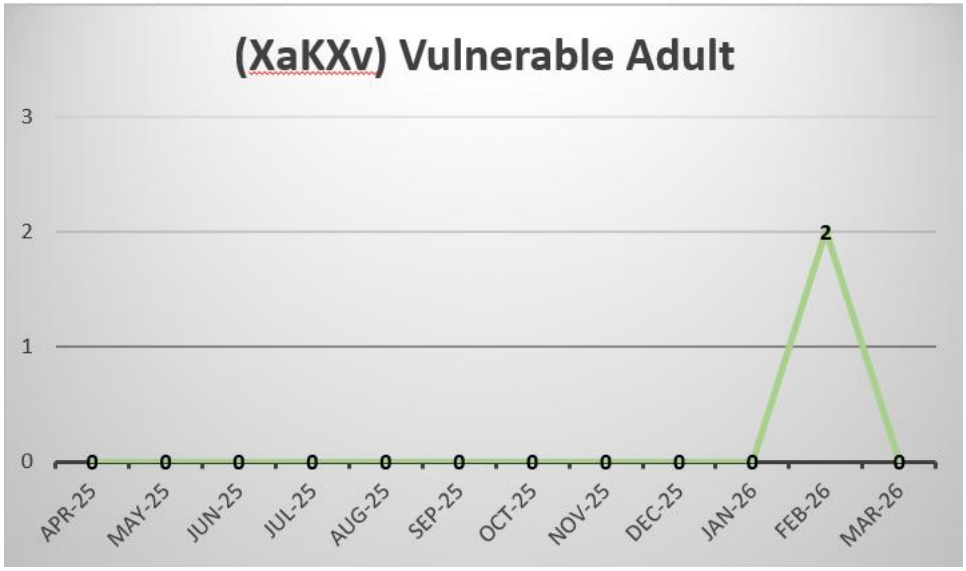
All teams within the organisation should have at least one representative.

Statistics:

The most common category of safeguarding incidents is suicidal ideation of patients or clients.

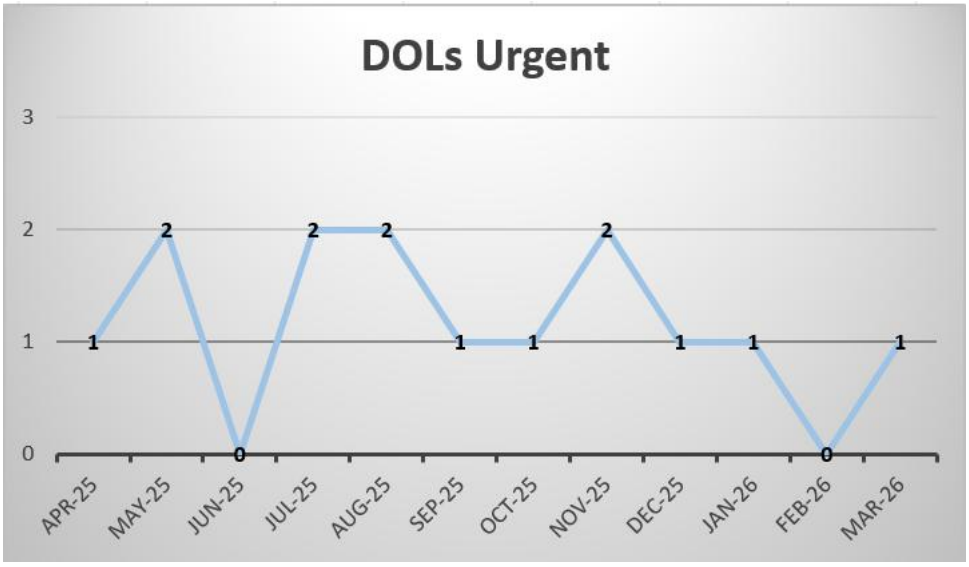


The above chart demonstrates the number of internal safeguarding concerns that have been raised.



The above chart shows the number of adult patient/client safeguarding concerns that have been escalated to the local authority safeguarding team. This happens when the situation is deemed serious, and the specialist safeguard team may need to be involved.

There were no children client safeguarding concerns escalated to the local authority safeguarding team during this reporting period.



We have a robust Deprivation of Liberty Safeguards (DoLS) process and policy in place, that we follow which is led by the Safeguarding Leads.

The Social Work team work closely with the In-Patient Unit medical and nursing team and the DoLS team at the Worcestershire County Council.

A safeguarding incident form is always completed when a DoLS is applied for.

We have Safeguarding statement on the St Richard's website:

https://www.strichards.org.uk/about/

"St Richard's Hospice is fully committed to safeguarding the welfare of all those we care for and support. We recognise our responsibility to promote safe practice and to work to protect all from harm. We work together to encourage a culture which embraces diversity and respects the rights of children, young people and adults. We support the right of all to be free from abuse and to be treated with respect and dignity. All safeguarding issues are managed by adhering to the adhering to The Care Act 2014, The Children Act 1989 and 2004. For full information on Safeguarding please read the details in the Frequently Asked Questions below."

5. Patient Experience

Demonstration of mental and physical health parity (Parity of Esteem)

Mental health support is provided for patients via the hospice Clinical Psychologists who support our clinical teams in relation to specific mental health support for patients.

Sessions were delivered during the year for staff to understand:

- Older adult mental health – anxiety, depression, self-harm
- Cognitive impairment and dementia
- Complex needs and self-harm

Our Psychological Care Facilitator (PCF) continues to provide active listening and emotional support for patients and carers experiencing low mood, worry, frustration or a loss of interest in activities which are increasingly impacting their daily quality of life. On initial assessment the PCF will decide upon, and share, the most suitable techniques from the well-being toolkit that she has developed.

Our digital assessments and care planning continue to support a holistic approach to care enabling those with mental health needs to have their physical care needs met in a way that is adapted for them.

Patient Outcome measures

Phase of Illness (POI) and The Australia-modified Karnofsky Performance Scale (AKPS) has been rolled out across all clinical services in this reporting year. This is recorded on our Electronic Patient Record.

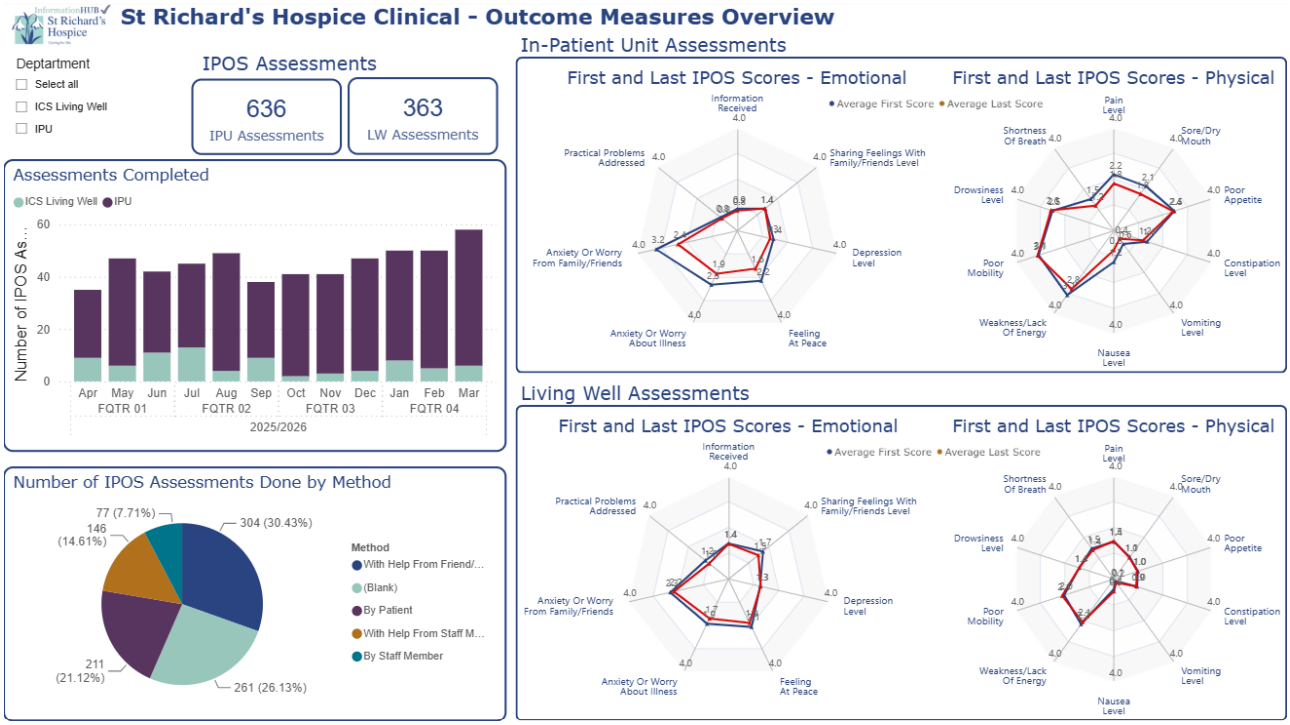
IPOS (Integrated Palliative Care Outcome Scale) is a validated tool which has been shown to support effective and personalised care. It ensures that the patient voice is heard, supporting patients with both physical, emotional, spiritual and practical concerns and highlighting to patients how these issues are all important to our Multi-Disciplinary Team (MDT). Our Living Well service

has an established use of IPOS to document patient outcome measures in addition to POI and AKPS. During this reporting period the use of IPOS has been converted from paper documentation to electronic and its use has been successfully rolled out to our In-Patient Unit supported by a variety of learning events and tools. There are plans to roll this out into our community service in 25/26 so that all our clinical services use the same suite of patient outcome measures. This will also enable us to benchmark with other hospices uses these tools.

Reporting on patient outcomes

We have developed an innovative Power BI report to report service level and individual level patient outcomes scores. At patient level, the Power BI report is used at weekly In-Patient Unit MDT and Living Well services to support personalised patient care.

The IPOS Power BI report allows data to be drilled down by service, by emotional or physical categories and by individual patient. This example below demonstrates the average results for 357 assessments performed.



Dementia awareness and support initiatives

All patient and client facing staff complete dementia awareness training as part of their induction.

Each department has access to a communication toolkit which helps staff to support patients with cognitive impairment.

We have supported the following numbers of patients with a dementia diagnosis since introducing the coding to capture this data:

37 patients April 2025 – March 2026

Compliance with the Mental Capacity Act

All Clinical Staff have three yearly one day training on the Mental Capacity Act as part of a rolling programme of statutory training. Safeguarding leads also provide ad hoc training when needed.

