St. Elizabeth Hospice (Suffolk)

St Elizabeth Hospice

Inspection report

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

Ratings

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

Summary of findings

Overall summary

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

- Services were delivered in a way to ensure flexibility, choice and continuity of care and were tailored to meet patients' individual needs and wishes. The service planned and provided care in a way that fully met the needs of local people and the communities served. It also worked proactively with others in the wider system and local organisations to plan care and improve services.
- Leaders ran services well, led innovations and supported staff to develop their skills. Staff understood the vision and values, and how to apply them in their work. Staff were motivated to provide the best care they could for their patients. There was a common focus on improving the quality and sustainability of care and people's experiences. Staff were proud to work at the service and felt respected, supported and valued. Leaders operated effective governance processes and staff at all levels were clear about their roles and accountabilities. The service engaged well with patients, staff and the local community.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

We found areas of good practice:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.

However:

- Not all clinical staff had completed safeguarding training at the appropriate level.
- Staff did not always fully record and sign changes to prescription records.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	**Outstanding** ☆	Our rating of this service stayed the same. We rated it as outstanding. See the summary above for details.

Summary of findings

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Background to St Elizabeth Hospice

St Elizabeth Hospice provided palliative and end of life care support to patients with a life limiting illness across Suffolk. The hospice is located in Ipswich and they provide inpatient and community specialist palliative care services in Great Yarmouth and Waveney. The hospice has 18 inpatient beds. At the time of the inspection the hospice was caring for 10 patients on the inpatient unit.

Facilities include an inpatient unit, hospice at home service, specialist palliative and clinical nurse specialist service, a virtual ward (community healthcare assistant service), outpatient services and family and bereavement support services. In addition, they provide the Zest service for young adult with life limiting illnesses, delivering young adult day services, support sessions and short breaks.

The director of clinical services was the registered manager.

The service is registered with the CQC to provide:

Personal care

Treatment of disease, disorder and injury

Diagnostic and screening procedures

Transport services, triage and medical advice provided remotely.

How we carried out this inspection

We visited the inpatient unit and observed a clinical nurse specialist home visit. We spoke with staff delivering inpatient, community and bereavement services. We held interviews with service leads, executives and the chair of the trustees. We spoke with 27 staff including clinical nurse specialists, nurses, health care assistants, doctors, bereavement staff, catering staff, reception and non-clinical staff. We also spoke with three patients and three relatives who had experienced support from hospice staff. We observed care and treatment provided in the inpatient unit, reviewed data about the service and reviewed five patient care records and eight prescription charts.

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

Outstanding practice

We found the following outstanding practice:

- Feedback from people who used the service and those close to them was continually positive about the way staff treated people. There was a strong, visible, person-centred culture. Staff went out of their way to support patients in the community, particularly at the start of the pandemic, including in their own time. Staff recognised the importance

Summary of this inspection

of care within communities in relation to providing support at the end of life. They had developed a compassionate communities project to raise awareness of dying and end of life care and equip the community to care for each other. They had increased the access to bereavement services for people, irrespective of whether they had a connection to the hospice. Feedback from patients and those close to them was consistently positive.

- Services were delivered in a way to ensure flexibility, choice and continuity of care and were tailored to meet patients' individual needs and wishes. The service planned and provided care in a way that fully met the needs of local people and the communities served. It also worked proactively with others in the wider system and local organisations to plan care and improve services. They had particularly focused on addressing inequalities in access to hospice services. This included providing short breaks for young adults with life limiting illness when transitioning from children's services. They had expanded the hospice services to meet the needs of a part of the community that previously had limited access. They had provided a virtual hospice service to help reduce hospital admissions and facilitate faster discharges into the community for patients wishing to be cared for at home. A hospice hub had been developed at the beginning of the pandemic and included volunteers delivering equipment and other essential items to patients and other services in the community.
- Leaders ran services well, led innovations and supported staff to develop their skills. Staff understood the vision and values, and how to apply them in their work. Staff were motivated to provide the best care they could for their patients. There was a common focus on improving the quality and sustainability of care and people's experiences. Staff were proud to work at the service and felt respected, supported and valued. Leaders operated effective governance processes and staff at all levels were clear about their roles and accountabilities. The service engaged well with patients, staff and the local community and took a leading role in the development of services to meet needs. The hospice had been recognised for innovations including a Hospice UK dying matters award, a High Sherriff of Suffolk award for work during the pandemic and were finalists in the Nursing Times 2021 community awards.

Areas for improvement

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

Action the service SHOULD take to improve:

- The service should ensure that all registered nurses' complete level three safeguarding training in line with intercollegiate guidance.
- The service should ensure staff fully document and sign when alterations are made to the allergy status or to the medicine's reconciliation section on the prescription charts.

Our findings

Overview of ratings

Our ratings for this location are:

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

Outstanding

Hospice services for adults

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

Are Hospice services for adults safe?

Good

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

Mandatory training

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

Nursing staff received and kept up to date with their mandatory training. Mandatory training compliance for nursing staff on the inpatient unit was 94% and within the community service was 98%.

Medical staff received and kept up to date with their mandatory training. Mandatory training compliance for medical staff was 80%. Overall training compliance for the hospice was 80%.

The mandatory training was comprehensive and met the needs of patients and staff. Staff completed training in areas such as basic life support, infection control and health and safety. Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training. Training rates were reported through the hospice governance processes and managers monitored against completion targets.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing and medical staff received training specific for their role on how to recognise and report abuse. All clinical staff had completed safeguarding adult and children training at level two. Some specialist staff had completed safeguarding training at level three, for example, clinical service leads, social workers and youth and children's transition staff. The

safeguarding policy did not reference up to date guidance such as the Intercollegiate document Adult Safeguarding: Roles and Competencies for Health Care Staff. Managers told us they were aware of the guidance and had identified key staff to complete level three training initially and were adopting level three training across the clinical team as an ongoing piece of work.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff demonstrated a good understanding of the recognition of types of abuse. The safeguarding policy contained clear guidance and contacts for escalating concerns, both internally and externally. Safeguarding alerts had been raised appropriately, for example, for patients with a grade 3 pressure ulcer.

