

Cornwall Hospice Care Limited

St Julia's Hospice

Inspection report

Cornwall Hospice Care - St. Julia's Hospice
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Ratings

Overall rating for this service	Outstanding 
Is the service safe?	Good 
Is the service effective?	Outstanding 
Is the service caring?	Outstanding 
Is the service responsive?	Outstanding 
Is the service well-led?	Outstanding 

Summary of findings

Overall summary

The inspection took place on 10 and 11 May 2016 and was unannounced. We previously inspected the service on 14 December 2013 and found no breaches of regulations in the standards we looked at.

The provider, Cornwall Hospice Care Limited is a registered charity committed to providing specialist palliative and end of life care for people, over the age of 18 years, irrespective of diagnosis. The provider runs two hospices in Cornwall, Mount Edgcumbe in St Austell and St Julia's in Hayle. St Julia's Hospice, is registered for 10 beds, and provides specialist care for people with life limiting illnesses. It is purpose built and located adjacent to St Michael's Hospital in Hayle. It provides inpatient care for people needing help with complex symptom management, pain control and end of life care. People are referred to the hospice by health professionals, in liaison with their GP or hospital consultant. At the time of the inspection, eight people were being cared for at the hospice.

Services included physiotherapy and lymphoedema clinics. (Lymphoedema is a chronic long term condition that causes swelling in body tissues. It can be a primary or secondary condition). The service had built a dedicated outpatient suite so they could provide more day services nearer to people's home, but this facility had not yet been commissioned for use.

The hospice had a team of about 50 volunteers, who worked in various roles such as greeting people and visitors at reception, chatting to people, serving lunch and making drinks and snacks. They also helped with laundry and flower arranging.

The service had a new registered manager, the Director of Patient Services who registered in December 2015. They managed both hospices, supported by a unit manager at each location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People received outstanding care from highly motivated staff who developed exceptionally positive caring and compassionate relationships with them. The service had an open and positive culture that placed people at the heart of everything they did. Staff treated people with sensitivity, dignity and respect. People's emotional and spiritual needs were met by staff who were knowledgeable and confident to care for and comfort them. Families and those that mattered to the person were supported to spend quality time with them.

People received excellent care, based on best practice from experienced staff with the knowledge, skills and competencies to support their complex health needs. For example, the hospice used national best practice tools to assess people's symptoms each day. This helped staff address each person's physical and emotional needs which improved their quality of life. People received their medicines on time and in a safe

way, and were kept peaceful, comfortable and pain free.

Hospice staff were committed to promoting excellent end of life care for people in Cornwall, by providing a programme of education and training for a wide range of health and social professionals working in hospitals, care and nursing homes and in the community. This meant more people received high quality end of life care from skilled staff in their preferred location and avoided hospital admissions. The hospice used link roles to lead and actively champion staff to provide people with evidenced based, best practice care. For example, for Motor Neurone Disease (MND), foot care and falls prevention.

The service was committed to excellence through research to identify ways to further improve their service. The hospice was awarded a prize by the Royal Society of Medicine in the research category section in 2015, for pioneering work in spinal pain relief. This meant those people were able to enjoy a much better quality of life. Hospice staff supported medical students to undertake a research in action study. They used verbal interviews to get feedback from seriously ill people about their quality of life, which informed their ongoing care and treatment.

The hospice provided a 24 hour advice line for people and health professionals. This provided advice on symptom management and pain relief for people having end of life care in the community, hospital and nursing homes across Cornwall. This helped avoid unnecessary admissions to hospital and has been extended to include an email advice service, with consultant staff providing a response within 24 hours.

Hospice staff worked in partnership with other organisations to benefit people receiving end of life care. For example, hospice staff worked with NHS staff in a specialist dementia care unit in Bodmin to develop the staff team to deliver high quality end of life care. This meant those people, who had very complex mental health needs, could remain in the specialist unit and receive end of life care from staff who knew and understood them.

People, relatives and professional feedback consistently showed the service provided at the hospice was holistic and person centred. Staff went that extra mile to respond to people's individual needs. For example, a member of staff did podiatry training to fill a gap in local service provision and a nurse did training in complementary therapies to provide people with relaxation through aromatherapy and massage.