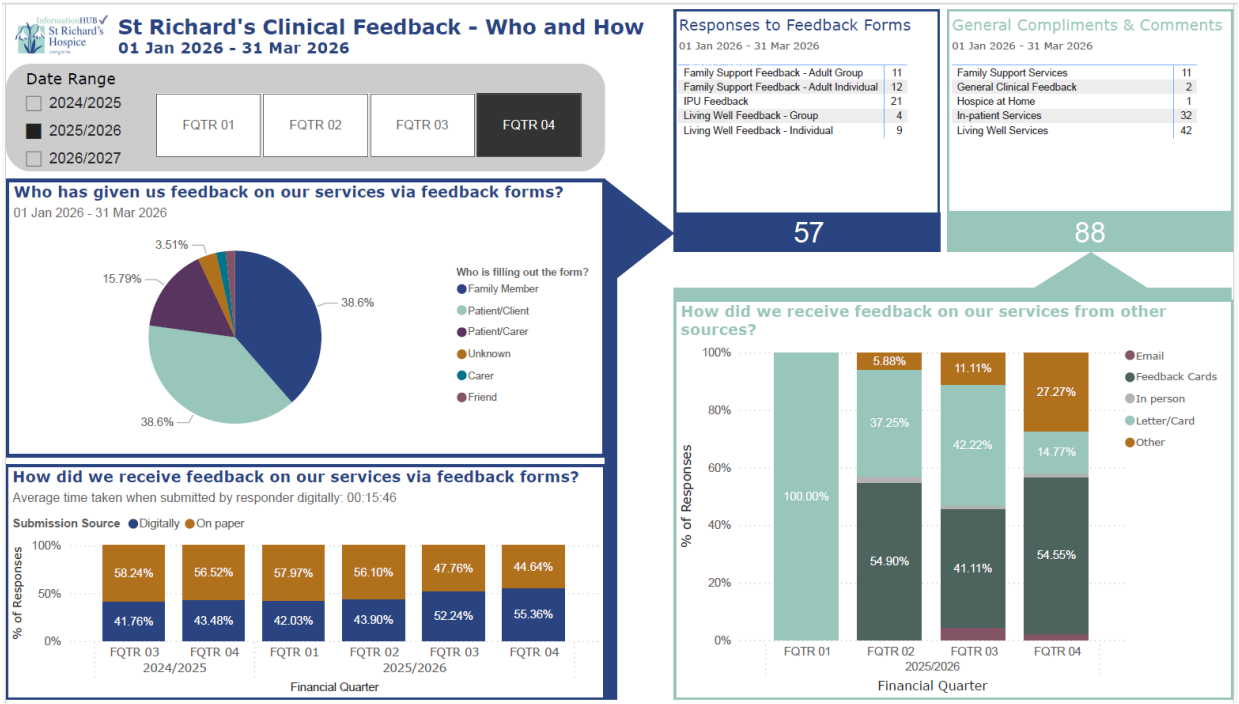
Where staff have concerns about a patient's capacity to make a specific decision, a full assessment is undertaken. This is recorded in the Mental Capacity Assessment and Best Interests template on SystmOne. An audit reviewing the recording of Mental Capacity Assessment and Best Interest in 2024 and repeated again in 2025, resulted in a revision of our electronic templates and additional training for staff.

Annual report on patient experience

Every patient / carer facing service i.e. Living Well, Community, In-Patient Unit and Family Support offer patients, clients and visitors the opportunity to provide feedback. The survey can be provided via digital, paper or via a link through a QR code. All surveys are anonymous, however, there is an opportunity to leave contact details if they want to discuss feedback with the manager. Any negative feedback below a certain score threshold triggers an email to the service manager.

The website contact form also allows for email feedback and completion of a general feedback form.

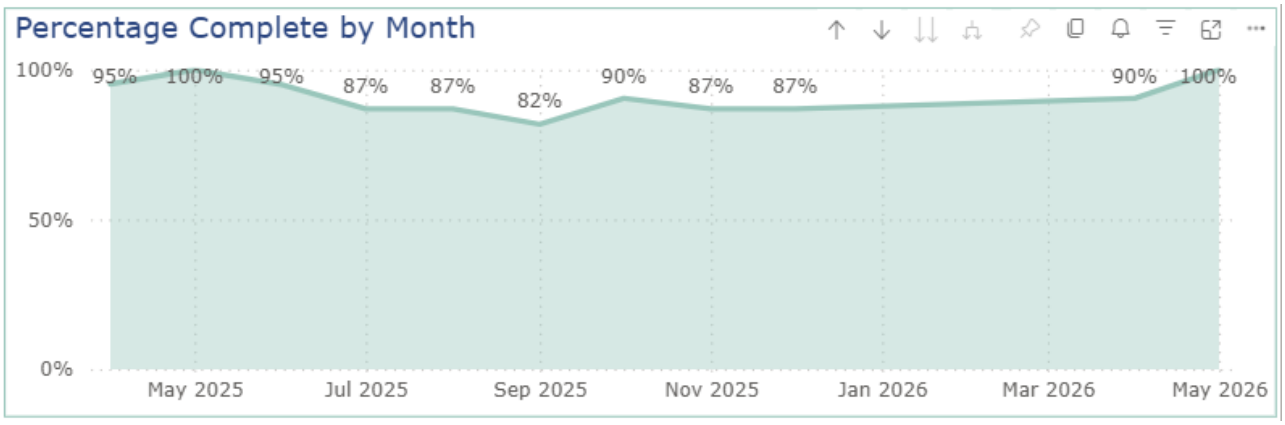
To monitor service user feedback a quarterly Power BI report is produced and shared with clinical teams. Below is an example of part of a report.



6. Infection Prevention and Control (IPC)

All patient and client facing staff carry out annual infection control e-learning.

Below is a chart showing the compliance figures for IPC training.



Infection prevention measures and compliance with Health and Social Care Act 2008 -

Quarterly Infection Prevention Control (IPC) meetings take place with the Infection Control Lead and Infection Control Link staff. Infection control audits are discussed and action plans reviewed.

- Environmental cleaning audits in line with the NHS National Standards of Healthcare Cleanliness 2021 are undertaken regularly and frequency of

audits is dependent of the functional risk of each area. The audits are reviewed and discussed within the IPC meetings.

- Each IPC Link represents a clinical department, and we also have an IPC Links who represents non-clinical teams. They are responsible for raising and discussing IPC matters within team meetings and for carrying out quarterly audits and completing actions associated with audits. The IPC Links can also access any relevant IPC training as required to ensure they keep their knowledge up to date.
- The IPC Lead attends the Integrated Care System IPC meetings, and any other external meetings/conferences as required. The IPC Lead shares any IPC updates of significance to the IPC Links.
- The focus for this year's International Infection Prevention Week in October 2025 was on building a culture of cleanliness and safety across the hospice. We came together — staff, volunteers, and visitors — to celebrate the importance of good hygiene and everyday actions that prevent infections. Through interactive activities like the handwashing light box, hygiene tips, and the IPC quiz, we highlighted how small steps make a big difference in protecting everyone. The week reminded us that infection prevention is everyone's responsibility — keeping our environment 'Clean, Safe, Together'**.**
- For an agenda for one of the IPC meetings please see appendix 2.
- 35 IPC audits were carried out during this reporting period, and no significant concerns were found.

Monitoring and reporting on Healthcare-Associated Infections (HCAIs)-

Staff clearly report any patients who were either admitted with an infection or acquired infections on the In-Patient Unit via an infection control reporting template on the Electronic Patient Record. If a patient has an infection, an incident report is completed, and the IPC Lead and Head of In-Patient Unit investigate and ensure all IPC risks are identified and suitable measures put in place.

The following infections have been recorded on the IPC template:

Infection	No. Recorded
C.Difficile	6
Influenza	2
Other	2 (PICC infection, Hepatitis C)
CPE	1
Blood-borne gram negative infections	1
COVID-19	3
Total	**15**

The hospice has access via the Acute Trust of PCR tests which will screen for Influenza and COVID-19 if patients for escalation of treatment and are symptomatic. We do not carry out CPE screening due to the invasive nature of the process for patients who are already in a single room. The ICB Infection Control Team are aware of our decision to not screen for CPE.

All 150 patient/client facing staff were offered the opportunity to have free flu vaccine via a clinic based at the hospice or via their local pharmacy.

Seasonal flu vaccination rates for this reporting period from the hospice clinic was 18 staff.

Some staff received their vaccinations via their own GP or Pharmacist, and these are not recorded.

7. Patient Safety

7.1 Incident Reporting

Patient Safety Incident Response Framework Principles (PSIRF) have been embedded within the hospice. The PSIRF moves away from reactive and hard-to-define thresholds for 'Serious Incident' and root cause analysis investigation and towards a proactive approach to learning from incidents. Quality of investigation is the priority with the selection of incidents for safety investigation based on opportunity for learning and need to cover the range of incident outcomes.

The electronic incident reporting platform has the ability to enable the investigator of an incident to approach the investigation by using the Systems Engineering Initiative for Patient Safety (SEIPS) framework for understanding outcomes within complex socio-technical systems and should be used for

investigation of incidents. The SEIPS framework is also used as a general problem-solving tool (e.g. to guide how we learn and improve following a patient safety incident, to conduct a horizon scan, and to inform system design).

All clinical incidents are recorded via an electronic incident reporting platform and investigated within 30 days.

Learning from incidents is shared in a variety of ways. The reporter of an incident also receives written feedback once the incident has been investigated.

Duty of Candour is carried out with all incidents that cause moderate to severe harm.

Incidents are reviewed by a senior reviewer and Duty of Candour has been carried out with 100% of incidents that have caused moderate to severe harm during this reporting period. There have been no incidents this year that have caused moderate to severe harm.

7.2 Health and Safety

There have been no HSE enforcement notices during this reporting period.

Regular maintenance checks of all equipment are carried out, and a clear log of these checks is maintained.

See appendix 3 for an example list of safety checks carried out to meet regulations.

Implementation of Central Alerts

Field safety notices, national patient safety alerts, device safety information, and medicines recall/notifications are received regularly and reviewed accordingly. All alerts are recorded and any actions captured with clear deadlines in place.

7.3 Pressure Ulcer and Falls Prevention

There have been fewer pressure ulcers reported in April- September 2025 which is proportionate to beds in use.

All patient beds have pressure relief mattresses in place as a preventative measure and our pressure ulcer policy is clear with regards to how often staff should reposition high risk patients.

Some pressure ulcers reported are already evident when someone is referred and admitted to the In-Patient Unit. The 'new' pressure ulcer incidents are pressure ulcers that are acquired in our care. The majority of the pressure ulcers reported are already evident when someone is referred and admitted to the In-Patient Unit.

For more information regarding pressure ulcer data please see The West Midlands Executive Clinical Leads in Palliative Hospices (Executive Clinical Leads in Hospice and Palliative Care).

8. Medicines Management

The Commissioning for Quality in Medicines Management Care Home/Hospice sector self-assessment audit was completed in December 2025. The assessment highlighted that compliance with Medicines Management has been achieved. Please see appendix 4.

Quarterly Medicines Management meetings take place where audits, medication use monitoring, medication errors, stock issues or any other medication related topics are discussed.

9. Equality, Diversity, and Inclusion (EDI)

Significant progress has been made on standardising our EDI data collection during this reporting year. A new template across all clinical services has been implemented and we are starting to see improved data on gender, sexuality, ethnicity, cultural background, spoken languages, religion and spiritual needs. We have used the framework from the Accessible Information Standard (2016) to ensure we record, flag, share and meet the individual communication needs of people with disabilities and sensory impairments who use our services.