Cleanliness, infection control and hygiene

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

Ward areas were clean and had suitable furnishings which were clean and well-maintained. The service generally performed well for cleanliness. Infection control audits were carried out and included regular reviews. Reports demonstrated that levels of cleanliness were high, and that action was taken to address issues. Examples of actions from the February 2021 audit included repairs to floor trims, and extractor fan cleaning was added to cleaning schedules.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Schedules were routinely reviewed as part of the regular infection control audit process. Enhanced cleaning was in place due to COVID-19, including frequent cleaning of high touch areas.

Staff followed infection control principles including the use of personal protective equipment (PPE). There were clear signs on the inpatient unit about the need for PPE. All staff and visitors were always required to wear a face mask. Compliance audits demonstrated 100% compliance with the use of PPE and handwashing practices in both clinical and non-clinical areas.

There was a COVID-19 standard operating protocol in place. This detailed guidance such as screening procedures for patients, staff and visitors, and guidance to minimise risks from aerosol generating procedures. The protocol was regularly updated in line with changes to national guidance.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Equipment used in patients' homes such as syringe pumps were bagged and returned to the hospice for cleaning.

There was no onsite mortuary, however, an air-conditioned viewing room was available for the deceased with guidelines for the length of time before transfer to a funeral director was required. There were effective arrangements with funeral directors and staff told us that collection was arranged promptly once the needs of the deceased and their relatives had been met.

Environment and equipment

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

Patients could reach call bells and staff responded quickly when called. Patients reported that staff always ensured their call bells were in reach and answered within a reasonable time.

The design of the environment followed national guidance. Patients were cared for in single rooms or shared bays with en-suite facilities. Shared bays were large enough to allow for social distancing. Rooms were designed to provide comfort and safety.

Staff carried out daily safety checks of specialist equipment. Clinical equipment, including beds, hoists and assisted baths were regularly maintained. Calibration of medical devices was carried out annually. Equipment that was faulty was repaired or replaced. Equipment used for emergency situations was appropriate and accessible for staff when needed. We saw this was logged as checked daily and single use equipment was within 'use by' dates.

The service had suitable facilities to meet the needs of patients' families. During the pandemic families could visit or stay with patients in their rooms. They were encouraged to wear personal protective equipment in line with guidance. Families were offered refreshments. Ordinarily, there was a family area that could accommodate overnight stays; however, this was not in use during the pandemic.

The service had enough suitable equipment to help them to safely care for patients. Syringe pumps were available in line with recommended guidelines and were appropriately checked during administration.

Staff disposed of clinical waste safely. Sharps bins were correctly labelled and disposed of within the appropriate timeline in line with national guidance.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Treatment escalation plans were in place to clearly record ceilings of care should the patient deteriorate. This included whether they would be transferred to hospital, or in the last days of life if they would be transferred home. Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Individual risk assessments were in use for risks associated with aspects of care such as potential skin damage, malnutrition, sepsis, moving and handling and the use of bed rails.

Staff knew about and dealt with any specific risk issues. These were recorded on the electronic reporting system and escalated appropriately. For example, grade 3 or above pressure ulcers were reported in line with safeguarding requirements. Infections were recorded and reported on a monthly basis. We reviewed a report between July and September 2021 and saw that 14 infection incidents had been recorded. These included urinary tract, wound and respiratory infections.

Incidents of pressure ulcers and falls were reported, reviewed and benchmarked against other hospices. Risk assessments and care plans were updated as required and action taken to minimise the risk of further harm.

There were risk assessments in place for complex patients on the inpatient unit. Examples included where patients required high levels of oxygen therapy, had a tracheostomy or required dialysis. In these situations, individual patient risk assessments were carried out prior to admission to ensure there were adequate equipment, staff and competencies

to safely care for them. One example was where a patient required a regular aerosol generating procedure as part of their routine care. Staff carried out an individual risk assessment to balance the risk of such a procedure in relation to COVID-19 and took mitigating action in line with national guidance, including the use of personal protective equipment and good ventilation.

Staff shared key information to keep patients safe when handing over their care to others. Handovers and multi-disciplinary meetings involved staff from across the inpatient unit team. Information was shared and up to date about patients' needs and care was comprehensively reviewed and adjusted to meet those needs. All aspects of care were discussed including symptom management, psychological needs of the patient and family, and enhanced care at the end of life, such as regular mouthcare.

Staffing

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

The service had enough nursing and support staff to keep patients safe. Staff told us that staffing establishment was based on the dependency of the inpatient unit. A dependency tool was in place and was reviewed on a weekly basis or where dependency levels changed. We reviewed the dependency score at the time of the inspection and saw that this was identified as routine. Previous weeks scores were either routine or low.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. A minimum level of staffing had been established. This included at least three registered nurses on shift during the day and two at night with equal numbers of healthcare assistants. Shift establishment was for eight staff on an early shift, six on a late and four on overnight. There were clear escalation processes for staffing issues. A meeting between managers and team leaders was held every morning to review staffing levels and identify any gaps.

The managers could adjust staffing levels daily according to the needs of patients. This included a review of the dependency on the inpatient unit and within the community services. There were arrangements in place to redeploy staff from one area to anotherutilise staff effectively to meet demand. . This meant that some inpatient staff worked shifts in the community and vice versa.

The number of nurses and healthcare assistants matched the planned numbers. Rotas showed a minimum of three registered nurses on shift during the day and two at night.

The service monitored vacancies across the service. At the time of inspection there were two vacant clinical nurse specialist (CNS) roles. Managers acknowledged issues with recruitment and had looked at ways to improve this over time. Examples included opening CNS roles to include development opportunities so that less experienced staff could be supported to gain the experience necessary. They had also rebranded one of the CNS roles so that it was open to paramedic practitioners to apply. We saw that recent recruitment had seen an increase in bank and physiotherapy staff.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Bank nurses were recruited to the inpatient unit to provide flexibility, for example, five new bank nurses had been recruited in the months leading up to the inspection. This enabled managers to book regular bank staff to work on the unit as needed. Agency staff were not routinely used on the unit. Managers made sure all bank and agency staff had a full induction and understood the service.

