

St Andrew's Hospice Limited

St Andrew's Hospice, Adult and Children's Services

Inspection report

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

Ratings

Overall rating for this location

Good



Are services safe?

Requires Improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Outstanding



Are services well-led?

Good



Summary of findings

Overall summary

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


- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse. The service controlled infection risk well. The service managed safety incidents well and learned lessons from them.
- 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.
- 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.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Staff did not always complete and update all risk assessments for each patient. Staff did not always keep detailed records of patients' care and treatment.
- Although, staff gave patients enough food and drink to meet their needs, the service had identified improvement was required in recording.
- Appraisal completion figures for clinical staff showed 37% had not been completed at the time of inspection.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
End of life care	Good 	Our rating of this service stayed the same. We rated it as good. See the summary above for details.

Summary of findings

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Summary of this inspection

Background to St Andrew's Hospice, Adult and Children's Services

St Andrew's Hospice, Adult and Children's Services provides care for people of all ages living with a progressive life-limiting condition, including cancer, motor neurone disease, cardio-vascular diseases, multiple sclerosis and Parkinson's disease.

Care is available in a range of settings, from overnight stays and respite to out-patient visits and home care.

The service is registered to provide diagnostic and screening procedures, transport services, triage and medical advice provided remotely, and treatment of disease, disorder or injury. The service had a registered manager in place.

How we carried out this inspection

We carried out an announced comprehensive inspection on 31 October 2023, and also interviewed the chief executive and the chair of trustees.

The inspection team consisted of two CQC inspectors and a specialist adviser with a background in palliative care. We looked at all key questions including safe, effective, responsive, caring, and well led.

During the inspection we spoke to 22 members of staff, nine patients and their families and we reviewed ten sets of patient notes. We also attended service handover meetings.

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>.

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Outstanding practice

We found the following outstanding practice:

- The design, maintenance, premises, and equipment were of a very high standard. The building had a range of facilities such as a hydrotherapy pool, gym, hairdressing facilities, a garden, playground, a peaceful cabin and a serenity garden, as well as a large entrance area including the restaurant and designated quiet seating areas; and
- The hospice provided a variety of day services to patients, such as 'Hospice at Home' offered to all families and used by more than 70% of families, and 'Andy's Amigos', a series of groups and therapeutic activities for children and young people, at the hospice each week.

Areas for improvement

Action the service MUST take to improve:

Summary of this inspection

- The service must ensure that all designated risk assessments are carried out and recorded for each service user (Regulation 12 (a), (b), (g)); and
- The service must maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided and of decisions taken in relation to the care and treatment provided. (Regulation 17 (2) (c)).

Action the service SHOULD take to improve:

- The service should ensure appraisal completion rates meet target for all staff; and
- The service should ensure care plans are fully completed and discussions around resuscitation and summary plans for emergency care and treatment are carried out and recorded.






Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
End of life care	Requires Improvement	Good	Good	 Outstanding	Good	Good
Overall	Requires Improvement	Good	Good	 Outstanding	Good	Good

End of life care

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

Is the service safe?

Requires Improvement 

Our rating of safe went down. We rated it as requires improvement.

Mandatory training

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

Staff received and kept up-to-date with their mandatory training. Managers monitored mandatory training and alerted staff when they needed to update their training. Mandatory training compliance rates were captured monthly and broken down into clinical and non-clinical staff against a target of 90%. Compliance was reviewed at the operational governance meeting which monitored completion rates and exception reports.

Mandatory training for non-clinical staff included health and safety including risk assessment (95% completion, November 2023), moving and handling - level 1 (96%), data security awareness (85%), infection control - level 1 (93%) and preventing radicalisation - level 1 (91%).

Similarly, mandatory training for clinical staff included infection control (94%), moving and handling (92%), combined basic life support (75%), medicine management - registered nurses (72%), mental capacity act – level 2 (90%), ‘National Early Warning Score 2’ training (84%) and restraint and de-escalation (88%).

The overall completion rate for clinical departments was 87%.

New staff were provided with a programme of orientation and basic skills needed to fulfil their roles and volunteer staff were included in training modules where appropriate

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.

Staff received training specific for their role on how to recognise and report abuse. At the time of inspection 95% of staff had received safeguarding adults level 1 training, 93% had received safeguarding level 2 training and 74% of staff had received safeguarding adults level 3 training.

End of life care

Compliance for safeguarding children training was level 1 - 94%, level 2 - 89% and level 3 – 80%.

We were told the fall in the compliance rate for safeguarding adults level 3 equated to six members of staff, reminders had been sent and this was to be reviewed at the next operational governance meeting.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. We observed safeguarding issues were discussed in handover and team meetings.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. We were given examples of staff contacting relevant agencies ensuring safety concerns were raised appropriately.

An example of learning was when staff raised a safeguarding concern and discovered the patient was already subject to a child protection plan but had not been made aware. Learning was identified to ensure staff were contacting all relevant social workers of patients to find out relevant information.

We saw evidence that safeguarding concerns had been discussed at staff meetings and actions agreed.

All new staff and volunteers were given a full induction which included safeguarding training, useful information and a checklist for managers to complete including confirmation of disclosure and barring (DBS) checks.

The hospice had developed a safeguarding policy aligned with the 'North East Lincolnshire Multi-Agency Safeguarding Procedures' policy and the safeguarding lead worked closely with the North East Lincolnshire Safeguarding Children Partnership (NELSCP) and the North East Lincolnshire Safeguarding Adult's Board (NELSAB). The service produced an annual safeguarding board report.

Cleanliness, infection control and hygiene

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

All areas were clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We saw all areas of the hospice were clean, well designed and equipped to a high standard to meet the needs of patients, visitors and staff.

Cleaning schedules were in place and we saw each area of the hospice had cleaning checklists completed by a member of the household team or nursing team as appropriate. There was a clear emphasis on maintaining and improving cleanliness and reducing healthcare associated infection. A housekeeping supervisor managed the cleaning and laundry service, and ensured patient environments were cleaned according to specified frequencies consistent with hospice policy and procedures, and national standards of healthcare cleanliness.