The clinical teams have been provided with communication and sensory toolkits to support patients' individual needs. Many of our leaflets have been redesigned in an Easy read format co-produced with a panel of people with Learning Disabilities at the Vale of Evesham School. Our communication team will continue to take this work forward.

The clinical services redesign has been considered by using our new Equality Impact Assessment framework. All future service redesigns or reviews, new services and new policies that are being introduced will now undergo this process. This framework helps us understand the impact of service change, on people with protected characteristics and those from groups/ communities who are more likely to experience barriers to healthcare or palliative care. This enables us to consider actions to mitigate these impacts and to consult and work in partnership with local communities and specialist organisations.

In this reporting period we have completed and reviewed eight equality impact assessments.

Recruitment and Inclusion policies

All of our People Services policies have EDI at the heart of them. Specifically, around recruitment, the hospice has a Recruitment and Selection Policy. The

hospice also has an Equality Diversity and Inclusion Policy. Please see appendix 5 and appendix 6 to access the policies.

10. Patient, Carer, and Public Engagement

Patient Feedback Trends (complaints, concerns, compliments)

Ten complaints and twenty concerns were received between April 2025 and March 2026. All have been investigated and closed apart from one ongoing vexatious complaint where we have fully investigated. The complainant has escalated this to the Health Ombudsman who are investigating. We have received no response from the Health Ombudsman at the time of issuing this report.

Our website outlines our complaints policy for the public and clearly explains how an individual can complain. We have a feedback and complaints handling process and policy in place. We take this seriously, aiming to resolve issues promptly and improve our practices accordingly. Actions are taken in response to feedback and recorded.

Public and patient engagement

As part of a quality improvement to increase medicines safety, patients and families were interviewed to ascertain their acceptance of and support for staff wearing tabards on drug rounds. Patient feedback was pivotal to us introducing the initiative.

11. Workforce Development and Training

Within this reporting period the following staff well-being events and satisfaction initiatives have taken place, including Move and Take a Moment Week, Men's Health Week, Neurodiversity week drop in, and Menopause.

During Clinical Service redesign, drop-in sessions were offered to support staff.

Wellbeing resources are available to staff and volunteers such as:

- Benenden
- Financial Wellbeing
- Hospice UK wellbeing Support
- Mental Health support
- Mindfulness
- Neurodiversity resources
- Nutritional advice
- Physical Health
- Sleep hygiene information

The following initiatives have been carried out to support staff and managers:

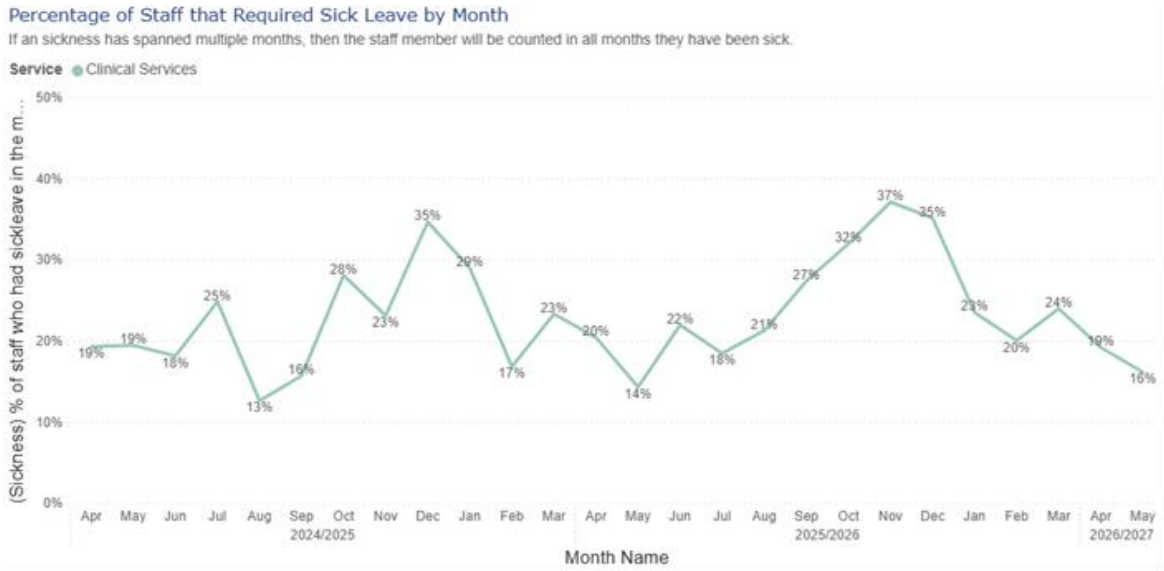
- Providing on the spot solutions and temporary adjustments - sit stand desk, fidget toys, ear plugs, advice & practical solutions to support etc

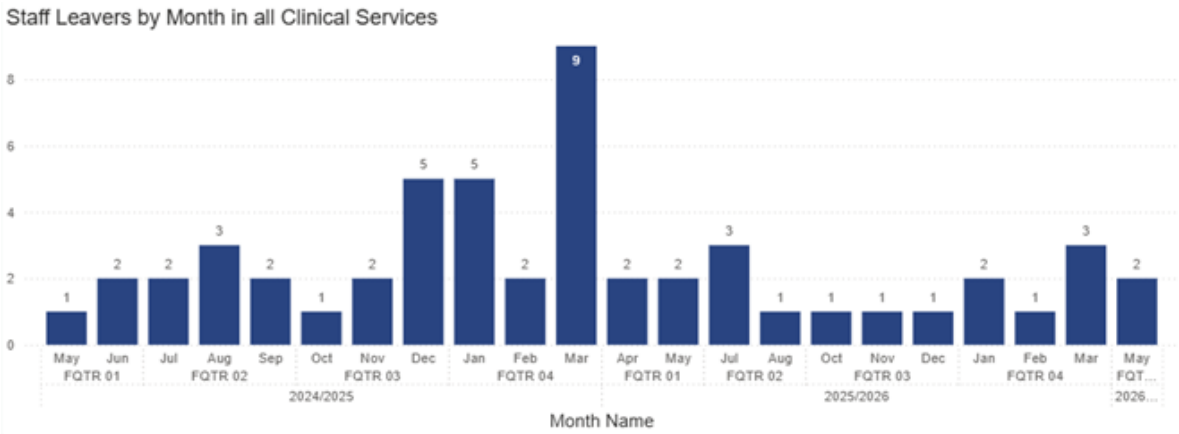
- Increased face to face interaction with staff and managers
- More conversations around adjustments with managers and staff to keep people well.
- Staff and managers proactively discussing absence so that they can anticipate and manage future absence and provide solutions.
- Managers guided and confident in using resources such as amended duties and phased returns to ensure safe supported returns to work resulting in less failed returns.

Workforce planning and staffing levels

Safe staff to patient ratios were managed throughout the reporting period by proactively managing patient numbers in accordance with available staffing levels.

We had to use agency nurses five times on the In-Patient Unit this year (between July and October 2025).





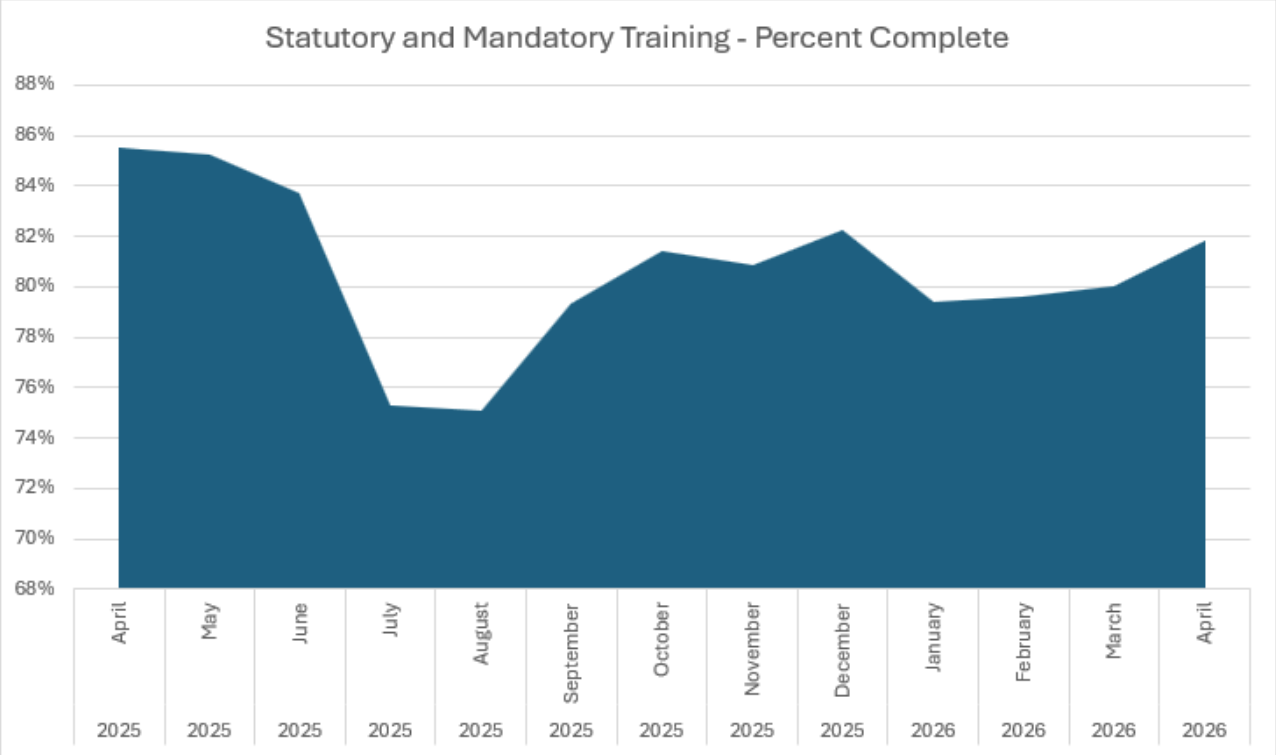
Staff recruitment, retention, and development strategies-

We have restructured our clinical workforce to improve equity of access and enhance care. This has provided career progression and development opportunities for staff at all levels including apprenticeships and access to post graduate qualifications.

Compliance with revalidation and professional standards

Professional registrations are checked at recruitment stage, and monthly reports are generated from the HR information system to ensure compliance with revalidation. Line managers ensure compliance with professional standards through regular managerial supervision and individual performance reviews.

Below is a graph showing statutory and mandatory training compliance of clinical teams from April 2025-March 2026.



Appendix 1

In-Patient Unit Learning from Deaths Review

NHS No: **Patient Initials:**

Admission Date and day: **Duration of hospice stay:**

Referred from (home, hospital, nursing home):

Death Details

Date of Death: **Time of Death:**

Worcester Suite until:

Has death occurred within 30 days of hospital admission?
Yes/No

If yes, has acute trust mortality review been requested and/or has feedback been given to the acute trust?
Yes/No

Diagnosis:

Other significant conditions:

MCCD Cause of Death:
1a:

1b:

1c:

1d:

2:

Coroner referral? **Yes/No**

If yes, please comment:

Was the GP practice notified within 24 hours?
Yes/No

Review notification of death letter:

Did it have sufficient information in it?
Did it copy in all relevant professionals involved in care?
Was it sent within 72 hours post death?