There was enough medical cover within the hospice. Staff told us that medical input was readily available, including out of hours when there were medical staff including consultants on call. There were nine members of the medical team working across the inpatient unit and community services. This included a medical director, seven specialist palliative care consultants (who rotate across the locality every two years), two speciality grade doctors, three trainee doctors and two nurse consultants. There were two or more doctors on the inpatient unit during the day. There was generally a consultant on site but where this was not possible remote consultant cover was available. At the time of the inspection there was a 0.7 whole time equivalent consultant vacancy which had been advertised but not recruited to.

Records

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

Patient notes were comprehensive, and all staff could access them easily. They used an electronic record system which contained risk assessments, care plans and medical, nursing and allied health professional records. Records were holistic, updated and included a proactive monitoring of performance status that acted as a trigger to deliver appropriate care. A June 2021 audit of medical handover sheets identified that these did not include relevant information about ceilings of care and discharge planning. A re-audit was scheduled for December 2021 after the results were shared with medical staff and agreed standards established.

When patients transferred to a new team, there were no delays in staff accessing their records. All clinical staff had access to the electronic patient record system across inpatient and community services. Letters to patient's GPs were generated from the system to ensure effective and timely communication.

Records were stored securely. Confidentiality was maintained using relevant encryption and password access. Records were routinely audited to ensure they were appropriately completed.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

We looked at eight treatment charts and two patient records on the inpatient unit. Allergies were recorded and venous thromboembolism (blood clot in the veins) risk assessments completed. Administration of medicines were accurately recorded, and explanations were given if medicines were not given for any reason. Staff made sure patients received their medicines, especially those that were time specific on time. The service had a service level agreement with the local NHS trust to provide clinical pharmacy and medicine supply service. Staff told us they were able to obtain medicines promptly. The pharmacist visited the inpatient unit once a week and attended the multidisciplinary meeting to discuss patient care.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. There was twice weekly consultant led ward rounds and a weekly multidisciplinary meeting where all patients were discussed, and treatment plans reviewed. We spoke to two patients who told us they had been involved in decisions about their medicines and understood what they were for. Patients told us they were able to obtain their pain relief quickly when needed. One patient told us that medical staff were very responsive and had adjusted the timing of a medicine to relieve pain. This allowed the patient to carry out their morning routine comfortably.

Staff stored and managed medicines and prescribing documents in line with the provider's policy.

Medicines and controlled drugs (medicines requiring more control because of their potential for abuse) were stored safely and securely. High strength-controlled drugs were stored separately on a clearly marked shelf for safety. Staff checked and recorded the temperatures of refrigerator where medicines were stored. FP10 prescriptions use was monitored and stored securely.

Staff followed current national practice to check patients had the correct medicines. Doctors checked the medicines that patients were taking when they were admitted to the hospice (medicines reconciliation). However, on the last inspection we saw that this was not always clearly recorded on prescription charts. On this inspection, we saw that staff did not fully document or sign when medicines were reconciled, or allergy statuses updated. However, managers told us this information was recorded in the electronic patient record system as part of a planned move towards using electronic prescribing in the future.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. The service received and acted on safety alerts appropriately. Medicine incidents were reported and investigated appropriately. Learning from incidents was shared with staff via 'drug memos' and discussed in medical meetings. These were also discussed at the 'Quality Assurance of Drugs' group, which meant that the executive team had oversight of medicines issues.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. The service had guidelines and policies in place to support prescribing and to check compatibility of medicines in syringe pumps. Staff worked collaboratively to review patient's medicines and told us they felt comfortable challenging prescribing decisions if needed. The service had conducted an audit for prescribing of opioids in the inpatient unit and in the community, recommendations made and implemented. An audit programme was in place, for example to check antibiotic prescribing.

Incidents

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

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with provider policy. Incidents and near misses were recorded on the electronic reporting system. We viewed a July 2021 quarterly incident report and saw that there were a number of metrics assessed as part of the

reporting. This included the time, location, level of harm and action taken. For example, an incident where a swap of the on-call rota resulted in difficulties contacting a consultant on call, led to changes to procedures to ensure that swaps were clearly communicated. All incidents we reviewed had no or low levels of harm. Outcomes of incidents were recorded and included care plan amendments, changes to systems and replacing equipment where required.

Pressure ulcer incidents and falls were reported to the quality assurance and improvement group. Monthly reports showed newly acquired and existing pressure ulcers for patients on the inpatient unit and those being cared for in the community. Pressure ulcers categorised as grade three or above were reported externally for safeguarding and to Hospice UK for benchmarking against other hospices. All pressure ulcer incidents were reviewed, and action taken to address learning. For example, where assessments or documentation were not completed in a timely way, this was raised at staff meetings to improve. We reviewed a 2021 falls report and saw that 14 of 15 falls resulted in low or no harm and one was moderate harm. Action as a result included amendments to care plans and changes to the use of equipment, for example, sensor mats. Information was also discussed with patients and their relatives to provide advice on reducing the risks of falls.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Staff gave examples of when they had apologised to patients when things went wrong. There was a clear process for offering an apology, an explanation and providing support. Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Patients and those close to them were kept informed of the outcome of investigations and were offered the opportunity to meet with senior staff to discuss any concerns.

Staff met to discuss the feedback and look at improvements to patient care and received feedback from incidents. Incidents were discussed at the quality assurance and improvement group. Actions were reviewed and reports made available to the care and clinical governance committee. There was evidence that changes had been made as a result of feedback.

Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

A 2020 priority for the hospice was to increase patient safety and reduce the incidence of patient harm, particularly from falls and pressure ulcers. The implementation of the new electronic incident reporting system supported this priority and enabled an improved reporting process. The service continually monitored safety performance to indicate how safe the service was in providing harm free care.

The prevalence of patient harm from incidents such as falls, pressure ulcers and medicines incidents were monitored and reported monthly.

Are Hospice services for adults effective?

Good

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Managers monitored national guidance and adopted this into policies and frameworks within the service. We saw that revised 2021 guidance, NICE quality standard (QS13) End of life care for adults had been reviewed at governance meetings. The guidance included revised standards for support for patients in relation to advance care planning, and, additional focus on support for carers.