Daily cleaning checks were in place and cleaning audits (October 2023) showed floors, stairs, windows, bathrooms and toilets were cleaned to a high standard.

End of life care

Staff followed infection control principles including the use of personal protective equipment (PPE). The infection control lead advised on the type of cleaning required in potentially infected areas and liaised with clinical teams and facilities teams following ward or bay closures due to outbreaks of infection. Suitable and sufficient personal protective equipment (PPE) was available to all staff carrying out activities where risk assessments had identified a need. All users of PPE were provided with information and instruction on the correct use and compliance with regulations.

There was hand sanitising gel available in all areas and we saw reception staff requesting that visitors used the gel before entering the main hospice. All staff adhered to the 'bare below the elbow' policy.

The 'Infection Prevention and Control Policy' outlined the operational and strategic arrangements for the prevention and control of infection within the hospice, and set out criteria and procedures to minimise the risk of infection for staff, volunteers, contractors and visitors. The policy was supported by guidelines for the barrier nursing of patients where necessary.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. During inspection we saw staff wore PPE and washed and gelled hands regularly. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

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. We saw systems had been installed within ward and clinical areas where patients were receiving care and treatment, and alternative arrangements, such as panic buttons were in place.

The design of the environment followed national guidance. The building was purpose built with offices on the upper floor. Clinical areas, wards, staff facilities, reception, a large 'hub' area for patients and visitors, faith room, family rooms, coffee shop and catering facilities were located on the ground floor. These were complemented in 'The Retreat' by the hydrotherapy pool, gym, hairdressing facilities, and a memory room, craft rooms, physiotherapy, assessment and treatment rooms. A garden, playground, a peaceful cabin and a serenity garden were located on site.

The hospice was bright, airy, exceptionally clean and well maintained throughout.

There were twelve bedrooms in the adults' inpatient area and four bedrooms in the children and young people inpatient area, 'cuddle beds' were available. All bedrooms had access and views of the grounds and garden areas.

All bathrooms and shower rooms were clean, and the furnishing were in good condition. Bathrooms had signs to show they had been cleaned and were ready for use. Specialist baths were available for patients to use which lowered down and had a door opening so that patients could access and leave the bath, staff told us this maintained patient dignity and safety.

Maintenance schedules were in place, these listed all contractors, key data, renewal dates, and routine maintenance and tasks. A fire policy and evacuation procedures were in place as well as fire evacuation records and fire risk assessments.

End of life care

Staff carried out daily safety checks of specialist equipment. The service had enough suitable equipment to help them to safely care for patients. Safety checks gave assurance that specialist equipment was fit for purpose. We saw checklists and quarterly audits to support this, for example resuscitation equipment, medication fridges, hoists, mattresses, blood glucose monitors, nurse call aids, suction machines and catheters, anaphylaxis box, syringe drivers. These had been completed appropriately.

The service had suitable facilities to meet the needs of patients' families. There were rooms throughout the hospice for families to meet and family members could stay with patients - all bedrooms were large, and could accommodate siblings, parents and other family members.

Staff disposed of clinical waste safely. There were sufficient clinical waste bins throughout the hospice.

Assessing and responding to patient risk

Staff did not always complete and update all risk assessments for each patient. 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. Although 'national early warning scores' were not used due to the nature of patients' conditions, and the frequency of review, staff completed NEWS2 and 'Paediatric Early Warning Score' (PEWS) training, to provide knowledge in identifying a deteriorating patient.

Patients were monitored regularly using other methods, such as Oxygen saturations, blood sugars, and the use of intentional rounding, and clinical observation enabling early recognition in a change to the patient's condition.

Staff completed risk assessments for each patient on admission/arrival, using a recognised tool, and reviewed this regularly, including after any incident. On admission, all patients had the 'Outcome Assessment and Complexity Collaborative' (OACC) assessment completed, supported by the 'Modified Karnofsky' score, 'Integrated Palliative Care Outcome Scale' (IPOS), 'Phase of Illness' and 'Barthel index' to identify where the patient is within their condition. Change was documented in the patient's journal and concerns in the patient's condition escalated to the nurse in charge or doctor and a plan of care agreed.

Within the children and young people's unit general observations were taken for patients as the baseline on admission, and continued to be taken and monitored. If observations raised concerns, these were escalated to the nurse in charge or doctor as required. Each child and young person had a care plan with a clear escalation process in place. Nurses had round the clock phone access to the paediatric palliative care consultants at a neighbouring hospice for support and advice.

Staff knew about and dealt with any specific risk issues. We saw staff monitored patient risks such as moving and handling, falls, nutrition, oral health, pressure damage, sight, hearing, communication, consent to bedrails and personal emergency evacuation plan (PEEP).

Audits were carried out on these risks, and findings showed 100% compliance in all risk assessments except consent to bedrails (90%), these results were shared at team meetings.

However, audits within the children and young people's unit (October 2023) identified deficiencies in the completion of risk assessments in moving and handling (60% compliance), hydrotherapy (29%), travel (20%), tissue viability (30%), hospice at home (71%).

End of life care

Following inspection the hospice provided evidence confirming this audit had not yet been concluded through the hospice's governance processes and was not final or complete. Once completed, audits were referred to the 'Service Quality and Improvement' meeting, consisting of the clinical lead and management team, for review and challenge where appropriate. Following this, audits were referred to an operational governance meeting of senior and operational managers to provide final oversight. This particular audit was due to be reviewed at the Service Quality and Improvement meeting in November 2023.

The action plan developed from this audit recommended all patients '...must have a completed, signed and up to date...risk assessment, where applicable' for each of these risk assessments.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. The service had links with the Alzheimer's Society and the local mental health service provider to support patients with dementia and mental health needs and the provision of advice and guidance.

Staff shared key information to keep patients safe when handing over their care to others. We attended team handovers and saw that relevant patient information was shared. Staff also shared key information with general practitioner and NHS services involved in patient care.

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. We reviewed staff rotas which showed the hospice was staffed to or above establishment levels.

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. Although there were no validated dependency tools for hospices, the hospice had developed a children's and young people's dependency tool, using the modified Karnofsky score and Barthel activities of daily living, to support the decision making process around safe staffing.