Advance Care Planning

1. **Was a My Wishes Advance Statement in place?**

If yes, is there evidence that this guided care?

2. **Was a ReSPECT plan in place with appropriate discussions?**

3. **CPR recommendation in place with appropriate discussions?**

4. **Was a Lasting Power of Attorney for *Health and Welfare* in place?**
   If yes, was the documentation viewed?
   How did this contribute to care?

5. **Please comment on any other advance care planning**
   ADRT, organ/tissue donation etc and were the patient's wishes upheld?

Nursing Care Review:

1. **Pressure ulcer/skin care**

2. **Elimination care** (micturition, catheter, bowels, stoma care etc)

3. **Falls including risk assessment and actual falls** (see incident section below)

4. **Nutrition and Hydration – Oral** (any special dietary needs?)

5. **Artificial Nutrition and Hydration– PEG/NG/IVI**

6. **Mouthcare**

7. **General nursing care comments** (include ADLs, symptom Mx etc)

Medical Care Review

1. **Review of medications:**
   A. VTE prophylaxis B. Symptom management C. Opioids and CDs. D. Oncology E. Critical medicines
   Comment on appropriateness of prescribing, prescribing errors. Including omissions by nursing team.

2. **Review of medical procedures**

Include interventional analgesia, paracentesis, radiotherapy and documentation

3. **General Medical Care Review:**

Family Support Care Review

Social Work Care Review

Spiritual Care Review

Therapies (Physiotherapy, Occupational Therapy, Complementary Therapy) Care Review

Communication, Cognition, Mental Health and Psychological Care Review

1. **Were the patient's communication needs identified and met?**
   Include general comments on communication with patient

2. **Mental health/psychological care/cognitive impairment needs.**
   How were these addressed?

3. **Was the patient ever thought to lack capacity?**
   Is there evidence of Best Interest Decision making or DOLs?

4. **Communication with family/loved ones/carers**
   Specifically, around changes in patient condition/dying phase

Documentation

1. Comments on In-Patient Unit documentation of care period

2. Were any incident forms generated during the patient's care?
If yes, did this cause harm to the patient and /or contribute to the patient's death?

3. Has mortality review S1 template been completed? **Yes/No**

Overall analysis (GSF format) – Multi-disciplinary care and Documentation

What went well?

What could have been done better?

Are we aware if any feedback has been received from the family/loved ones or carers?

Mortality Review Actions (hospice/external/individual):

In attendance: **Date:**

Name	Role	Score

Scoring: 1 = Very poor 2 = Poor 3 = Adequate 4 = Good 5 = Excellent

(Total score divided by number of attendees) **TOTAL SCORE =**

Appendix 2

Infection Prevention Control Meeting
Tuesday 06 January 2026 at 10:00am
Rosehill

St Richard's Hospice
Caring for life

Agenda

1.	**Introductions and Welcome** Apologies		**Att.**
2.	**Minutes of the previous meeting** (21 October 2025) Matters arising. Review of action log	**All**	**1**
3.	**National Cleaning Standards Audit** (October - December 2025)	**NH**	**2**
4.	**Items for discussion** - CQC Quality Statements/Recent Outstanding rating - IPC link staff roles (including hand hygiene sessions/raising awareness) - Flu/Respiratory illness, including COVID-19, Norovirus etc - IPC conferences and courses (discuss Zoom course on 20 January)	**All**	
5.	**National Infection Prevention Control Board Assurance Framework Audit**	**CGi**	**3**
6.	**Review of audit summaries from quarter 3 2025-2026** - Hand Hygiene - Respirator and Cough Hygiene - Blood and Bodily Fluids	**All**	**4**
7.	**Update on Universal Hoods**	**CGi**	
8.	**Items for information/standing items** - Herefordshire and Worcestershire Health Economy: Infection Prevention & Control Forum (ICB IPC meeting) - Hospice UK Infection Prevention and Control	**CGi**	

	- National infection prevention and control manual for England		
9.	**Items to be escalated to Clinical Quality Management Group**	**All**	
10.	**Any Other Business**	**All**	

Date of next meeting: Tuesday 07 April 2026 at 10:00am, Rosehill

Appendix 3

St Richards Hospice – Health and Safety checks and audits

Regular preventative maintenance on all hospice buildings and equipment is undertaken to meet regulations.

The following is an example of the regular checks carried out on medical equipment.

Check	Frequency	By Whom
Fire alarms/extinguishers and doors	Weekly – annual	External specialist and in house checks
Medical Gas pipeline system	Quarterly	External inspection
Flowmeters & Suction	Biannual	External specialist
Nurse call system	Annual	Internal checks specialist when required
Portable medical equipment (e.g. B.P/Temp/infusion pumps/nebulisers)	Annual recalibration and maintenance	External specialist
Defibrillator and emergency medicines	Weekly check	
Patient Lifting equipment	6 monthly checks	External provider
Water Hygiene (legionella)	Monthly	Internal checks and External
Beds and recliner chairs	Annual	Internal /external

Herefordshire and Worcestershire
Integrated Care System

Commissioning for Quality in Medicines Management (CQIMM)

Care Home / Hospice Sector Self-Assessment Checklist

2025/26

Care Home/ Hospice Sector Self-Assessment Checklist

Purpose: Audit of Safe Medicines Use within the Organisation Setting.

This self-assessment tool has been designed for use in Organisation settings across Herefordshire and Worcestershire. It can be used to regularly assess or audit arrangements within the Organisation. Contractually this can be required to be submitted once a year to the Commissioner upon request or can be requested to be completed and submitted as part of any quality assurance discussions between the Commissioner and the Organisation.

This checklist cross references the "Herefordshire Worcestershire Commissioning for Quality in Medicines Management FY 2025 26" which is included within the contracting arrangements with the Organisation.

Further information is available from NHS Herefordshire and Worcestershire ICB/ICS Medicines Commissioning Team via hw.medicines@nhs.net

When completed please return to Herefordshire and Worcestershire ICB Quality Team via

icb.qualityfeedback2icb@nhs.net

Organisation Sector Self-Assessment Medicines Management Checklist				
Name: Claire Gijselhart (Associate Director of Care Quality), Sarah Onions (Clinical Director and Medical Governance Strategy Lead) and Alisdair Tompson (Pharmacist)	**Audit Date: December 2025**			
Address: St Richards Hospice-Worcester				
1. Key Legislation	**Yes**	**No**	**N/A**	**Supporting Evidence**
Standard: The Organisation has a named Medicines Lead responsible for safe medicines use within the Organisation	Yes			Claire Gijselhart (Associate Director of Care Quality) and Sarah Onions (Clinical Director-Medical Governance and Strategy Lead).
Standard: A clear reporting process is in place from the Organisation Medicines Lead to the named Organisation/Organisation Manager	Yes			Claire Gijselhart (Associate Director of Care Quality). Vantage reports (incident reporting platform).
Standard: The Provider can evidence that pharmaceutical services delivered comply with national and local service specifications plus national professional circulars at the same time acting in accordance with specific commissioning arrangements in place between the Provider and the Commissioner	Yes			There is a service level agreement between PCT Healthcare Ltd and St Richard's Hospice. The service is provided from a registered pharmacy premises, and a registered pharmacist visits

				the hospice once a week. The premises is inspected by the MHRA and Home Office. The provider attends the quarterly medicines management meeting to monitor provision against service specification and contract. This meeting also gives the opportunity to acknowledge what is working well and to raise concerns or ideas for improving service.
2. Medicines Governance	**Yes**	**No**	**N/A**	**Supporting Evidence**
Standard: The Organisation has an up-to-date Medicines Policy (reviewed within the last year)	Yes			New Medicines Management policy written and will be ratified in JAN 2026. Will ensure annual review of policy.
Standard: All prescribing, including Independent Prescribers (Non Medical) Prescribing Policy is within prescriber competencies, is appropriately managed and monitored to be within the scope of a professional governance framework (as applicable)	Yes			We are compliant. The ICB prescribing policy link has been added to key policies and we follow this policy.

Standard: The Organisation Medicines Policy is in line with NICE Guidance SC1 Managing Medicines in Organisations	Yes			Reviewed guidance 23.12.24. We follow this guidance.
Standard: The Organisation can demonstrate reference to Safe and Secure Handling of Medicines in their Policies relating to medicines	Yes			Link added to new Medicines Management policy Dec 2025. The following is outlined in the Nurse Independent Prescribing Policy: *We have issued a position statement on the separation of prescribing and dispensing / supply / administration by the same healthcare professional.*
Standard: The Organisation can evidence assurance against the Medicines Policy through a programme of audit	Yes			Audit plan in place with a clear governance process
Standard: Please state which audits have been completed in the last year in relation to the Medicines Policy itself.	Yes			Oxygen audit Emergency medicines audit IPU and LW Critical medicines audit

				Community medicine advice audit x2 Controlled drug annual self-assessment audit. Audit of medicines refrigerator temperature check. Management of prescription stationary audit. Antimicrobial audit. Monthly CDAO audits. Opioid Toxicity audit. Medical prescribing audit Prescription stationary audit IPU medicine management evaluation Blood transfusion audit CCTV audit

Standard: Medicines management training for all staff (including bank staff) handling medicines is planned, delivered and recorded and can be evidenced	Yes			Three yearly medicines management training for HCA's and Nurses and bank nurses. An annual drug calculations test is also carried out for nurses. Trainee doctors on induction complete an opioid prescribing workbook. All doctors have regular CPD time.
Standard: Allergy Status is confirmed and documented within patient records, Medicines Administration Record (MAR) charts and audits are undertaken against this requirement	Yes			All suspected allergic drug reactions are documented on the patient record (S1) to their drug allergy status. Drug allergy status is assessed across all services first assessment and double checked with the Shared Care Record. We would liaise with Primary Care if appropriate to assess whether

				referral to specialist allergy service is required. Allergy status is clearly documented on our universal assessment and on paper drug charts and this is audited annually. Allergy documentation is audited annually as part of the medicines prescribing audit.
Standard: Antibiotic Management. Audits are undertaken to ensure that patients receive prescribed antibiotics in a timely manner for the length of the course which must be indicated. Please provide examples of audits completed	Yes			Antimicrobial audit Dec 2025.
Standard: A risk and incident management framework with clear lines of reporting and compliance with national incident reporting is in place. Themes and trends of incidents involving medicines are analysed towards learning and prevention of recurrence. Please state which LFPSE compliant system is being used to record incidents or whether LFPSE is being accessed directly.	Yes			Quality report provides information about incidents and trends within incidents. Discussion of medication error incidents takes place within quarterly Medicines