The Five Priorities of care at the end of life were incorporated into the care planning process within the hospice. We saw that patients were assessed to ensure they were recognised when in the last days of life and that individual care plans were in place with involvement of the patient and those close to them.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. There was a holistic approach to assessing patients' needs that included psychological and emotional needs. Handover records showed that the needs of both patients and their relatives and carers were considered. Staff worked together to support those needs. Referrals for psychological support were made and psychological and family support services were available within the hospice.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, particularly those with specialist nutrition and hydration needs. There were enough menu choices available to meet people's needs. Alternative meal choices were provided. A September 2021 snapshot survey on the inpatient unit found that 100% of patients felt their food and drink needs were being met, choices were offered, food and drinks were within reach and assistance was given when needed.

Patients with specialist nutrition and hydration needs were regularly assessed and information shared with catering staff. For example, all young adults cared for on the Zest unit had individual nutrition plans kept within the kitchen which included likes, dislikes, preferences and any specific needs or allergies.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Fluid and nutritional intake was evaluated as part of the daily nursing assessment. Information was shared at handover.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. The risk of malnutrition was assessed on admission and regularly reviewed. Patients were offered food and drink based on their individual needs and wishes. Catering staff made every effort to provide food that the patient wanted and could tolerate, particularly in the last days of life when comfort was a priority. Oral care was provided for patients in the last days of life, with the focus on ensuring comfort. There was a mouth care protocol which followed recognised guidance and a link nurse on the inpatient unit monitored for changes in guidance to ensure care was up to date and effective.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. Support was accessed through referral and staff were able to seek appropriate advice as required.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Tools included those for use with patients who were non-verbal and those with dementia. Patients had clear plans for the management of pain and other symptoms. Staff administered pain relief and monitored its effectiveness. Patients were reviewed medically daily and prescribing ranges were adjusted as required to ensure that patients had access to the pain relief they required.

Patients received pain relief soon after requesting it. Staff were observed responding promptly to requests for pain relief. Patient feedback demonstrated that staff were prompt to respond when patients were in pain.

Staff prescribed, administered and recorded pain relief accurately. Prescriptions were clearly recorded and included ranges so that staff could titrate doses according to patient need. Pain and other symptoms were monitored on a daily and continuous basis and staff had access to clear guidance about effective treatment for the range of symptoms at the end of life.

Patient outcomes

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

The service participated in relevant national clinical audits. This included audits of pressure ulcers, falls and medicines errors. Results from these were reported to Hospice UK for benchmarking against other hospices. Data from these audits was reported internally to the quality improvement group and monitored for trends. Action was taken to improve as a result. For example, improving falls risks was one of the safety priorities within the hospice, both in relation to the inpatient unit and for patients cared for at home.

Managers and staff used tools to improve patients' outcomes. The hospice used the Palliative care outcome score (IPOS) to understand the overall experience and status of patients at a specific point in time. Patients self-scored based on their experience of symptoms. The scores were recorded at different stages of a patient's treatment. We reviewed a 2019 day-care report where IPOS scores were rated at three or four (severe or overwhelming) at the beginning of treatment. Repeat scores at 3-5 and 7-8 weeks showed improvement. For example, 23% of new patients experiencing breathlessness rated their symptom as severe or overwhelming. This reduced to 14% at the second IPOS score and 4% at the third.

Patients on the inpatient unit had IPOS questions completed on admission and then weekly at the multidisciplinary meeting. The service used the Australia-modified Karnofsky performance scale (AkPs) to identify patients' overall status and ability to carry out activities of daily living. Patient outcomes were discussed at handovers and multidisciplinary team meetings. This helped clinical staff to evaluate the effectiveness of their treatment and care and informed discussions with patients and their family about changes to treatment and care.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Internal audits were routinely carried out. We viewed audits relating to do not attempt cardiopulmonary resuscitation decisions, records audits, non-medical prescribing and oxygen prescribing. Actions to improve were evident. For example, issues identified with prescription decisions by non-medical prescribers not being shared with patient GPs was identified as due to changes to the electronic patient record. Changes to the non-medical prescribing protocol were made to ensure clarity.

Audits of patients' preferred place of death showed that 87% of those who died achieved their preferred place of care at the end of life.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The hospice had an objective as part of their business plan to address inequalities in palliative and end of life healthcare provision and build capacity and culture by ensuring they had the right people with the right skills. As part of this they had developed nursing career pathways for healthcare assistants, registered nurses and clinical nurse specialists (CNS').

There were clear competency frameworks for roles within the service. This included for clinical nurse specialists and registered nurses. Competency was assessed in line with training and development opportunities. Examples included symptom management, syringe driver, assessment and consultation skills.

Healthcare assistant competencies had been identified following a training needs analysis. An education plan had been implemented to address learning needs identified and this was delivered through reciprocal arrangements with the local NHS trust. The healthcare assistant competency framework identified core skills such as mouthcare, wound care, symptom management and personal care. Competencies were assessed following the delivery of training. We viewed completed competency assessment records for a range of clinical staff.

Staff following the CNS or registered nurse career pathway had access to additional specialist training. This included masterclasses for registered nurses and palliative care master's degree level modules for CNS'. The pathways included rotational opportunities through different departments within the hospice.

Managers gave all new staff a full induction tailored to their role before they started work. Induction training and the opportunity to work shadow shifts was available to staff new to their role. Probationary reviews were carried out to monitor progress and development plans identified to support staff in their role. A bank or agency induction programme was in use.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff we spoke with told us they received a regular appraisal. A review of clinical staff appraisal rates showed that achievement of annual appraisals was over 90%.

Managers supported staff to develop through regular, constructive clinical supervision of their work. All clinical staff had access to clinical supervision. This included group supervision for inpatient and community staff. Clinical nurse specialist had access to team and individual supervision. Medical staff had regular supervision and learning sessions facilitated by the consultants and medical director.

The clinical educators supported the learning and development needs of staff. A clinical education programme was evident, with learning and development sessions aligned to the hospice business plan. Education was planned and staff were supported to attend. Some training sessions had been suspended during the initial stages of the COVID-19 pandemic, with adjustments made to enable virtual and online learning. Face to face learning sessions had resumed at the time of the inspection.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff told us they were involved in shared learning and information exchange as part of staff meetings, information emails and team sessions.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Training needs were identified through a comprehensive analysis process for each clinical role. Additional training was identified based on the objectives for the service and developments in patient needs. For example, managers had identified the need for more training in learning disabilities and autism in line with the planned growth of the Zest service and caring for more complex patients throughout the hospice. This was planned for 2022.