The service used bank and agency staff to fill any gaps in service. Managers used bank staff in the first instance to fill any gaps but when this was not possible, they would use an agency. The hospice managers tried to source the same staff wherever they could.

The service had low and/or reducing vacancy rates. Any vacancies were advertised internally and externally, clinical roles were advertised on job sites, the hospice website, social media and supported by recruitment campaigns.

The hospice kept detailed records of starters and leavers, and monitored and recorded all staff absences.

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

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

End of life care

The service had enough medical staff to keep patients safe. The hospice ensured that all patients received treatment and care from appropriately recruited, trained and qualified clinicians and practitioners.

The hospice had seven-day medical cover provided by five speciality doctors. Three speciality doctors provided cover for ten sessions, Monday to Friday (between 8am and 4pm). An on-call rota was in place at weekends between 0900 and 1700. This enabled patients to be reviewed seven days a week and allowed for seven-day admissions.

Procedures were in place that ensured clinicians complied with professional codes of conduct and maintained their competency throughout their term of self-employment under practice and privileges arrangements with the hospice.

Doctors were self-employed and did not use the hospice for private practice.

Records

Staff did not always keep detailed records of patients' care and treatment.

Patient notes were not always comprehensive; however staff could access them easily. Records were stored securely using a combination of paper-based records and an electronic system which could only be accessed with an individual login.

Information needed to deliver and understand patient care including medical and spiritual needs of patients was detailed in the patient care plan. Nursing staff visiting patients in the community had access to patient files, and they could easily access patient information and referral documentation.

An audit of adult inpatient records (September 2023) showed 91% compliance with the standards of the hospice' record keeping policy. Concerns were identified with the recording of mental capacity assessments, for example only one (out of ten) '...had any mention that capacity had been assessed...'

The records audit of the wellbeing service (October 2023) identified '... staff are not completing all of the patients care plans...' on the electronic system, and also identified '...discussions around resuscitation and 'ReSPECT' forms are not always carried out...'

Following inspection the hospice provided evidence confirming these particular audits were in the process of being reviewed through the Service Quality and Improvement meetings in October and November 2023.

The outcomes of these audits had resulted in the development of recommendations and action plans not yet completed at the time of inspection.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. The service had a medicines management policy, and a medicines reconciliation procedure in place.

End of life care

Staff completed medicines records accurately and keep them up to date. The hospice had a contract with the local mental health provider for pharmacist hours to assure the service was meeting the required standards and consistency in storage, prescribing and administering of medication. This included two hours support each week, during which the pharmacist checked drug cupboards in the adult inpatient unit and the children and young people's unit.

We checked medication records, and also reviewed medication visit reports from the local mental health provider. Although, the visit reports identified some issues, these had been appropriately identified and actioned immediately by the service, lessons learnt, and were not repeated.

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.

Staff knew what incidents to report and how to report them. Staff told us they knew how to report incidents and use reporting systems and all those reported were reviewed, investigated and reviewed for learning.

Staff raised concerns and reported incidents and near misses in line with the service's policy. There were 24 hospice acquired pressure ulcers ranging from category 1 through to unstable in the twelve months before inspection. There were 15 falls, the majority 'no harm', with two low harm and one moderate harm. In the same period 52 medication errors were reported with the majority 'no harm' and one 'low harm' during this time period.

All were discussed at the quality and improvement meeting as well as team meetings and those involved completed a reflective piece where appropriate.

The service had no never events on any wards. The hospice did not record any never events in the last twelve months.

Managers shared learning with their staff about never events that happened elsewhere. Learning from incidents was completed through managerial review, discussion with staff, reflective practice and team meetings.

Staff reported serious incidents clearly and in line with the service's policy.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. We saw the hospice had a duty of candour policy in place. Duty of candour had not been undertaken with any patient or family member as there had been no occasion where it had been needed.

Is the service effective?

Good 

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

Evidence-based care and treatment

The service provided 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.

End of life care

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Patients' physical, mental health and social needs were assessed, and care and treatment delivered in line with legislation, standards and evidence-based guidance.

The hospice followed up to date guidance to ensure patients received effective and high quality care including National Institute for Health and Care Excellence (NICE) guidance 'Care of dying adults in the last days of life' (QS144 and NG31), 'End of life care for adults' (QS13) and 'End of life care for infants, children and young people with life-limiting conditions: planning and management' (NG61).

The hospice had also developed a range of clinical guidelines and protocols; these included, for example patient centred care, consent, infection control, medicines management, symptom management, advanced care planning, mental capacity, lymphoedema management, and diabetes management.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Handovers included a discussion of each adult inpatient, those receiving wellbeing services, and those in children's services. The meetings identified the patient's needs, such as diagnosis, communication, mobility, elimination, and nutrition and hydration.

Staff also referred to the 'Recommended Summary Plan for Emergency Care and Treatment' (ReSPECT) form in place, and resuscitation status.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. In addition, handover documentation included evaluation of a patient's symptoms and concerns, 'Integrated Palliative Care Outcome Scale' (IPOS), functional impairment to compare effectiveness of different therapies and to assess the prognosis (Karnofsky), as well as whether or not a patient could perform a task or activity independently, with assistance, or if they were fully dependent (Barthel).

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. Clinical teams worked with onsite catering staff to ensure all dietary requirements were met for all patients, including those needing thickeners or on a blended diet. We saw a menu for patients to choose from in each patient room, with a choice of items, some with high calorific value and essential nutrients for those with a reduced dietary intake. This enabled patients with the ability, mentally and physically, to choose their food and feed themselves. We saw staff ensured individual allergies were observed.

Menus included cultural, vegetarian, vegan and specific diets meeting food allergy needs. Catering staff understood and were able to meet individual needs and provided appropriate nutrition to patients.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. A nutritional risk assessment was completed on every patient on admission to the adult inpatient unit. Patients with an identified high nutritional risk were referred to the community dietician for advice. Patients and families completed a form providing food likes and dislikes, dietary needs, allergies, and whether the patient required enteral feeding under the care of a dietician.