				Management meeting. Incident reporting platform in place. Learning team support staff to reflect and identify learning needs following medicine errors. Reflections saved on vantage incident reporting platform. Incident trends discussed with clinical leadership team in a monthly Quality Management meeting. We use Vantage Incident reporting system which is LFPSE compliant.
Standard: The Organisation will be aware of the NHS England » The NHS Patient Safety Strategy engaging, sharing and learning from incidents with partners in the Herefordshire Worcestershire Integrated Care System to help prevent recurrence	Yes			PSIRF implemented and incident reporting policy being updated to include PSIRF principles. Leadership and Executive Teams aware of PSIRF principles and a 'Just Culture'. Patient safety mandatory training in place for all patient facing

				staff, executive team and clinical trustees. Attend ICB patient safety meetings to share learning re: PSIRF implementation and learning from incidents.
3. Formularies/ Prescribing Guidance	**Yes**	**No**	**N/A**	**Supporting Evidence**
Standard: The Provider is aware of the ICB Prescribing Policy and all clinicians reference this in their prescribing considerations and decisions	Yes			Sent to medical team and prescribers for reminder and reference
Standard: The Organisation is aware of the HW ICB Clinical and Prescribing Policies, Guidance and Pathways	Yes			We use the updated Palliative Care Formulary. We also use SPAGG (Specialist Palliative Care Audit and Guideline group). We do receive a regular ICS newsletter which gives information regarding reviews of prescribing decisions and policies. Trusted resources documents added to I connect (where hospice policies/procedures

				stored) and the EPR and will be reviewed every 3 years. We use the ICB pharmacy guidance for prescribing opioids. We follow the local guidance for antibiotic use.
Standard: The Organisation is aware of the Joint Medicines Formulary applicable across all providers of services to patients registered in Herefordshire and Worcestershire	Yes			The newly revised Medicines Management policy 2025 has the link to the joint medicines formulary within it.
Standard: The Organisation is aware of examples of specific requirements to prescribe medicines by "brand." Please state examples you have come across in the Organisation	Yes			Medicines policy states which opioid brands are to be prescribed I.e. Matrifen patches and Zomorph capsules. Some Anti-epileptic medications are prescribed by brand.
Standard: The Organisation is aware that "special" unlicensed medicines should only be considered where alternative licensed options have been exhausted	Yes			See Medicines Management policy for details under unlicensed medication section.

				SRH has an off-licence template where we can record details within the patient electronic record.
Standard: The Organisation is aware of the DH expectation of Medicines which should not be prescribed but bought Over the Counter (OTC) for short term self-limiting conditions and this is applied within the Organisation. Please provide recent / current examples			N/A	N/A
Standard: The Organisation has a Homely Remedy Policy and has agreement for this to be utilised in the case of specific self- limiting conditions requiring medicines support for less than 48 hours	Yes			Homely Remedy section within Medicines Management policy.
Standard: Where medicines are designated "specialist" or are required to be prescribed by hospital based or specialist clinicians there should be detailed arrangements made in the care plan for individuals to ensure that medicines are ordered; stored; administered and disposed of safely. The GP practice should ensure that these medicines are noted on the patient record at the practice.	Yes			Hospice is mindful when discharging patients on specialist drugs. Collaborative approach followed with clear communication re: who is reviewing and prescribing the specialist medication.
Standard: The Organisation does not agree to enter into any pilot, project, trial arrangement involving medicines including topical medicines without discussing first with the Commissioner	Yes			Reminded teams of this and we are complaint with this process.

and ICB Medicines Commissioning Team via hw.medicines@nhs.net. Examples would include the use of sample packs of • Those products categorised as "medical devices" including e.g. eye drops • barrier creams, • dressings, • cleansing products • wound care products, • continence and stoma products, and • food supplements including thickeners				
4. Controlled Drugs (CDs)	**Yes**	**No**	**N/A**	**Supporting Evidence**
Standard: The Organisation has a current CD policy in place and can evidence assurance throughout the organisation via regular audit	Yes			Reference t CD's within newly revised Medicines Management policy CD annual audit. Hospice UK CD audit carried out in 2025 (annually). There is an opioid section of the annual IPU prescribing audit. Opioid toxicity audit carried out three yearly. CDAO carries out monthly CD audits.
Standard: The Organisation has a Nominated Person to work in accordance with governance arrangements for the	Yes			CDAO attends CD LIN quarterly meetings and

safe use, management and reporting of incidents in relation to CDs in line with NICE Guidance Where the organisation is required to be registered with CQC the organisation will provide assurance on these requirements for ICB purposes.				educational networks. CD occurrence report completed and sent to CDAO West Midlands every quarter. Quality report submitted to ICB April 2025 (annual report).
Standard: The Nominated Person will liaise with the NHS England Controlled Drugs Liaison Officer and CD Local Intelligence Network (CDLIN) members if requested following incidents involving Controlled Drugs	Yes			CDAO attends CDLIN meetings and sends quarterly reports.
Standard: Specifically, what audits have been completed in the last 12 months in relation to Controlled Drugs together with their outcomes?	Yes			CDAO monthly audits. CCTV audit regarding checking of stock CD count Nov 2025. Prescribing audit August 2025. Opioid toxicity 2025. CQC CD annual self-assessment audit Jan 2025. <u>Outcomes:</u> Nursing team reminded of process of checking stock CD's twice per day.

				Nursing team reminded of correct process regarding marking an error in CD register. Prescribing audit outcomes: Cancelling prescriptions correctly. Prescribers writing name at least once per drug chart. Opioid toxicity audit outcomes: opioid monitoring charts not always completed when signs of toxicity first identified. Improving completion of opioid forms discussed.
5. Medicines Handling & Assessment	**Yes**	**No**	**N/A**	**Supporting Evidence**
Standard: The Organisation should be fully compliant with the requirements and standards outlined in accordance with NICE NG5 Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes (March 2015)	Yes			The systems for learning and identifying learning from errors are: We carry out health record reviews at daily ward rounds; critical medicines

				reviews and prescription chart reviews are carried out by the Pharmacist weekly. Annual general prescribing audit, new annual critical medicines audit, annual CD self-assessment audit with a monthly CD audit via CDAO. If medication errors do take place, staff as per 'just culture' and Duty of candour report errors via vantage incident reporting system and a thematic overview is carried out. Staff are supported to carry out reflective learning and meet with the Learning Team as appropriate against a PSIRF framework. Near miss incidents are also reported to aid learning. When patients are admitted to the inpatient unit a doctor will carry

				out medicine reconciliation. We review a patient's prescriptions from GP connect via the shared care record. Allergies would also be documented, and information taken from GP connect via SCR. Medications and their efficacy are reviewed on a daily basis by Nurse or Doctor, in the inpatient unit. Where appropriate, self-management may be discussed with a patient. All patients are offered the opportunity to be involved with their medicines. We take a multi-disciplinary approach for all of our patients, and their medical and non-medical management plans.

				We write a detailed discharge letter for other providers when a patient leaves our care, and we include a list of medicines in jargon free language for the patient and health care professionals.
Standard: Organisations are encouraged to have a policy of supporting self-administration of medication where possible and safe to do so to maintain independence. Please confirm in place	Yes			We encourage self-administration in Living Well as it is an outpatient service. We encourage independence of certain medicines such as inhalers, eyedrops, nasal sprays. Refer to MM policy for details.
6. Medicines in Healthcare Settings	**Yes**	**No**	**N/A**	**Supporting Evidence**
Standard: The Organisation should have systems and procedures in place to maximise the appropriate use of "patients own medicines" on arrival/ transfer from other settings	Yes			Patient own medicines boxes can be used but this does not include CD's. Admitting Doctor reviews the medications.
Standard: The Organisation should have a medicines reconciliation process which ensures updates in relation to medicines	Yes			Clear guidance in new Medicines Management

for e.g. new residents, hospital discharge details, medication reviews or information from other clinical settings to ensure continuity and accurate up to date medicines information on receipt and transfers of care				policy regarding safe use of and storage of patients own medicines. All services review medications throughout care journey.
Standard: The Organisation has a nominated person from their GP practice linked to the Organisation in respect of medicines ordering and queries	Yes			Contracting Pharmacy linked answer all queries and medication ordering goes through them.
Standard: The Organisation undertakes stock checks before ordering only what medicines are required each month including checking stock levels of topical medicines such as creams, ointments, supplements, laxatives and PRN medicines before ordering to minimise waste	Yes			Coordinator of shift only order when we run lower than expected stock. Pharmacist reviews and rotates stock every week also.
Standard: The Organisation is using or working towards using Proxy Access for ordering medicines on behalf of patients – only ordering what is required each month using a 28-day supply model for regular repeat supply requests (N.B. Reference to in use expiry dates) as applicable to your service	Yes			Non urgent and non-CD patient medicines are ordered using an FP10 and only the number required are ordered.
Standard: The Organisation has completed the Information Governance GDPR/DSP Toolkit or is working towards completion of this document- please provide detail	Yes			Data security and toolkit compliant 26.6.25 (expires June 2026).

Standard: Organisation staff have NHS net email addresses and routinely use this to communicate securely with other healthcare professionals	Yes			No nighttime staff have access to NHS.NET emails currently but day coordinators and managers do.
7. Medicines Supply and arrangements for disposal	**Yes**	**No**	**N/A**	**Supporting Evidence**
Standard: The Organisation should have a community pharmacy provider of both repeats and acute medicines supply routinely. Please state details	Yes			Contract with Pharmacy. Pharmacy supplies all pharmaceuticals. (Peak Pharmacy)
Standard: The Organisation has a Organisation link person from their community pharmacy supplier of medicines to the home to receive advice and discuss medicines requirements	Yes			Peak Pharmacy.
Standard: The Organisation should be able to supply upon request any *pharmaceutical* advisory visit details if the community pharmacy provides such a service, their recommendations and any action plans generated	Yes			Weekly visits from contracting pharmacy. Contract details are available if needed.
Standard: The Organisation should have procedures to ensure that there is no inappropriate destruction of any medicines still in use at the end of each month or upon receipt of a new medicines supply	Yes			SOPS for destruction of medicines in place (CD/Non-CD)
Standard: Specifically, quantify the number of medicines sent for destruction in the last 2 months with details of name, formulation, quantity to			N/A	N/A

include topical and PRN medicines and reason for disposal (care homes only)				
Standard: The **Greener NHS (england.nhs.uk)** Strategy will look to reduce the number of medicines disposed of as waste including containers or packaging associated with re- packaging of medicines. Therefore, Organisations will be expected to work to reduce waste medicines and their associated containers using primarily medicines dispensed in their original licensed packaging	Yes			Most medicines are ordered as stock so can be used with multiple patients. Waste is disposed of as per legal requirements.
8. Medicines Safety	**Yes**	**No**	**N/A**	**Supporting Evidence**
Standard: The Organisation has a named lead for Medicines Safety. The Organisation will be able to demonstrate the governance structures for escalation of issues	Yes			Claire Gijselhart (CDAO and Associate Director of Quality) and Sarah Onions (Clinical Director and Medical Governance and Strategy). All patient safety alerts reviewed and recorded with relevant actions.
Standard: The Provider has a comprehensive procedure for identifying medicines that may be designated 'high risk', "time sensitive" or where patients may present as "high risk" in terms of their raised potential for harm in normal use. This should also include safe management where medicines shortages apply. Admission detail and ongoing	Yes			Critical medicines outlined in Medicines Management policy. Pharmacist completes for every patient a

arrangements with clear communication between clinicians and other healthcare professional staff of prescribing; administration and record keeping preventing "missed doses".				template which looks at any critical medicines. On admission, medical team carry out medicine reconciliation.
Standard: Specifically, which medicines audits (minimum of 3 audits) have been completed out of the following list in the last year: • Controlled Drugs • Medicines not available at the time of admin • Anticoagulant medicines • Safe use of insulin • Audit of use of PRN medicines • Audit of refrigerator temperature records		**No**		Audit of refrigerator temperature records Controlled Drugs audits (self-assessment audit and monthly CDAO audit). (Anticoagulant audit due June 2026). (Diabetes audit is a 2 yearly audit- due in October 2026).
9. Equipment used with Medicines	**Yes**	**No**	**N/A**	**Supporting Evidence**
The Organisation has a process in place to ensure equipment is used and tested as per manufacturers guidance (thermometer, resus equipment, diabetes testing equipment)	Yes			Yearly recalibration of equipment is carried out and this is documented.
Standard: Where equipment is shared, is it decontaminated between each use and prior to use on another individual	Yes			Yes, a variety of wipes are in place and staff also have

				daily cleaning schedules.
Standard: The Organisation can evidence daily recording of fridge temperatures with evidence of action taken if temperatures fall outside the range of 2°C to 8°C	Yes			Drug fridge logs kept and temperature recorded daily with instructions on what staff need to do if temperature incorrect. Data logger continuously monitors temperature.
15. Free Text for additional observations or comments:				