Managers made sure staff received any specialist training for their role. There was a process to identify and plan specialist training based on the needs of patients. A risk assessment had been carried out to identify the types of specialist need that may present within the hospice. This included for patients who may require assisted nutrition or non-invasive ventilation. As part of the assessment, the need for staff with specialist skills was identified and arrangements were in place to ensure training was provided prior to patients being admitted to the inpatient unit.

Managers identified poor staff performance promptly and supported staff to improve. There were clear processes in place to manage performance, including individual training and competency processes.

Managers recruited, trained and supported volunteers to support patients in the service. Volunteers had tailored induction and access to ongoing support.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Weekly inpatient multidisciplinary meetings were held to discuss patients and improve their treatment and care through holistic working. Members of the multidisciplinary team included medical, nursing, physiotherapy, occupational therapy spiritual and psychological support staff.

Staff worked across health care disciplines and with other agencies when required to care for patients. Clinical nurse specialist and community staff worked together with district nurses and other support staff to care for patients in the community. They attended gold standards framework meetings, supporting the recognition of patients nearing the end of life and working with the MDT to better support patients needs to provide the right care at the right time. We observed this in action and saw that staff worked proactively across service boundaries to provide high standards of care for patients.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. Spiritual and psychological support services were available within the hospice. Staff referred patients for mental health assessments and support as needed. They liaised with patients' GPs and other community services to ensure that mental health needs were met.

Seven-day services

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

Consultants and speciality doctors led daily ward rounds, including weekends. There was medical and senior nurse support for the inpatient unit 24 hours a day through the on-call system.

The hospice at home service was available seven days a week.

Health promotion

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

The service had relevant information promoting health and wellbeing. This included advice and support on nutrition, pain control, emotional and spiritual needs. Staff cared for patients with a holistic approach and regularly monitored patients' wellbeing.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They had completed training in the Mental Capacity Act 2005. Individual patient care plans included an assessment of mental capacity. The assessment was decision specific.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Consent to share information with relevant healthcare professionals was sought from patients on admission or entry to the service.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. They involved relevant family members or carers in decisions where a patient was unable to give consent.

Staff made sure patients consented to treatment based on all the information available. Procedures were explained with supporting patient information leaflets where appropriate and relevant. Staff clearly recorded consent in the patients' records. Decision making relating to do not attempt cardiopulmonary resuscitation (DNACPR) involved discussions with patients and where appropriate their family or carers. We reviewed the results of a June 2021 DNACPR audit and found that while discussions with patients were clearly recorded, this was not always the case with

discussions with next of kin. Feedback from the audit was given to clinical staff with the aim to improve practice. A report was made available to the quality improvement group and a repeat audit was planned for December 2021 to review the effectiveness of the measures implemented. Staff had received training in advance care planning and there was a clear drive to improve the recording of advance decisions.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. The hospice consent policy included guidance in the event of the need for best interest decisions where patients lacked mental capacity. Patient records included guidance and space to record mental capacity assessments and best interest decisions. In addition, there was guidance on parental consent and assessing the decision-making competence of young people (Gillick competency) in the event of the decision relating to a young person under the age of 16.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. At the time of the inspection there was no patient with a DoLS in place, however, staff understood their responsibilities in relation to this. Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Are Hospice services for adults caring?

Outstanding ☆

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed interactions and saw that without exception these were focused on the needs of the patient and those close to them. Staff gave patients the time they needed to ensure their needs were met. They were quick to respond to requests for help, answering call bells promptly and consistently checking on patients.

Patients said staff treated them well and with kindness. Patients and family members consistently told us that staff treated them with dignity and respect. One patient told us that staff 'go out of their way for you'. Relatives told us that staff were consistently kind, caring and respectful.

Feedback from a local GP described hospice staff coming together to plan and support the sudden deterioration of COVID positive patients in the community at the start of the pandemic, often in their own time. They described the care that patients received from hospice staff as 'defining compassion'. They also described the care and support that they received from staff, to enable them to care for their patients in the community, in the highest terms.

Staff followed policy to keep patient care and treatment confidential. Records were appropriately security protected and staff ensured discussions about patient treatment and care were held discreetly.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff ensured that care after death included honouring the spiritual and cultural wished of the deceased person and those close to them.

Hospice staff worked to engage with the community to increase awareness of dying matters. For example, a compassionate community project had been developed, offering local communities' guidance on how to support each other through grief, as well as helping to tackle the taboo around death and spark important conversations about dying and bereavement. The aim of the project was to better equip people in their communities to better support each other around end of life care issues. The hospice won the Hospice UK Innovation in Dying Matters Award as the lead for the project in collaboration with other local hospices and the local university.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. The 'one call' service enabled people in the community to be signposted for appropriate support and advice. The Living Grief service provided emotional, wellbeing and bereavement support to patients, their families and the wider community. Patients being cared for in the community and the inpatient unit were supported but a multidisciplinary team that included psychological and spiritual support services.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. All patient facing staff had completed advanced communication training. We observed staff communicating in supportive ways when talking to family members about what to expect in the last days of life. Where family members were visibly anxious staff talked them through symptoms and how these would be managed. Staff were seen to be caring and compassionate, they understood the impact of the last days of life on the family and approached all interactions with empathy.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff treated the patient and their family holistically, caring for their emotional, psychological and social needs as well as physical. Family members were supported to continue visiting patients during the pandemic and in line with national guidance. Staff supported patients to communicate with loved ones using technology. Staff spent time with patients and their loved ones to minimise stress and answer questions to alleviate anxiety.

The hospice provided a Living Grief service for emotional support and wellbeing. The service provided support to anyone who was facing bereavement or who had been bereaved. Prior to the pandemic, the focus for bereavement services had been on the families of those who had died whilst being cared for by the hospice. As a result of the pandemic the Living Grief service had expanded to meet the needs of the wider community, providing support for people in Suffolk who had suffered a bereavement irrespective of whether the person had died under the care of the hospice or not. An enquiry line was available for support from the emotional and spiritual wellbeing team. Online bereavement groups were set up from May 2020. Feedback from these included that people felt less alone in their grief and that they felt better informed about the grieving process. For example, one participant said, 'hearing people talk openly about grief made it feel relatable to me and it was comforting to know I wasn't alone in what I was experiencing.'