End of life care

Initial and ongoing nutritional assessments were completed in the children and young people's unit and documented on the individual nutritional care plan, ensuring adequate nutrition and fluid intake was maintained. The assessment and associated nutritional plan identified those at risk of malnutrition, contained a fluid balance chart, and monitored adequate fluid, bowel and stoma output; positioning, required assistance, weight updates, and dietician input were also recorded.

Within the wellbeing service, a 'Holistic Needs Assessment' and regular reviews identified and met nutritional needs. Patients' appearances were monitored through wellbeing groups.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. The service was supported by and referred issues for advice to a dietician or the speech and language therapy (SALT) team. Staff actively promoted healthy eating, as well as a balanced diet.

Nutrition and hydration audits of the adults inpatient unit and the children and young people's unit were both completed in 2023. The audit for the adults inpatient unit highlighted the following:

- "100% compliance with documenting patients care plans, food choices, food and fluids intake and encouraging or refusal of diet and fluids."
- 80% compliance with documenting care plan reviews, recent weight record (although this aspect of care provision is very rarely required with our patients due to their palliative condition) and allergies; and
- 60% or below compliance with documenting dietician involvement, staff awareness on referring to the dietician or S.A.L.T teams, religious and cultural dietary requirements and staff completion of Nutrition and Hydration mandatory training.

The audit for the children and young people's unit identified '...significant improvement required within the nutrition and hydration care we deliver...'

We were provided with evidence that action plans had been developed to address the issues within the adults inpatient unit by March 2024, and within the children and young people's unit by September 2023. These included identifying training needs for all patient facing staff, provide training for all staff around religious and cultural dietary choices, and to identify a link nurse role for nutrition and hydration.

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. On admission to the adult inpatient unit, staff completed the 'Outcome Assessment and Complexity Collaborative' measures to determine the distinct clinical stages of a palliative patient's illness. These included an IPOS symptom assessment, which was reviewed and updated after five days, or when there was a change in the patient's condition. Following this and observations through intentional rounding, further measures to address pain were put in place.

Within the children and young people's unit each patient had a pain care plan to ensure all children and young people were kept comfortable and free from pain through appropriate pain relief prescribed either as needed (PRN) or as part of regular medication.

End of life care

Children and young people's pain score was assessed, documented, actioned and re-evaluated as required. Two pain scores were used within the unit and the most appropriate used for each patient, a self-reporting 'faces' pain rating scale tool (Wong-Baker's), and a revised face, legs, activity, cry, consolability scale (FLACC). Further, the care plan included other factors including underlying causes and alternative methods to relieve pain such as distraction techniques, music, environmental factors and repositioning.

Within the wellbeing service a 'Holistic needs' assessment was undertaken to determine areas of concern, such as pain, and reviewed when the patient attended the hospice, and also when the patient had their three monthly review.

Patients received pain relief soon after requesting it. Patients and their families told us nursing staff administered medications on time and reacted quickly to requests for pain relief or management of other conditions. They told us that nursing staff checked patients pain levels and asked if they needed further medication.

Staff prescribed, administered and recorded pain relief accurately. Medication charts reviewed were completed, dated and signed correctly. Staff prescribed the correct medications and understood the importance of pain management.

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. The hospice took part in local and national audits, for example infection control, and benchmarked itself against other services in the area and nationally. Benchmarking compared areas such as discharges, bed occupancy, pressure ulcers and medication errors.

The hospice also identified areas to improve through patient feedback following care and death of a patient ('VOICES'), surveys, patient outcome tools and used national tools to audit storage and documentation management of controlled drugs.

The hospice used different ways to record patient's wishes, wants and needs such as ReSPECT assessment, IPOS and recording of preferred place of care and death (PPC/PPD).

Outcomes for patients were positive, consistent and met expectations, such as national standards. The IPOS tool was used to help the service focus on what mattered most to patients and their families and provided focused person centred care through identifying health and lifestyle preferences, pain management, appetite, mobility, and mental health. An audit of IPOS showed an overall decrease (improvement) in indicators of 38% between first and final assessment. All individual indicators showed a decrease for example, pain - 47%, nausea - 58%, poor appetite - 22%, and feeling anxious/worried about treatment/illness pain - 46%.

Managers and staff used the results to improve patients' outcomes. The hospice audited the achievement of preferred place of death (PPD), identifying 86% of patients who preferred to die at the hospice did so, and 37.5% of those preferring to die at home achieved this. To increase the achievement of preferred place of death, the service identified a range of reasons why this had not happened and developed an action plan in response, identified initiatives included:

- the completion of national early warning score 2 (NEWS 2) training and end of life care training which includes advanced care planning and preferred place of death by all staff;
- evidence of conversations and updated PPD status recorded in the electronic record and in the handover record; and
- patients preferences discussed at twice weekly multi-disciplinary team meetings and daily discharge meetings.

End of life care

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The service completed an ongoing and comprehensive programme of clinical audits in the adult inpatient, children and young people's unit and the wellbeing unit. These audits were discussed at the service and quality improvement meeting and shared through the operational governance process. The findings were also shared through team meetings to ensure actions and recommendations were completed.

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 service had identified clinical supervision as a priority and this was being met by both planned group clinical supervision and less formal personal clinical supervision across all clinical service areas, including access to peer debrief. Both the adult inpatient unit and the children and young people's unit held bi-monthly team meetings that were recorded, and included time for sharing and supervision debrief. Staff in the family support and bereavement team had access to clinical supervision by an external provider.

Reflective discussion was used as a key part of investigation and learning from incidents, and supported staff involved. Clinical staff within the children and young people's unit had access to specialist consultant doctors in children's palliative care, to discuss and examine specific cases and topics for debrief and learning. The children and young people's unit also facilitated debrief meetings following the death of a child receiving care from the hospice. All staff had regular one to one meetings with their line manager.

The service had appointed a head of education and training who was developing clinical supervisor training provision and education for staff.

All staff had monthly onsite access to the North East Lincolnshire lead nurse for safeguarding support, supervision and guidance.