Appendix 5

St. Richard's Hospice CARING FOR LIFE Reg. Charity No. 515668	TITLE: RECRUITMENT AND SELECTION POLICY STREAM:

GENERIC POLICY STATEMENT:

This information is designed to reflect and promote best practice within St Richard's Hospice. Staff and volunteers are encouraged to use their judgment at all times and base their decision making and actions on the guidance provided. Issues relating to policy should be notified to the appropriate policy stream lead and any changes that are approved by appropriate committees must be documented in the St Richard's Hospice Policy Log.

AUTHORS:	Amanda Walford, Head of People Services
ACCOUNTABLE DIRECTOR:	Chief Executive
RATIFIED BY:	People Services Committee
DATE OF APPROVAL:	26th June 2023
REVISION DUE:	June 2026

COVERAGE OF THE POLICY:
All staff

RELATED POLICIES:
Equal Opportunities Policy
Training and Development Policy

References

Data Protection Act (2018) [on line] Available at https://www.legislation.gov.uk/ukpga/2018/12
Department of Health (2013) Bloodborne viruses in healthcare workers [on line] Available at https://www.gov.uk/government/collections/bloodborne-viruses-bbvs-in-healthcare-workers
Equality Act (2010) [on line] Available at: https://www.legislation.gov.uk/ukpga/2010/15
Rehabilitation of Offenders Act (1974) [on line] Available at https://www.legislation.gov.uk/ukpga/1974/53
Gov.UK Checking a job applicants right to work [on line] Available at https://www.gov.uk/check-job-applicant-right-to-work

Right to work checks: employer guidance (updated March 2023) [on line] Available at https://www.gov.uk/check-job-applicant-right-to-work
Workers and temporary workers: sponsor a skilled worker (updated April 2023) [on line] Available at https://www.gov.uk/government/publications/workers-and-temporary-workers-sponsor-a-skilled-worker

POLICY HISTORY LOG

Date	Name	Job Role	Change/suggestion

INTRODUCTION:

The purpose of this policy is to ensure that St Richard's Hospice employs the most appropriate employees and workers in a fair and consistent manner free from discrimination.

POLICY STATEMENT:

St Richard's Hospice is an equal opportunities employer and is committed to ensuring that there is no discrimination on the grounds of age, disability, gender reassignment, marriage/civil partnership, pregnancy, maternity, race, religion or belief, sex or sexual orientation at any stage of the recruitment process or in terms and conditions offered to new staff, or promoted employees.

The organisation will monitor the composition of its workforce in order to identify areas that may need positive action measures to promote equal opportunity and diversity.

Regulatory environment and Legislation:

This policy complies with the Equality Act 2010 and Data Protection Act 2018 and the UK General Data Protection Regulation (UK GDPR).

SCOPE:

This policy is applicable to all employment opportunities at St Richard's Hospice, whether permanent, fixed term, bank workers or for employees undertaking permanent or short-term secondment to another area within the organisation.

RESPONSIBILITIES:

People Services are responsible to ensure compliance with this policy, provide advice and support on its application including ensuring that those conducting interviews on behalf of the organisation are appropriately trained.

The Chief Executive and People Services Committee are responsible for monitoring this policy.
Line managers are responsible for maintaining staffing levels in line with service and budgetary requirement.

POLICY PRINCIPLES:

The Vacancy

- All vacancies will be discussed between the appropriate Head of Department and member of the Senior Management Team.
- Managers should consider alternatives to previous arrangements and anticipate and plan for organisational changes in designing job roles. Service requirements will be re-appraised, and a decision made whether a straightforward replacement is required for the role or whether a change in emphasis requires different skills and expertise.

- A new job description and person specification will be drawn up ensuring that criteria relate directly to the requirements and care should be taken not to overstate these requirements.
- In the case of new posts or significant changes to duties, the job description and person specification will be evaluated by trained members of the Job Evaluation Panel using the Croner Job Evaluation tool.
- No vacancy will be advertised without permission of a member of the Senior Management Team and, if the post requires additional budget, submission to the Finance and Business Committee will be made.

Advertising

- Advertising of all positions will be carried out internally and all employees will be notified of any positions that arise during their employment by way of the internal newsletter, 'The Weekly Update'. The majority of posts will also be advertised on the St Richard's Hospice website and where applicable, NHS Jobs and specialist websites.
- Advertisements will include the job description and person specification as well as an indication of the salary level.
- Positions requiring a DBS check should state the level required on the advertisement.
- Positions requiring a driving licence and access to a vehicle should be stated on the advertisement (e.g. community roles).
- Advertisements will make it clear that the positions are open to all suitably qualified candidates regardless of age, disability, gender reassignment, marriage/civil partnership, pregnancy, maternity, race, religion or belief, sex or sexual orientation. Details of positions will be fully circulated so as to ensure access to all applicants.

Applications

- Applicants will be encouraged to apply directly online where all relevant information will be made available.
- Application forms will contain relevant questions needed for selection.
- Informal visits to the hospice will be encouraged in order for the candidate to appreciate the area of work.
- Records of requests for information and completed applications for a period of six months following the closing date.

Shortlisting

- After the closing date, shortlisting will be undertaken independently by at least 2 members of the selection panel using the hospice standard short list form. Screening will be carried out by matching details provided by applicants to the requirements of the job and will be applied consistently to all applicants.

- Shortlisted applicants will be notified of invitation to interview. The invitation will include the opportunity for the applicant to specify any reasonable adjustments required to enable them to attend at interview.

The Interview Process

- Interviews will be carried out more than one person, and the interview panel will usually include the Line Manager and a representative of People Services. Any conflicts of interest must be declared.
- No assumptions will be made on the grounds of protected characteristics and in accordance with the Equality Act 2010.
- Questions will relate to the requirements of the job as established by the job description and person specification. The interview panel should agree on the format of the questions. The interview will follow the format of the St Richard's Hospice interview criteria form (Appendix 2) to ensure that all candidates are allotted the same questions, are given accurate and consistent information and that all pre-employment checks are discussed.
- Candidates must be allotted the same time and opportunity to respond and ask their own questions.
- Interviewees will be asked to clarify contact details of at least 2 work referees at interview (3 work referees for clinical staff), one of which must be the candidate's existing or most recent employer. Personal or academic references will only be accepted in circumstances when a candidate has insufficient work history to provide the required employment references. References will not be requested prior to the acceptance of an employment offer in writing.
- Applicants will be assessed at the end of interviewing against pre-defined criteria set out on the interview criteria form.
- Candidates will be asked to provide evidence of eligibility to work in the UK at interview and may also be asked to provide evidence of qualifications and/or registration. Candidates for medical vacancies should also be asked to supply details of their Responsible Officer to enable a formal request for information to be made prior to confirmation of employment.
- No decision should be taken until all the candidates have been interviewed.
- Interview comments and scoring should be recorded fully on the interview criteria form. On completion of interviews the panel should discuss the strengths and weaknesses of the applicants and then make their selection.
- If the decision is unclear or there is more than one suitable candidate who could be appointed to the role, then the panel will arrange second interviews. Dependent on circumstances, the second stage may be a second formal panel interview or an informal meeting where individuals are invited to submit feedback to the original panel before a final decision is reached.
- If no candidate reaches the required standard the advertising process will be reinstated.
- The successful candidate will be contacted as soon as possible after the interview, and a provisional offer will be made in writing. The provisional offer will contain details of the post including salary, hours of work,

probationary period and annual leave entitlement. An Occupational Health pre-employment questionnaire and DBS details form (where applicable) are to be included. The provisional offer will determine that it is subject to satisfactory references and DBS clearance (where applicable).
- Records of the interview process will be retained for a period of six months.

Promotion

- All employees will be made aware of promotional and career opportunities via the Weekly Brief and be asked to email People Services to express interest.
- Progression will be determined by performance against objective criteria.
- Some posts may be offered as development opportunities and training, and job experience will be open to all eligible staff.
- Unsuccessful internal candidates will be given feedback
- The process surrounding promotion will be free from discrimination. All those involved in the recruitment process must preserve confidentiality to protect the identity of internal candidates e.g. by providing a private waiting area.

Medical check

- No medical information will be requested prior to offer of employment.
- Successful applicants will be required to complete a medical assessment form on acceptance of offer and may be required to attend a medical check with the Occupational Health Service. All health care workers will be screened in compliance with the Department of Health guidelines to protect patients from exposure to blood borne viruses (Hepatitis B, C, HIV). We also reserve the right to enquire re vaccination status for recommended vaccines e.g. influenza

Employment of foreign nationals

- It is the responsibility of the organisation to ensure that checks are conducted to ensure that all employees and workers are eligible to work in the UK in compliance with Home Office guidance.
- A sponsor licence is required to employ someone outside the UK to work here. This includes citizens of the EU, Iceland, Liechtenstein, Norway and Switzerland who arrived in the UK after 31 December 2020.
- Should an interview panel recommend the appointment of a foreign national, People Services will check if the job is suitable for sponsorship. This will usually be applicable for skilled workers only.
- The Chief Executive will take a final decision regarding whether to sponsor a skilled worker.
- Sponsorship of a worker does not guarantee that the individual will be granted a visa.