Feedback data showed a 23% increase in participants knowing what to expect, a 25% increase in knowing where to access support, a 7% increase in their ability to support themselves and an 8% reduction in isolation. The team had set up a 'walk on' bereavement group, facilitating group walks for people who had been bereaved. The hospice had also set up '565', a service for children and young people providing emotional support for bereavement or where they had a family member with a life limiting condition. One to one and group support was provided.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. We observed staff in the community discussing care with the patient and family. This included aspects of symptom management, explaining options and taking care to talk through expected changes. We observed a clinical nurse specialist talking through care with a family who were concerned about symptoms in the last days of life. They were treated with professionalism and kindness. Discussion included support for mouth care and hydration, as well as management of symptoms.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. There was a range of feedback mechanisms across the services, including surveys within each service. In addition, on the inpatient unit patients were asked to give 'real time' feedback, where a senior staff member spoke with patients about their experience. Results we viewed included that staff were 'lovely', 'kind' and 'brilliant' and that anything patients needed was provided. As well as asking for patient feedback, staff caring for them were asked about what they felt had gone right with the patients care, as well as 'what couldn't you do that you wanted to do?' This enabled senior staff to explore different influences on patients' experience.

Staff supported patients to make advance decisions about their care. Staff had received training and there were processes in place to ensure advance decisions were discussed at an early stage in the patients care. Patients were helped to focus on what was important to them towards the end of life and staff supported them with this, ensuring patient wishes were central to care planning.

Patients gave positive feedback about the service. An inpatient unit survey feedback in September 2021 showed that 100% of patients felt their needs were met and that they were treated with dignity and respect. A June 2021 community nursing survey showed that 100% of relatives felt they were respected, were confident in the services, that patients were treated with dignity and would recommend the service. An emotional and wellbeing service survey showed that 100% of patients found that the therapist treated them with warmth and empathy and 94% stated the support they received helped them to better deal with their situation.

Patients and family members, we spoke with told us that staff were professional and kind. One relative told us their family member had been treated as an individual and that they 'wish that everyone was able to get this level of service'. Another family member told us that 'compassion, care and dignity' was central the support given to the patient and the family.

An evaluation of the Zest, young person's short break service for young people with life-limiting illness showed that 100% of participants and their families experienced either good or excellent care and had increased confidence as a result of the support provided. Feedback from family members included that it gave parents time to spend with their other children and increased the independence of the young person accessing the service.

Outstanding ☆

Hospice services for adults

Are Hospice services for adults responsive?

Outstanding ☆

Our rating of responsive improved. We rated it as outstanding.

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the needs of the local population.

The hospice actively worked in partnership with the local Integrated Care System (ICS) to meet the health and care needs of people living in the area. The hospice chief executive was a member of the ICS board and chaired the end of life care board. The director of patient services was co-chair of the end of life alliance programme board and the medical director was a member. Hospice staff were members of the integrated neighbourhood teams, including for community nursing, compassionate communities and promoting health equity.

The hospice had strategic objectives that included addressing inequalities in palliative and end of life care provision; and, to work in partnership with the community to equip them to better support each other through life-limiting illness. The hospice recognised increasing demand on its services, an increase in the over 65 population, increasing complex needs and growing health inequalities.

The service worked closely with other organisations in the wider healthcare system to design and plan palliative and end of life care services within the scope of their strategy. They had developed a compassionate communities project, working with other local hospices and a local university to develop a model to equip the community to better support each other. This included providing compassionate conversation training for people in the community, for example, café workers. More formal support was provided by hospice staff, including volunteer supervision. The service won the Hospice UK 2021 Innovation in Dying Matters Award for this collaboration.

In 2019 the hospice launched a partnership with a local Clinical Commissioning Group (CCG) to provide support for patients in Great Yarmouth and Waveney. This was in response to the recognition that Great Yarmouth had a higher than average mortality rate in the East of England and had some of the most deprived areas in the United Kingdom. The hospice provided specialist palliative care support services as part of the partnership. This included Clinical Nurse Specialist input, emotional and wellbeing services, education and specialist support to patients with life limiting illness in the local East Coast community. The hospice also provided specialist support to a six bedded inpatient unit providing end of life and palliative care within the local community hospital.

Equality and diversity were considered within policy changes and impact assessments were carried out in relation to service changes and developments. There was an equality lead within the hospice and there was a clear focus on collaborating and co-producing services with vulnerable and harder to reach groups to provide more accessible and tailored services to meet their needs.

From the beginning of the COVID-19 pandemic the hospice worked collaboratively to respond to the needs of the community. This included the development of a ‘one call’ hospice hub where 24/7 advice was provided to support

individuals and professionals in the community with the provision of end of life care. The hospice responded to identified need and developed specific support. The formation of the hub included the development of a pandemic logistics team to coordinate and provide personal protective equipment (PPE) and other equipment such as syringe pumps. They provided and supported volunteers within the local community to deliver out of hours prescriptions throughout the community. This enabled the use of? skilled staff and other resources to focus on supporting patients in the community to die well in their own homes. A virtual ward was created with a team of healthcare assistants supporting patients in the last six weeks of life to be supported at home. This helped to avoid unnecessary hospital admissions, improve discharge processes and support patients to achieve their preferred place of care at the end of life. The hospice was a finalist in the Nursing Times nursing in the community award and achieved the Suffolk High Sheriffs award for this work.

The service had systems to help care for patients in need of additional support or specialist intervention. The hospice worked with children's services to support children and young adults to transition to adult services. This was in recognition of an increase in young adults with life limiting conditions and an increased number transitioning into adulthood. The Zest programme supported young people aged 14 and upwards with progressive and incurable illnesses to ensure that they received appropriate specialist care. The service supported 36 young people and 124 family members through regular clinical reviews, monthly social group for patients, a parent support group, whole family drop-in sessions and coordinated support with transition.

In 2019 the hospice set up short breaks for young adults (18+), held over a weekend at the hospice enabling them to meet with friends. This was in recognition of the changes from children to adult services where ordinarily the short break provision was not available within adult service provision. The model was co-produced with young adults and their families. The hospice worked with a local university to evaluate the service and showed an increase in confidence for those young people accessing the service.