Managers gave all new staff a full induction tailored to their role before they started work. All new staff were given an induction pack which explained the service vision and goals, useful information and a checklist for managers to complete. Volunteers to the service were also given a full induction and a training pack. All new staff completed three and six monthly reviews within their probationary period to support their development.

Managers supported staff to develop through yearly, constructive appraisals of their work. The service provided appraisal completion figures for clinical staff (total 46) which showed 63% were completed within the required timeframe, 37% were outstanding. We were told this was due to capacity at a senior level, and the completion of all outstanding appraisals had been planned.

The appraisal process was designed to give employees positive feedback, support with development and identify training needs. The service had developed a 'Our Hospice, Your Career' booklet which identified the levels of performance for staff to achieve 'improvement', 'achieving', 'exceeding' and 'excelling' outcomes against performance objectives.

Following the appointment of the head of education and training, a weekly programme of symptom management sessions facilitated by one of the hospice doctors had been instigated. This was in addition to regular clinical skills training delivered to nurse assistants by registered nurses.



End of life care

Further development of services had been made through individuals sharing opportunities facilitated by the service, such as:

- the spiritual care lead's contribution to the development of NHS England guidelines for chaplaincy;
- the children and young people's unit lead nurse attending palliative simulation training at a specialist children's hospice;
- the head of the children and young people's unit completion of leadership training;
- lymphoedema specialist training;
- accredited moving and handling key trainer certificate;
- palliative symptom management training programme for clinical staff;
- Caldicott Guardian training; and
- Freedom to Speak Up Guardian training.

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. Within the adult's inpatient unit, these included twice weekly multidisciplinary team (MDT) meetings with senior clinicians from the hospice, hospice doctor, specialist palliative care community nurses, the palliative home care team, palliative care social workers, spiritual care lead and physiotherapist to discuss patient care and treatment. A weekly palliative MDT led by the palliative care consultant was held, where all new cases, complex cases and all after death analysis was discussed. Discharge meetings were held each day.

Within the children and young people's unit, weekly MDT meetings were held including senior clinicians from the children's team, hospice doctor, palliative care social workers, spiritual care lead and physiotherapist. Individual patient needs were discussed at weekly meetings with the paediatric palliative care consultants, this was replicated for shared patients cared within the hospice. A child death overview panel was held to discuss all child deaths in the locality.

Joint adult inpatient unit and children and young people's unit transition meetings were held internally and externally with other services to look at the transition of young adults into alternative services including other adult hospices.

Staff worked across health care disciplines and with other agencies when required to care for patients. Discussions with other local health and care providers took place on a regular basis, to progress collaborative support for patients. Part of the role of the newly appointed head of adult palliative and end of life was to develop collaborative relationships with other local service providers. The hospice contributed to the Northern Lincolnshire End of Life Strategy, supporting the development of collaborative working across Northern Lincolnshire and developing care pathways.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. The service had long established links with the Alzheimer's Society and the local mental health service provider to support patients with dementia.

Collaboration with other organisations to provide training and development opportunities was in place. An example of this was the delivery of a 'Palliative Symptom Management Overview' programme, joint working with another hospice to support the ambulance service with collaborative palliative care.

End of life care

Seven-day services

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

Consultants led daily ward rounds on all wards, including weekends. Patients are reviewed by consultants depending on the care pathway. The hospice had seven-day medical cover provided by five speciality doctors. To mitigate recruitment challenges the children and young people's model of care had been reconfigured to provide a 'Hospice at Home' service and development of the children and young people's unit day service. To help facilitate this, the service had developed collaborative working with a local hospice resulting in access to 24 hour advice and support from three paediatric palliative care consultants and the clinical nurse specialist team.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. The service had a nursing establishment for 24 hours each day to cover for the inpatient units. Informal arrangements were in place for calls to be made to the speciality doctors in an urgent situation. The service actively used anticipatory planning and prescribing; this allowed nurses to increase medication as required, and in an emergency, contact was made with the local out of hours service for support and advice.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards/units. Posters were displayed within the hospice and inpatient areas, providing information and services available for the treatment of health conditions. The service provided gym, physiotherapy and hydrotherapy facilities on site.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff showed a clear understanding of the difficulties the patient group could have with nutrition and maintaining a healthy diet. Leaflets available explained the availability of different meals, preferences and special diets. There was an extensive dietary menu with healthy choices available.

The service displayed information for patients on eating well, self-care and there was a wellbeing service.

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. Staff demonstrated an understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), and the procedures and documentation used by the hospice to assess a patient's capacity. We reviewed mental capacity assessments recorded and these had been completed correctly.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

The hospice had a 'Mental Capacity Act 2005 and Deprivation of Liberty Policy' in place. Audits provided showed policies and procedures were accessible to staff, staff understood their roles and responsibilities when assessing mental capacity, staff documented that the patient had mental capacity at face-to-face contact and recorded this on the electronic system. These findings were consistent with our review of patient documentation.

End of life care

However, audits provided showed ‘...mental capacity was recorded on the electronic system during significant interventions, such as discharge planning and advanced care planning, but the recording was inconsistent’. Recommendations and action plans had been developed to increase consistency.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We observed staff seeking consent from patients before examination, observations, and delivery of care. In most cases this was implied consent and not documented. However, when an intervention was required, formal written consent was obtained.

Staff clearly recorded consent in the patients’ records. Conversations about care included family members when possible and this was documented in the patient record.

All do not resuscitate forms (DNACPR) reviewed during our inspection were completed correctly and where appropriate were discussed with the patient.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Although MCA and DoLS training was available, audits provided showed some staff (two) had not completed this. Plans were in place to ensure compliance was increased.

Is the service caring?

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

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. On arrival in the hospice all patients were greeted appropriately and staff developed relationships with patients, family members and carers. New staff introduced themselves and explained who they were and their role. Patients said staff were kind, caring and treated them with dignity and respect, taking time to explain their care, treatment and prognosis.

The hospice had created a number of family rooms and bedrooms which maintained privacy and dignity of individual patients and allowed families to stay together during care and treatment.