Criminal Records

- Where a DBS check is to form part of the recruitment process, we encourage all applicants called for an interview to provide details of their criminal record at an early stage in the application process for transparency reasons. We guarantee that this information will only be seen by those who need to see it as part of the recruitment process.
- All candidates will be asked to disclose unspent convictions during the application and interview process. Where the nature of the offence has a relevance to the role applied for, the suitability of the candidate will be considered in this context. Candidates will not be asked to disclose information relating to spent convictions unless the role being recruited for is exempt from the provisions of the Rehabilitation of Offenders Act 1974 (ROA). When this is the case an appropriate Disclosure and Barring Service check will be requested.
- Where an individual has disclosed a conviction, or a conviction is revealed through a DBS check, a discussion will take place with the applicant regarding the offence and its relevance to the position to assess the suitability of the applicant for the job.
- When considering the matter, a thorough risk assessment will be undertaken. After careful consideration, a decision should be taken as to whether the individual should be appointed. The hospice does, in these circumstances, reserve the right to refuse offer of employment. If the decision is not to proceed with the appointment, then the applicant will be written to, formally withdrawing the offer of employment.
- Failure to reveal information relating to unspent convictions (and spent convictions in the case of excluded jobs and professions under the Rehabilitation of Offenders Act) could lead to the withdrawal of an offer of employment or disciplinary action which could lead to termination of employment.
- It is the responsibility of both the applicant and People Services Department to clarify whether a conviction is spent or unspent.
- If a member of staff is convicted of a criminal offence whilst in employment, they must report this to the Head of People Services immediately. In these circumstances, the Head of People Services and their Line Manager will be expected to conduct a thorough risk assessment to ascertain if any formal action should be taken.
- If a member of staff is concerned about a conviction, they should speak directly with their Line manager or Head of People Services. On some occasions this will require referral to the Designated Safeguarding Lead and relevant procedures followed.
- DBS checks will be repeated every 3 years for clinical staff and every 5 years for non-clinical staff working within the hospice building.

Record keeping

- Records for unsuccessful candidates will be retained securely on the hospice servers for a period of 6 months after the closing date.

- Staff records are retained on the iConnect HR Information System. Access to these records is limited to authorised personnel only. Following transfer of candidate information to iConnect, all records held on shared drives and email folders must be deleted.
- Anyone can ask for access to personal information retained individual to them. This request – a subject access request – must be made in writing to the Data Protection Officer at St Richard's Hospice (dataprotectionofficer@strichards.org.uk).
- Records will be kept in accordance with GDPR and the NHS Information Governance Toolkit.

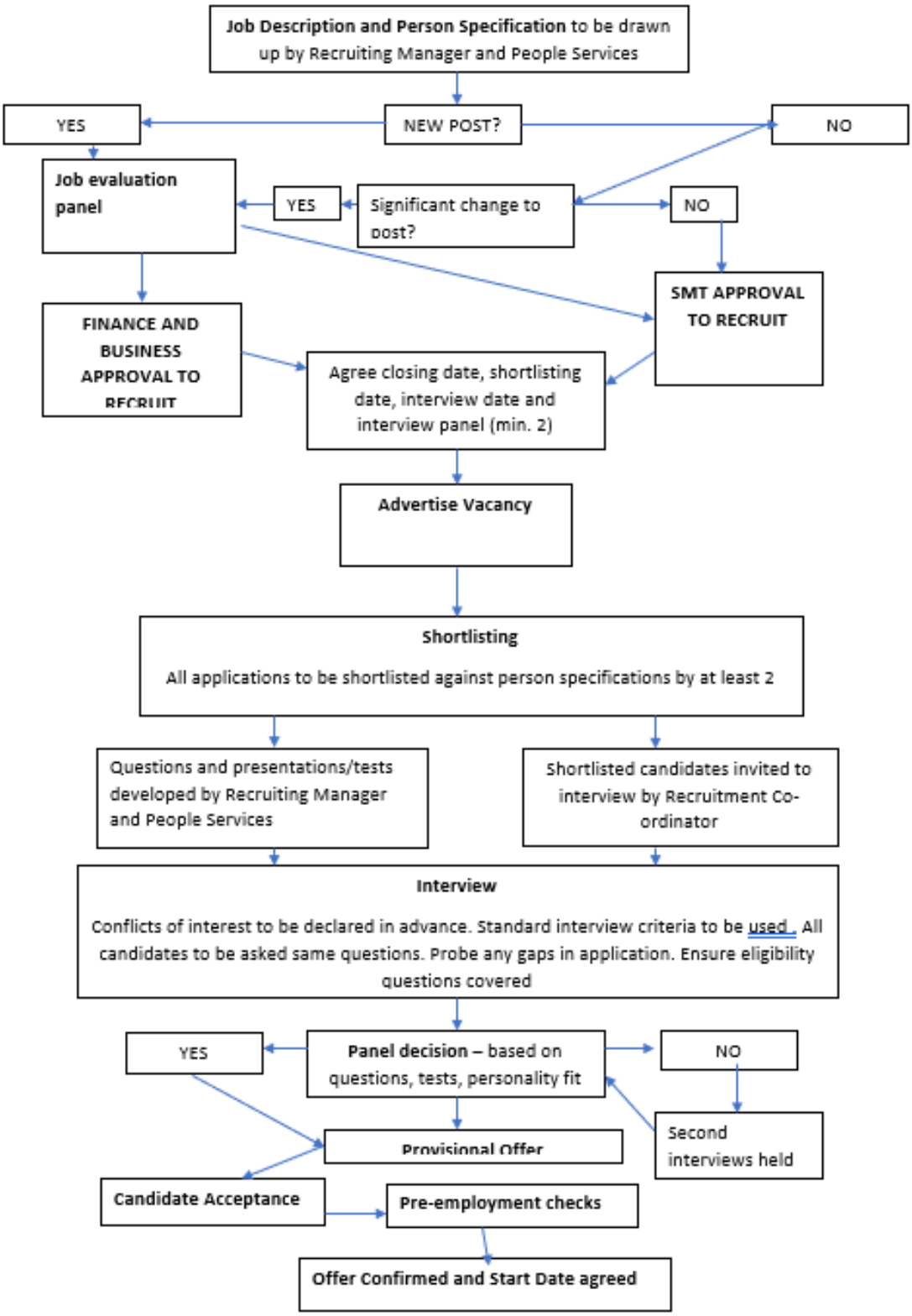
REVIEW AND MONITORING: This policy's effectiveness will be monitored and reviewed periodically through St Richard's Risk Register and the Council of Governors.

AUDIT: Adherence to this policy will monitor and St Richard's will investigate all reported instances of deemed deviation from our principles. These will then be reported to the Council of Governors via the appropriate Sub-Committee.

TRAINING: Staff will be advised of the policy content on induction and access to the policy will be available to all via the staff intranet.

ENFORCEMENT: Significant breaches of this policy by individuals, will be handled under St Richard's disciplinary procedures.

APPENDIX 1 - RECRUITMENT AND SELECTION FLOW CHART



APPENDIX 2

INTERVIEW COMMENTS FORM

Post	
Candidate Name	
Interviewers Nam	
Interview Panel	
Conflicts of Interest declared	

Questions	
	5. Excellent **4. Good** **3. Average** **2. Marginal** **1. Poor**
	5. Excellent **4. Good** **3. Average** **2. Marginal** **1. Poor**
	5. Excellent **4. Good** **3. Average** **2. Marginal** **1. Poor**
	5. Excellent **4. Good** **3. Average** **2. Marginal** **1. Poor**

Ending the Interview

Candidate Questions	
You will work in an environment with people with life threatening illnesses, do you think this will cause you any difficulties?	
If not touched on previously, as if candidate has experienced a recent and/or close bereavement?	
Competency in IT (any training required?)	
Proof of qualifications/registration	
Proof of eligibility to work in UK	
Disclosure and barring service: Discussion to take place if appropriate for level of post Sight of existing DBS/CRB disclosure if appropriate Explain all offers conditional and staff involved in regulated activity cannot start at SRH before clearance received unless in receipt of clearance within 6 months (ADDITIONAL DBS CHECK TO BE MADE REGARDLESS OF TIMING OF EXISITNG)	

Permission to check references – ensure both professional and current or most recent employer included	
Notice period	
Salary and benefits	
Holiday commitments	
Inform candidates when they will be contacted	
Interviewer Comments	**Overall Score**
Overall Conclusions - Please include rationale	
HR Manager Sign Off	

Candidate informed of Outcome	**Date**
	By

Appendix 6

St Richard's Hospice Caring for life Registered Charity No. 515668	TITLE: EQUALITY, DIVERSITY AND INCLUSION POLICY POLICY STREAM: PEOPLE SERVICES

GENERIC POLICY STATEMENT:

This information is designed to reflect and promote best practice within St Richard's Hospice. Staff and volunteers are encouraged to use their judgment at all times and base their decision making and actions on the guidance provided. Issues relating to policy should be notified to the appropriate policy stream lead and any changes that are approved by appropriate committees must be documented in the St Richard's Hospice Policy Log.

AUTHORS:	Head of People Services Equality, Diversity and Inclusion Lead
ACCOUNTABLE DIRECTOR:	Chief Executive
RATIFIED BY:	People Services Committee
DATE OF APPROVAL:	29 May 2024
REVISION DUE:	31 May 2027

COVERAGE OF THE POLICY:

This policy applies to employees, volunteers, job applicants and potential applicants, trainees and students on placement, consultants, contractors, casual and agency workers.

For the purpose of clarity, all the above are referred to collectively as 'staff'.

RELATED POLICIES:

All HR Policies and Procedures
Hospice Statement of Purpose (2023)

References

Equality Act 2010 [on line] Available at:
http://www.legislation.gov.uk/ukpga/2010/15/pdfs/ukpga_20100015_en.pdf

POLICY HISTORY LOG

Date	Name	Job Role	Change/suggestion
08.03.2024	Amanda Walford	Head of People Services	Additions re harassment as forthcoming duty on employers to take reasonable steps to prevent sexual harassment at work (expected Oct 24)

INTRODUCTION:

St Richard's Hospice is committed to equality of opportunity and providing services which are free from unfair and unlawful discrimination. We undertake to embed equality, diversity and inclusion (EDI) considerations into all aspects of our work including service development, employment practices and development of policies.

We aim to create and maintain an environment where dignity, understanding and mutual respect, free from prejudice, discrimination and harassment, is experienced by all and where staff, volunteers and those accessing our services feel able to challenge discrimination and unacceptable behaviour.

We value people as individuals with diverse opinions, cultures, lifestyles and circumstances.

POLICY STATEMENT:

St Richard's Hospice is an equal opportunities employer. The aim of this policy is to ensure that no person receives less favourable treatment or is disadvantaged on the grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy or maternity, race, religion or belief, sex or sexual orientation, or is disadvantaged by conditions or requirements which cannot be shown to be relevant to performance. It seeks also to ensure that no-one is victimised or subjected to any form of harassment or victimisation.

We aim to create a supportive and inclusive environment where people can reach their full potential without prejudice and discrimination and are committed to being a caring and welcoming place for all.

This policy aims to remove any potential discrimination in the way that people are treated by colleagues and the organisation, including:

- People with disabilities
- People of different sexual orientations
- People who identify as transgender or gender diverse
- People of different races
- People on the grounds of their sex

- Those of faith and of no faith
- In relation to their age
- In relation to their social class
- In relation to their medical condition(s)
- People who work part time
- Those who are married or in a civil partnership
- Those who are pregnant, have recently given birth or are breastfeeding.