Facilities and premises were appropriate for the services being delivered. Inpatient services were provided in four bedded bays or single rooms. Patient bedrooms were spacious and light with access to the gardens from them. The Zest service rooms had been refurbished with input from young people and their families to enable a fully accessible, warm and welcoming environment. There was a sensory room for young adults transitioning from children to adult services.

Meeting people's individual needs

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

Staff made sure patients living with poor mental health, learning disabilities and dementia, received the necessary care to meet all their needs. Staff had received training to support patients with additional needs. The Zest team included specialist learning disability staff who rolled out training for the wider hospice team. There were dementia champions throughout the hospice team and staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. For example, following feedback from the relative of a patient with hearing loss, managers

were exploring the use of a range of tools to better support communication needs over the long term. They had trialled the use of an app and were looking at basic sign language skills for staff. Staff had access to tools to aid communication, for example, picture prompts and personalised 'this is me' records to support understanding non-verbal cues in patients unable to verbalise their needs.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Telephone and in person interpreting services were available.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Staff had received training in cultural and religious beliefs. They worked collaboratively with local community services to meet people's needs and preferences. End of life care training by the education team included a facilitated session exploring end of life care from a Muslim perspective.

Access and flow

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

Managers monitored waiting times and made sure patients could access services when needed. Referrals to both the inpatient and community services were triaged based on need and were assessed in line with patient dependency and staffing levels. Service activity was recorded on a patient dashboard. This was updated daily and included inpatient unit bed occupancy against available beds and a waiting list. At the time of our inspection there was no waiting list and on average patients did not wait longer than a few days for admission. Support was available in the hospice at home and specialist palliative care services for patients in the community waiting to access the inpatient service.

Managers and staff worked to make sure that they started discharge planning as early as possible, assessing patient's discharge needs as part of their admission processes. This included identifying patients' preferred place of care at the end of life. The multidisciplinary team worked together to ensure that patients' discharge needs were met. At the start of the COVID-19 pandemic the hospice created a hub for the coordination of palliative care and end of life services. This included a virtual ward, where healthcare assistants provided support in the community for patients in the last six weeks of life. The aim of the service was to support patients who wanted to die at home, prevent unnecessary admissions to hospital and support with discharge from hospital. Data showed that during this time 87% of patients supported by the hospice achieved their preferred place of death and that 94% of families surveyed said they were helped in a crisis.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. They encouraged patients and their relatives to discuss concerns as they arose so they could be resolved as quickly as possible.

Managers investigated complaints and identified themes. Complaints were aimed to be resolved within 20 days. Where this was not possible complainants were kept informed of progress. Twelve clinical complaints had been received in 2020/21. The primary theme was around communication. Feedback was provided to complainants and they were involved in the investigation process and asked what they needed to achieve resolution.

Managers shared feedback from complaints with staff and learning was used to improve the service. For example, good communication was discussed at staff meetings and managers worked to understand issues that may impact this.

Staff could give examples of how they used patient feedback to improve daily practice. For example, by making sure alternatives were available when a patient said they did not like the fruit that was on offer.

Are Hospice services for adults well-led?

Outstanding ☆

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

Leadership

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

Leaders demonstrated high levels of experience, capacity and capability. They understood the challenges and priorities of the service and proactively sought to address them. They worked collaboratively with partner organisations, stakeholders and other services to deliver high-quality and patient centred services.

There was a clear management structure with defined lines of accountability. The day to day management of the service was the responsibility of the senior leadership team. This included the chief executive officer, medical director and director of patient services. They were supported by directors of hospice support teams, medical and nursing leads, and department leads. The senior leadership team was accountable to board of trustees.

We spoke with the chair of the board of trustees who told us they were kept informed by the senior leadership team. Members of the board of trustees chaired various sub-committees. These included governance and oversight, care and clinical governance, people and culture and finance and investment.

Staff we spoke with told us that leaders were visible and supportive. There were development opportunities for staff to enhance their leadership skills. 'Aspiration' management training had been completed by six staff members in the last year. Internal development sessions were available for team leaders and managers through whole day peer to peer support days. These focused on sharing knowledge, skills and career development opportunities. A clinical nurse specialist pathway had been developed to support nurses to develop into that role. This included nurses being recruited directly into a development role, as well as seven inpatient unit nurses completing the programme to take up clinical nurse specialist roles on the inpatient unit and in the community. Healthcare assistants were supported to develop their careers, this included routes into assistant practitioner roles, and registered nurse training.

Vision and Strategy

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

The hospice had a vision to ensure 'all in our community affected by life-limiting illness are able to live fully and die with choice and dignity'. They had developed a three-year strategy in 2020 to support the delivery of high quality care aligned to national and local end of life care strategies. They worked with key partners within the local integrated care systems to develop a collaborative strategy with involvement from patients, carers, partners, staff and volunteers.

The strategy set out the changing needs of the community and identified strategic objectives. These included the provision (and support for partners) to deliver proactive and reactive patient centred care. They had a focus to address inequalities in palliative and end of life care and to work with the community to help equip them to better support each other through life limiting illness. They aimed to build their capability and culture through innovation. They sought feedback on the objectives through a combination of one to one interviews and internal and external surveys and feedback was positive.

Progress against the delivery of the strategy was monitored against ambition milestones for each of the three years. There was clear evidence that a number of these milestones had been achieved within the ambition timeline. For example, in 2020/21 they had taken action to embed the palliative and end of life care hub, extended the scope and scale of the Zest group, embedded collaboration into the culture and, with partners, understood the needs of the local communities. Additional milestones involved improving governance controls, embedding collaboration into the culture and introduced an integrated management system to support informed decision making.

Culture

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

We observed that staff were passionate about providing high quality care and were proud to work for the hospice. Staff worked well together and there was a cohesive team approach. Feedback was mostly positive about staff's experience of working within the hospice, with those we spoke with reporting that leaders were approachable, responsive and focused on the needs of patients.

Staff were valued by the senior leadership team and there were examples of individual staff and teams being nominated for awards in recognition of this.

Staff told us they had the opportunity to raise concerns safely and without fear of reprisal. There was a whistleblowing policy and a named freedom to speak up guardian who staff could approach with concerns if they did not feel able to approach a line manager.