Staff followed policy to keep patient care and treatment confidential. Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. All staff spoke quietly to patients to give reassurance and maintain confidentiality. All staff we observed were discreet and responsive to the needs of patients and those close to them in a respectful and considerate way. The service understood and respected the personal, cultural, social and religious needs of patients and how they related to care needs.

Patients said staff treated them well and with kindness. All patients, family and carers we spoke with were complimentary about staff, care and treatment. Family members and friends were asked to complete a questionnaire (‘VOICES’) following the death of a patient on how they felt their loved one was cared for:

End of life care

- 78% strongly agreed there was enough help available to meet the personal care needs of the patient;
- 88% agreed there was adequate privacy;
- 68% agreed that they were always kept informed about the patient's condition; and
- 58% stated they received enough emotional support whilst their relative/friend/significant other was in the hospice.

Comments showed an overwhelmingly positive view, for example 'I would like to thank you and your staff for granting my father his end of life wish "care and comfort" thank you very, very much...'; 'Amazing staff and care given to my beautiful sister thank you xxx' and '...thank you all for giving my mum...the absolute best care in her last days. You are all angels. thank you for all the support you gave us during her stay. Can't thank you enough...'

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

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. All contact between staff and patients was conducted professionally, sensitively and in a way which respected confidentiality and the emotional wellbeing of both patients and their relatives and carers. All staff demonstrated understanding of the emotional impact a life-limiting condition had on patients and their relatives and took this into account when providing care and treatment. During our inspection, staff told us emotional support came in different forms and was tailored to the needs of the individual. Services at the hospice worked together as a multidisciplinary team to support the emotional needs of the patient and their families.

The service had developed a 'mood board' within the children and young people's unit to allow those accessing the service to choose the emotion they were feeling (for example calm, relaxed, 'OK', happy) which staff used to understand their feelings and tailor their care. Emotions were written, as well as displayed with faces, enabling all patients to choose their emotion. All emotions were then displayed on the board and revisited at the end of their stay.

Staff supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity.

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

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. The service had a 'Spiritual Care Policy' in place which encouraged staff to have responsibility for supporting individuals' spiritual care needs through understanding why, how and to whom to provide spiritual care. The policy was supported by training in 'Spiritual and Religious Care Competencies for Specialist Palliative Care' such as understanding the nature of spirituality in a palliative care setting and the ability to develop a rapport with patients and carers.

The service had also developed a 'Religion and Culture Information Book' as an introduction to some of the cultural, religious and spiritual practices of a wide range of religions and cultures, for example beliefs, sacraments and diet.

End of life care

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.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. The service had access to interpretation and communication services to facilitate contact with patients.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. In addition to the 'VOICES' questionnaire, all patients, family and carers were encouraged to complete compliments and suggestions, and patient/family experience forms throughout care and treatment.

Quality boards were displayed throughout the adult's unit, children and young people's unit and the hospice hub to share monthly performance information as well as accomplishments, developments, and actions responding to feedback. For example, one suggestion was to go out for short trips, and the response was to arrange a trip to the local auditorium to watch the Christmas pantomime, and a visit to a seal and nature sanctuary.

Staff supported patients to make advanced decisions about their care.

Is the service 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. Facilities and premises were appropriate for the services being delivered. The hospice was committed to a partnership approach to working with a variety of organisations such as the Integrated Care Board (ICB), the East Midlands Children's and Young People's Palliative Care Operational Delivery Network, the Humber and North Yorkshire Health and Care Partnership, and the Community Health and Care Collaborative.

Within these partnerships the hospice contributed to task and finish groups, attended ICB meetings, influenced the ICB delivery plan ('Palliative and End of Life Care, Statutory Guidance for ICBs'), and produced a summary document of the work of the hospice collaborative.

The hospice strategy identified collaborative relationships with North East Lincolnshire Health Care Partnership, Humber and North Yorkshire (HNY) Hospice Collaborative, local hospices, and North East Lincolnshire and Yorkshire Strategic Clinical Network.

End of life care

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. The service had long established links with the Alzheimer's Society and the local mental health service provider to support patients with dementia and mental health needs.

The hospice worked to reach local communities and worked with professionals to understand the local need for palliative and end of life care. The spiritual care lead (SCL) along with other members of the wellbeing and bereavement teams promoted the 'Dying Matters Week' in the community, setting up information displays and speaking to members of the public at key strategic locations in the community. Further work was done to reach communities, for example LGBTQ+, and those living in deprived areas.

Fundraising and clinical teams presented to schools about the hospice and the care provided. An annual 'Light up a Life' service was open to anyone who had been bereaved, not just those who had accessed palliative or hospice 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.

The hospice provided a variety of day services to patients, such as 'Hospice at Home', and 'Andy's Amigos'.

The hospice at home service was offered to all families and was used by more than 70% of families. This provided a facility whereby staff visited patients and families in their home and provided equivalent services to those in the hospice. Patients and families were offered sessions in their own home or combined these with sessions in the hospice. Staff picked up and dropped off patients when needed.

'Andy's Amigos' is a series of groups and therapeutic activities for children and young people, at the hospice each week. The groups were tailored to suit the needs and ages of the children attending. Examples provided were sensory play, baking, arts and crafts, board games and video games. Sessions were also tailored to specific events, for example Halloween, cultural events, Easter, parties and pamper days.

A wheelchair accessible cinema was available at the hospice for patients to attend 'Movie Nights' and was also used when children were staying for overnight respite. The on-site coffee shop offered drinks and snacks to take in.

'Andy's Amigo's' also organised regular day trips and activities, we saw recent trips to local farms, the pantomime, and the 'Polar Express' had taken place and were planned. A 'Circle Club' was held to introduce young adults accessing the children's hospice to the adult wellbeing service and was also open to younger adults. The 'wellbeing service' offered a range of activities, therapies and treatments to patients, such as arts and crafts, holistic needs (Supporting Holistic Independent Needs of Everyone), gardening, and yoga.

In addition, dementia groups were held twice weekly focussed on physical games, music therapy, reminiscence, dancing and crafts.