Some of the above are protected characteristics under the Equality Act 2010 and discrimination is prohibited.

REGULATORY ENVIRONMENT AND LEGISLATION:

This policy is compliant with the Equality Act 2010 and all changes known to be in force on or before 31 July 2023.

DEFINITIONS:

The terms equality, inclusion, diversity and equity are at the heart of this policy.

Equality	ensuring everyone has the same opportunities to access services and fulfil their potential free from discrimination
Inclusion	ensuring that everyone feels comfortable to be themselves at work and feels the worth of their contribution
Diversity	understanding, recognising and respecting differences and valuing people as individuals with diverse opinions, cultures, lifestyles and circumstances
Equity	recognising barriers which lead to some groups being more advantaged than others, and putting measures in place to eliminate those barriers to ensure equal opportunities for all
Protected characteristic	Characteristics defined as protected by the Equality Act 2010, i.e. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation
Direct Discrimination	where someone is treated less favourable due to one, or more, protected characteristics either intentionally or unintentionally
Indirect Discrimination	where someone is disadvantaged by an apparently neutral provision, criterion or practice which is applied to all. This may have the consequence, usually unintentionally, of

	coursing a disadvantage. An example of this could be a regulation concerning clothing or headwear which may disadvantage someone with a protected characteristic
Victimisation	specifically treating someone less favourably because they have complained about or provided information regarding discrimination or harassment
Harassment	any unwanted conduct that has the purpose or effect of violating someone's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for them.

We acknowledge that equality and diversity are not inter-changeable but inter-dependent. There can be no equality of opportunity if difference is not valued and harnessed.

SCOPE:

This policy applies to employees, volunteers, job applicants and potential applicants, trainees and students on placement, consultants, contractors, casual and agency workers.

It applies to all areas of employment including recruitment, training, deployment, career development and promotion. These areas are monitored and policies and practices will be amended if required to ensure that no unfair or unlawful discrimination, intentional, unintentional, direct or indirect exists.

The Hospice is committed to promoting equality of opportunity for patients, carers and visitors. Further information can be found in the Hospice Statement of Purpose

RESPONSIBILITIES:

The Board of Trustees and Executive Team take overall responsibility for the development of equality and diversity and will ensure compliance with this policy.

The Equality, Diversity and Inclusion Lead acts as the lead for interpreting the Equality Act 2010 and associated legislation at St Richard's Hospice, ensuring management and staff understand their collective and individual responsibilities.

The Equality, Diversity and Inclusion Steering Group is chaired by the Equality Diversity and Inclusion Lead and includes representatives from all teams across the hospice. The group meet 6 times a year. The aims of the steering group include discussing and taking forward priority areas of work that need to

be addressed in terms of equality/equity/diversity and inclusion. This can be in relation to supporting staff and volunteers, in particular with learning and education. We also work towards removing barriers to enable people of all backgrounds and situations to access our care and support.

The Head of People Services will ensure that this policy is implemented and monitored and that all personnel policies and procedures are administered with the objective of promoting equality of opportunity and eliminating discrimination.

All line managers will demonstrate their commitment to promoting equality and diversity and take timely and appropriate action when issues are raised. They are responsible to set an appropriate standard of behaviour, to lead by example and ensure that team members adhere to the policies.

Individuals at all levels have responsibility to comply with this policy and treat others with dignity and respect. The personal commitment of everyone to this policy and the application of its principles are essential to eliminate discrimination and provide equality and equity throughout the organisation.

Hospice staff will have a mandatory requirement to complete Equality Impact Assessments for every new service development or new policy. An equality impact assessment (EIA) is an evidence-based approach designed to help organisations ensure that their policies, practices, events and decision-making processes are fair and have done everything that is reasonable to remove barriers to participation or disadvantage any protected groups from participation.

It also ensures that we actively consult and involve people with lived experiences from different protected groups.

POLICY PRINCIPLES:

All employees, workers, volunteers whether part time, full time or temporary, will be treated fairly and with respect.

Selection for employment, promotion, training or any other benefit will be on the basis of aptitude and ability.

Part time and fixed term staff should be treated the same as comparable full time or permanent staff and enjoy no less favourable terms and conditions (on a pro-rata basis where appropriate), unless different treatment is justified.

All employees have the right to the same contractual pay and benefits for carrying out the same work and all pay decisions will be determined in line with our Pay and Reward Policy.

Staff are invited to comment on this policy and suggest ways in which it may be improved by contacting the Head of People Services.

Breaches of this policy will be dealt with in accordance with our Disciplinary Procedures. Serious cases of discrimination may amount to gross misconduct resulting in dismissal without notice.

If staff believe they have suffered discrimination, they should raise the matter through the Grievance Procedure.

Policy Statements on Equality, Diversity and Inclusion

Creating an inclusive work environment

The hospice recognises its legal obligations under the Equality Act 2010. It undertakes to offer equal access for everyone to representation, services, employment, training and pay. Policies and procedures are in place with the aim of preventing discrimination within the organisation.

Staff and volunteers are encouraged to raise any EDI-related issues or concerns they experience or witness. Any such concerns will be taken seriously and will those raising the matter will be supported.

Recruitment and Selection

Our Recruitment and Selection policy is designed to prevent discrimination in the recruitment process and all those involved will be provided with appropriate training. Vacancies will be advertised widely to attract a diverse pool of candidates. We undertake to provide reasonable adjustments to applicants where appropriate.

Protected Characteristics

The Hospice undertakes to challenge assumptions concerning individuals who have protected characteristics as follows: -

Age

- We will ensure that people of all ages are treated with respect and dignity
- We will ensure that people are given equal access to employment, training, development and promotion opportunities
- We will ensure that requirements specified in job advertisement have only those criteria justifiably necessary to undertake the work

Disability

- We will provide any reasonable adjustments to ensure people with disabilities have access to our services and employment opportunities.
- We encourage those who are disabled to tell us about their condition to enable us to provide appropriate support

- We will seek to improve access to information by ensuring availability of hearing loop systems and information in alternative formats such as Large Print, Easyread, audio and video formats
- We aim to find out as much information about an individual's communication needs and preferences when they are first referred to us so that we can meet their individual needs at all stages of their support journey

Race

- We will challenge racism wherever it occurs
- We will respond swiftly and sensitively to racist incidents
- We will actively promote race equality and inclusion

Gender

- We will provide support to prevent discrimination against transgender or gender diverse individuals who have undergone, are undergoing or who are planning to undergo gender reassignment. This includes providing support if/when someone is socially transitioning.
- We will actively ensure we ask and use an individual's preferred name(s) and pronouns.

Sexual orientation

- We aim to promote a working environment where people feel safe and comfortable to be themselves, however they identify their sexual orientation.
- We will promote positive images of people who identify as LGBTQ+
- We will actively participate in local LGBTQ+ Pride celebrations as a hospice every year
- We will ensure that we have details of local LGBTQ+ support organisations such as Out2gether to signpost staff/volunteers should they need them.

Religion or belief

- We will ensure that employees' religion or beliefs and related observances are respected and accommodated wherever possible
- We will respect people's beliefs where the expression of these beliefs does not impinge on the legitimate rights of others or on policies which are critical to a healthcare environment

Pregnancy or maternity

- We will ensure that people are treated with respect and dignity during pregnancy or maternity leave and take account of their needs

Marriage or civil partnership

- We will ensure that people are treated with respect and dignity regardless of marriage or civil partnership status

- We will ensure that no individual is disadvantaged as a result of their marriage or civil partnership status

Training and Development

We are committed to providing training opportunities to raise awareness of EDI issues among employees and volunteers and encourage on-going professional development in this area.

Service Delivery

We will ensure all services and activities provided by the organisation are inclusive and accessible to everyone. We will collect feedback and evaluate the impact of services on different groups.

Policy Statements on Anti- Harassment and Victimisation

We are committed to providing a working environment free from harassment and ensuring all staff are treated, and treat others, with dignity and respect.

Harassment and victimisation are forms of unlawful discrimination and, if proven, will be treated as gross misconduct under the Disciplinary Policy. Harassment may involve conduct of a sexual nature (sexual harassment) or be unwanted conduct relating to a protected characteristic. Individuals can also be victims of harassment because of their association with someone who has a protected characteristic. It is also possible for someone to be subjected to harassment because colleagues wrongly believe them to have a protected characteristic.

A person may be harassed even if they were not the intended 'target'. For example, a person may be harassed by racist jokes about a different ethnic group.

Unwanted conduct can include any kind of action or inaction, behaviour, exclusion, written or spoken words, jokes, imagery or physical contact that the victim finds offensive. The test of harassment is, at least in part, subjective. You

Sexual harassment is any unwanted conduct of a sexual nature, including conduct which the harasser may perceive as harmless. This can include any unsolicited or unwelcome conduct of a sexual nature such as making sexual

advances, staring, making inappropriate comments, telling sexual jokes, displaying or sending images or other materials of a sexual nature.

Harassment can be less favourable treatment because they have rejected or submitted to unwanted conduct of a sexual nature or conduct related to sex or gender reassignment

- Condoning any form of harassment is harassment in itself
- The Hospice regards the harassment of its employees by third parties such as visitors as unacceptable behaviour which will not be condoned. The organisation will take such steps as are appropriate and reasonably practicable to protect employees from such behaviour. Any incidents of third-party harassment should be reported immediately to the manager or supervisor
- Allegations of harassment must not be made lightly. If it is found that an individual has made an allegation of harassment without foundation in malice, or has given false evidence or information in relation to an allegation, then this will be regarded as gross misconduct
- If you are being harassed, consider whether you feel able to raise the problem informally with the person responsible. You should explain clearly that their behaviour is not welcome or makes you uncomfortable. If you are not able to do this, you should speak to your line manager or a member of the People Services team who can provide confidential advice and assistance in resolving the issue either formally or informally.
- If informal steps are not appropriate or have not been successful you should raise the matter formally.
- We will investigate complaints in a timely and confidential manner. The investigation will be conducted by someone with appropriate experience and no prior involvement in the complaint, where possible.
- Staff who make complaints or who participate in good faith in any investigation must not suffer any form of retaliation or victimisation as a result. Anyone found to have retaliated against or victimised someone in this way will be subject to disciplinary action under our Disciplinary Procedure.

REVIEW AND MONITORING:

The policy will be monitored and reviewed by the Equality, Diversity and Inclusion Lead and the Head of People Services, including review of job applicants and career progression of existing employees.

This policy's effectiveness will be monitored and reviewed periodically through St Richard's Risk Register and the Board of Trustees.

AUDIT: Adherence to this policy will monitored and St Richard's will investigate all reported instances of deemed deviation from our principles. These will then be reported to the Board of Trustees via the appropriate Committee.

TRAINING: Staff will be advised of the policy content on induction and access to the policy will be available to all via the staff iConnect.

All staff must complete annual mandatory training concerning Equality, Diversity and Inclusion.

ENFORCEMENT: Significant breaches of this policy by individuals, will be handled under St Richard's disciplinary procedures.

St Richard's Hospice

Caring for life