The culture of the service encouraged openness and honesty. Patients and families could provide feedback through a variety of methods and concerns were acted on promptly. Staff had a good understanding of the duty of candour and apologised when things went wrong.

There were clear clinical career pathways for staff. There were opportunities for both clinical and non-clinical staff to follow leadership and other training and development programmes to enhance their careers.

There was a strong emphasis on the safety and wellbeing of staff. There were measures in place for staff working alone in the community, including the use of personal safety devices. There was enhanced support for staff during the pandemic with access to internal and external counselling and wellbeing support. Leaders were aware that morale had been impacted by the pandemic and organisational changes and worked with staff to listen to their concerns and took action to address them. Staff had access to group and individual supervision, including specific sessions to reflect on difficult situations. The senior leadership team facilitated wellbeing webinars with staff to understand challenges and identify opportunities for support. Staff had access to an employee assist support line.

Governance

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

There were effective governance structures, processes and systems of accountability and a clear governance framework. Individual trustees chaired sub-committees, for example, a care and clinical governance sub-committee and a people and culture sub-committee. The trustees and senior leadership team reported back to the board, providing summaries, meeting outcomes and action points.

Monthly quality assurance and improvement group (QAIG) meetings were held. The group reviewed a range of monitoring and quality performance data including quality improvement and assurance audits, safety incidents and risks, training compliance, staffing, complaints and patient experience feedback. Quality and safety information from the group was then reviewed at the care and clinical governance sub-committee.

Staff were clear about their roles and accountabilities and who to report to. Staff were committed to improving the quality of service and maintaining high standards of care. They were involved in discussions about the performance of the service and were encouraged to report issues and work together to learn and develop the service.

There are arrangements in place to manager and monitor contracts and service level agreements with partners and third-party providers. Contract reviews were informed through the use of quality indicators and feedback.

Management of risk, issues and performance

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

There were clear processes for identifying and mitigating risks. There were operational and board assurance risk registers. Environmental risks such as fire safety and equipment use had been mitigated through the use of regular assurance checks in line with guidance. Risks associated with a lack of staffing had been partially mitigated with the hospice's 'grow your own approach' to staff development, and their work with the local university to provide training to upskill the future workforce.

Individual risk assessments were carried out for each patient on admission and reviewed regularly during admission. Risks from falls and pressure ulcers were mitigated with appropriate measures such as the use of safety and pressure relieving equipment.

Environmental risk assessments were undertaken by internal facilities staff and external contractors. There were effective arrangements in place to mitigate the risks from fire, legionella and slips, trips and falls.

Current and future performance was monitored through a range of information and we saw evidence of this in quality and performance reports. Information included safety measures, feedback and performance against key performance indicators. This information was shared with commissioners as part of ongoing performance monitoring.

Information Management

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

There was a holistic understanding of performance and this was integrated with patient and family views and information on quality. In 2020 the hospice introduced an integrated management information system to support informed decision making. Clear performance measures were evaluated and reported on. Staff had access to integrated quality and performance data. This included incidents, staffing, patient and family feedback, complaints and service activity performance. Service performance was tracked over time to support the identification of areas for improvement. Where variations in performance were apparent, action was taken to make improvements.

There were effective arrangements to ensure data and statutory notifications were submitted to external bodies, as required. This included local commissioners and the Care Quality Commission (CQC). Quality dashboards were shared with commissioners to report on performance.

Staff had access to up-to-date information about patients' care and treatment. The system was aligned with those used by local GPs and community services to ensure integration and access to information. The information systems were secure, with systems encrypted and password protected.

Engagement

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

There was a strong emphasis on working collaboratively with external partners to develop services for patients. Leaders worked with the integrated care system to understand the needs of the local communities and develop collaborative service initiatives. Feedback from external partners was consistently positive about how leaders engaged with them to support and improve services and outcomes for the local population.

Patients and their families were involved in shaping and improving the service and culture. A range of engagement processes were in place. This included feedback surveys across services and consultation with patients, family and carers on how services were delivered and developed. Survey results were consistently positive, with a high level of satisfaction. The hospice participated in a national bereavement survey and developed clear and timely action to improve where necessary.

Staff were consulted routinely on proposed changes to services. They had been involved in the development of the organisational values and strategy and were encouraged to participate in engagement events with the senior leadership team.

Learning, continuous improvement and innovation

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

There were a range of quality improvement activities within the hospice and staff actively participated in these. We saw that services were regularly reviewed to ensure they met the needs of patients and the local community. Examples included reviewing and improving multidisciplinary meetings for community services, with the addition of learning from case reviews. There were clear quality improvement aims within the annual quality account that included safety, patient experience and effectiveness. The quality account was reviewed and updated annually.

Innovation was at the heart of delivering high quality end of life care and staff and leaders worked collaboratively with other providers in the local community to develop these. They worked in partnership to identify health inequality within the winder health system and adopted a 'what are we missing?' approach with partners to meet these needs.

At the start of the pandemic the hospice worked with local commissioners to increase capacity to respond to the needs of the local community and support other providers. This included a temporary increase in bed capacity, the development of a virtual ward, a logistics team to mobilise resources in the community and bereavement and emotional support lines. They expanded their 'one call' telephone line to take calls from people in the community that were not already under the care of the hospice. This line included support for professionals caring for patients in the community, including GPs, care homes and families. The service provided direct support for patients in the last six weeks of life to support preferred place of death, admission prevention and support with hospital discharge. They received a High Sherriff of Suffolk award for work during the pandemic and were finalists in the Nursing Times 2021 community awards.

The education team worked with care homes wishing to improve their delivery of palliative and end of life care through a care home accreditation scheme. This involved working with managers and staff to provide training and shadowing opportunities within the hospice. They supported improvements by undertaking 'critical friend' visits and recommending actions.

The hospice had developed an integrated care academy in partnership with a local university and other voluntary sector and NHS providers. The aim of the academy was to lead research into integrated care and population health with a focus on supporting the longer-term needs of the most vulnerable in the community. There was a focus on harnessing

the spirit of collaboration from the pandemic to support the best healthcare for all; to support vulnerable groups and develop professional expertise to respond to future health and wellbeing crises. St Elizabeth's role was to support a training and development centre. There were plans to increase the number of places for student nurses, paramedics, radiographers and starting a new course in physiotherapy.