The lymphoedema service provided advice, support and treatment for patients who had secondary lymphoedema related to a cancer diagnosis or progressive life-limiting disease. Treatment was provided in the outpatient clinic. All patients had an initial assessment with a specialist lymphoedema nurse and a treatment plan put in place. The service aimed to minimise the patients' current symptoms and educate patients around long-term self-management. Referrals were received from nursing teams within North East Lincolnshire.

End of life care

A complementary therapy service offered non-invasive interventions in addition to medical treatment, such as massage, aromatherapy, Reiki, reflexology and relaxation. Sessions were arranged in advance and individualised to the patient's needs using a 'Measure Yourself Concerns and Wellbeing' (MYCaW) questionnaire.

An on-site hair studio was available for outpatients, inpatients and the public. Hydrotherapy services were run by physiotherapists and enabled patients to identify their concerns, needs and goals. The hydrotherapy room featured a tracking hoist so patients with limited mobility were easily able to access the pool.

Physiotherapy services were offered as part of the wellbeing service and if mobility or breathing was identified as one of the patients' major areas of concern through the holistic needs assessment, they attend a personalised programme and progress to self-management.

A spiritual care team was in place made up of a spiritual care lead (SCL) supported by three volunteers and provided religious, spiritual and pastoral care to patients, their families and carers, staff and volunteers.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff were able to demonstrate access to translation services when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Patients dietary needs were recorded at assessment and on-site catering staff were made aware of any specific requirements. Menus had options for culturally appropriate food and drink, vegetarian, vegan and specific diets concerned with food allergies.

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 not in line with good practice.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Referrals into the adult inpatient unit were made by health or social care professionals, patients or their families, consent had to be obtained prior to making a referral. Referrals were made for symptom management, respite or for end-of-life care. Patients were contacted within 48 hours, and the referral triaged.

A discussion between the lead nurse, clinical lead nurse and the doctor on duty resulted in an admission date, depending on urgency of need and current place of care. Potential admissions and inpatients were discussed twice weekly at a MDT.

The hospice had set best practice criteria as follows:

- End of Life – admit within same day whenever possible or within 24 hours; and
- Symptom management – depending on severity of symptoms and support available to patients admitted within 24 to 48 hours.

The hospice facilitated requests for urgent respite where possible, routine respite was offered and pre-planned.

In October 2023, the hospice received 29 referrals for the adult inpatient unit, three were for future respite, and one for information only. Of the remaining 25 referrals:

End of life care

- nine patients were admitted within 24 hours;
- five patients passed away before their intended admission within 24 hours;
- two patients delayed their admissions to remain at home with family, and both were admitted within four days;
- three admissions were delayed by the hospital as patients were having further treatment or were too poorly to move; and
- six patients were delayed by the hospice due to bed and staffing capacity.

This meant 36% of referrals were admitted into their PPC/PPD within the hospice best practise timeframe.

Children and young people were most frequently referred to specialist paediatric palliative care advice and support services through a health or social care professional working closely with the family. However, anyone was able to refer to the hospice, including a self-referral or from the family or guardian.

Once a referral was received, a staff member contacted the family directly to ensure they were aware of the referral and consent, fully understand the referral criteria, the service and the need for an initial assessment. Following this, a decision was made whether the child or young person met the referral criteria and was then accepted onto the service. Parents then had access to inpatient support (respite), community support (hospice at home), group sessions ('Andy's Amigos'), hospital support visits, trips out, emotional/psychological support, care after death ('Butterfly suite') and bereavement support.

The service was adapted and personalised to each individual child or young person and their family depending on their needs. The hospice had access to paediatric palliative care consultant advice and support from a neighbouring hospice enabling localised symptom management.

Patients were referred to the hospice wellbeing services through a variety of routes, following their consent. Referrals were accepted from health and social care professionals, family and friends, and the patient themselves. Once referred, contact was made to the patient within 72 hours to arrange an initial needs assessment within 14 days of the referral; the palliative care team or the 'living with and beyond cancer' team refer directly without a further needs assessment.

The initial assessment covered all areas of care including physical, practical, emotional, family, relationship and spiritual concerns. Patients were referred to one or more appropriate services within the wellbeing service. Reviews of the needs assessment were carried out and updated every three months, and if necessary, a further support was given through speciality doctor clinics on Friday mornings.

Managers and staff started planning each patient's discharge as early as possible. A MDT meeting was held every weekday morning to discuss referrals into the hospice and complete discharges. This was attended by the discharge team, the head of service, the intermediate care at home team, the community inpatient unit team and the head of older people services.

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. The service displayed information on how to make a complaint and patients were given advice on the process when needed. Patients and family members told us they were aware of how to raise a complaint.

End of life care

Staff understood the policy on complaints and knew how to handle them. Staff were encouraged to raise any situation that may escalate to something further, enabling support to be offered to the patient and their family, and supervision and guidance provided to staff.

Managers investigated complaints and identified themes. The service managed complaints well, involving the complainant, providing them with assistance and support as needed. Support was also given to staff involved in any complaint. All complaints received were notified to the chief executive officer and progressed in line with the service complaints policy.

We reviewed the last three complaints received by the service. These involved a patient being spoken to in a loud manner, a family member travelling a long distance when not necessary, and antibiotics not administered. Each complaint had been fully investigated, one upheld and two not upheld.

Managers shared feedback from complaints with staff and learning was used to improve the service. Learning from the upheld complaint involved acknowledgement of the mistake and how this would be addressed differently in the future; processes had been reviewed and documentation updated.

Staff could give examples of how they used patient feedback to improve daily practice. Complaints not upheld also led to discussion at team meetings where staff had recognised patient's perceptions could differ from theirs. Further, staff accepted they needed to be more aware of how they communicated in all circumstances. Staff recognised the anxiety parents may have felt, the need for involvement at the time of admission from a doctor, and the importance of an initial conversation with the parents.

Is the service well-led?

Good 

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

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.

The senior management team had the relevant skills, knowledge, experience and integrity to run the service. The service had a clear management structure in place and staff said the senior leadership team were visible and accessible. Staff told us they felt they knew who to go to with concerns and that they were able to raise issues with confidence.

The hospice was a 'company limited by guarantee' and a registered charity acting as a non-profit organisation. Recently revised articles of association confirmed the appointment of trustees with responsibility for the operation of the hospice. Responsibilities were delegated to the chief executive officer and the senior team through a governance and meeting structure.

End of life care

We interviewed the chief executive officer and the chair of trustees who clearly had an effective working relationship and a common understanding of the priorities and issues facing the hospice. All managers within the hospice were positive about services provided, the senior management team and their role within the organisation. A board effectiveness assurance process was in place.

We were provided with examples when trustees and senior managers worked together to pursue projects, for example 'link' trustees worked with departments and senior managers based on their specialisms, specific roles were undertaken by trustees (freedom to speak up guardian), and trustees developed external relationships and represented the hospice at a range of events.

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 and strategy in place, 'Making each day count' (2021-2024), which identified the service vision and values, achievements, key commitments, and strategy. This had been developed with partner organisations, service users and their families, through a programme of communication and engagement.

The vision of the hospice shared by all staff was to provide '...excellence and choice for everyone affected by a life-limiting illness', supported by a mission to '...make every day count for people with life-limiting illnesses and support those who care for them', and the following values:

- delivering holistic care for all;
- transforming communities;
- making a difference; and
- striving to improve and innovate.

The hospice board had developed a series of strategic objectives, and was developing the vision and strategy for 2024 onwards.

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.

Staff patients and their families told us there was an open culture and they felt confident to raise concerns with their managers. The hospice actively encouraged diversity, creating a work environment that respected and included difference, promoted equal career development opportunities and training in line with the workforce strategy.

The hospice had a 'workforce reform project' in place to further develop 'parity, equity and inclusion' in the workforce following staff wide consultation. Examples of initiatives developed were culture presentations, unconscious bias training, coaching and mentoring, equality and diversity training, celebration of the cultural calendar, staff surveys, and the employee voice group.

End of life care

Safe spaces had been created for staff which included accessible toilets and break rooms for employees with a disability, designated prayer room, designated quiet lunch and rest areas, and a restaurant with a range of food options

The hospice had signed up to the 'mindful employer charter', and the 'investors in volunteers' and worked with external organisations, for example other local charities and the North East Lincolnshire Council Health Care Partnership,

Governance

Leaders operated effective governance processes, throughout the service.

Governance processes were in place, and these demonstrated a consistent and regular approach to monitoring risk and areas for improvement. Managers were clear that the interpretation and application of specific auditing questions and approaches was used to ensure transparency, challenge and demonstrated good governance.

For example, although internal audits showed low compliance in the completion of hydrotherapy, travel and tissue viability risk assessments in the children and young people's unit, these had been identified and were subject to specific improvements at the time of inspection.

The hospice had identified areas for improvement in the audit regime which demonstrated an approach to drive performance through identifying and implementing actions needed.

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.

The service had risk management frameworks in place which supported the identification of risk, and identified actions and responses. The service had two risk registers, strategic at board level, and an operational register managed by the operational governance team. These were reviewed twice each year.

Example of risks identified were:

- Strategic:
 - Recruitment, retention and succession planning including skills mix and loss of key staff;
 - Future funding - sustainable income streams; and
 - Compliance with legislation and regulations.
- Operational:
 - Cost of living and energy costs;
 - Reduced capacity to deliver inpatient care; and
 - Health and safety.

The service had a 'Business Continuity and Resilience Plan' (August 2023) in place to deliver capability to manage any emergency or incident outside the business's normal coping mechanisms. This identified potential impacts of disruption to the service's ability to function normally and how to proactively improve resilience. The service had developed 'action cards' to direct focus, outline actions needed, and the need for adjustments based on experience and events.

End of life care

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.

Information systems were integrated and secure, to prevent unauthorised access of information.

Systems were used to record and share patient sensitive data and there were clear processes to ensure compliance with access protocols.

Managers understood performance targets including quality and data from clinical and internal audits. The trust participated in national clinical audit projects and clinical outcome quality indicators.

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.

In addition to the 'VOICES' questionnaire following the death of a patient, the hospice also collected 'compliments, comments and suggestions' and sent 'patient and family experience' forms to all patients under the care of the hospice. We reviewed comments recorded and saw these were overwhelmingly positive, and where suggestions had been made, we saw these were acted upon.

The service had completed and analysed staff surveys for the last three years. These showed most staff '...feel able to bounce back as quickly as I normally would', '...believe my views are listen to and valued', '...able to effectively switch off from work to make time for rest and relaxation. However, '...staff morale was lower than anticipated'.

In response, the hospice had taken action to increase communication, consult staff on key decisions, introduced 'active employee voice', coached and supported line managers in their support of staff wellbeing and engagement and continued with the 'workforce reform' project.

Volunteer survey results (2023) showed people were proud to be a volunteer (99%), felt valued and appreciated (95%), staff made them feel part of the team (96%) and felt they made a difference (98%).

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.

The hospice looked for ways to introduce innovative practice to improve the care and treatment of patients. Some examples of these were as follows:

- Cuddle beds had replaced some inpatient beds within the children and young people's unit for when a family member wanted to be closer to their loved one without the size restrictions of a single bed;
- Comments had been received from some patients that they felt unsupported following their diagnoses and not been given the information needed to confidently self-manage their condition.

End of life care

In response, the wellbeing team developed a seven week programme to give palliative patients and their carers the information and skills required to manage their condition more independently, giving them control. The programme covered pain management, fatigue and conserving energy, emotional support, mobility and exercise, spiritual care, anxiety and relaxation and advanced care planning. A different topic was discussed by specialists each week and was accessible to all patients. Feedback was that all patients' confidence regarding condition management increased;

- The children and young people's day unit had been developed into 'Andy's Amigos' a therapeutic outpatients unit that delivered a wide range of activities to support patients and their families; and
- 'The big give back' had been developed for volunteers. This included:
 - a social calendar of events;
 - volunteer role profiles;
 - dedicated volunteer team;
 - 'Better impact' communication portal;
 - training portal;
 - volunteer wellbeing coordinators;
 - employability skills;
 - volunteer newsletter; and
 - 'Young Person Volunteer Awards'.