The hospice worked in partnership with other professionals to provide support at joint clinics for people with chronic long term conditions such as Motor Neurone Disease. This meant people benefitted from a seamless service, rather than having to attend separate appointments with each specialist. Feedback from Healthwatch Cornwall and other professionals showed hospice staff were taking a lead role to influence and further improve end of life services in Cornwall. (Healthwatch Cornwall is the independent people's champion for publicly funded health and social care services).

People said they felt safe and well cared for at the hospice. They were protected against the risks of potential abuse because staff were trained in recognising potential signs of abuse. They knew how to report concerns internally and to outside agencies, and were confident concerns would be investigated and dealt with. People were cared for by sufficient numbers of skilled and experienced staff. People said staff spent time with them and their families and provided support, comfort and reassurance. Robust recruitment checks were undertaken before staff and volunteers began to work for the service to ensure they were suitable to work with people.

People were protected because risks were identified and managed. Accidents and incidents were reported, with actions taken to minimise avoidable risks for people. Environmental risks were assessed with actions

taken to improve safety. Equipment, gas and electrical appliances were regularly serviced and there was an ongoing programme of repairs and maintenance. Staff reduced the risks of cross infection for people through good hand hygiene and regular cleaning.

People had access to high quality food, and their nutritional and hydration needs were met by excellent catering services. People were offered choices and were fully involved in making decisions about their care and treatment. Care plans clearly explained how people would like to receive their care, treatment and support and their preferred place of end of life care.

People's human and legal rights were respected because staff understood their responsibilities in relation to the mental capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). They knew how to complain and were confident any concerns would be taken seriously. Staff were open and honest when things went wrong and were committed to learning and responding to people's feedback and experiences.

People received a consistently high quality of care because senior staff led by example and set high expectations about standards of care. The provider had a range of robust systems to monitor the quality of care provided, which included feedback surveys, audits and monitoring staff practice and made continuous improvements in response.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service is safe.

People were supported by enough staff so they could receive safe care at a time and pace convenient for them.

People were protected because staff were trained on recognising potential signs of abuse. They knew how to report concerns and were confident any concerns reported would be investigated and dealt with.

People felt safe because individual and environmental risks were assessed and reduced as much as possible.

People received their medicines on time and in a safe way.

Robust recruitment checks were undertaken before staff and volunteers began to work for the service to ensure they were suitable to work with people.

Good 

Is the service effective?

The service was effective.

People, relatives and healthcare professionals consistently praised the excellent standards of care, treatment and support provided by hospice staff

People received excellent care, based on best practice from experienced staff with the knowledge, skills and competencies to support their complex health needs.

People benefitted from pioneering pain relief treatment and the hospice had been awarded a prize for innovation.

Staff had an excellent understanding of their responsibilities in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People had access to high quality food and drink, for as long as they were able and wished to.

Outstanding 

Is the service caring?

The service is caring.

People and relatives said staff developed exceptionally caring and compassionate relationships with them. People mattered and staff went over and above their role to provide exceptional care for each person.

The ethos of care was person-centred and valued each person as an individual. Staff were exceptionally skilled at helping people to express their views and communicated with them in ways they could understand.

People's emotional and spiritual needs were met by staff who showed empathy and were confident to care for and comfort them.

People having end of life care were kept peaceful, and pain free. Families and those that mattered to the person were supported to spend quality time with them.

Bereavement services were tailored to people's individual needs and supported loved ones to come to terms with their loss after the person's death.

Outstanding 

Is the service responsive?

The service is responsive.

People received exceptionally personalised care that responded to their individual needs.

Staff worked with each person in innovative ways to improve their quality of life and maintain their independence.

People's care and support was planned proactively in partnership with them.

The service had a complaints process and written information about how to complain. No complaints had been received in the past 12 months.

Outstanding 

Is the service well-led?

The service is well led.

People, staff and external professionals gave us exceptionally positive feedback about the excellent quality of end of life care at

Outstanding 

the hospice.

The leadership team promoted strong values of person-centred care and worked in partnership with other organisations providing high quality, evidence based end of life care for the people of Cornwall.

The leadership team promoted an open and positive culture that placed people and staff at the centre of the service.

People, relatives and staff views were sought, and their suggestions and ideas were implemented.

The service had a range of quality monitoring systems to monitor the quality of people's care and the environment. Staff continuously made improvements in response to their findings.

St Julia's Hospice

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 10 and 11 May 2016 and was unannounced. The inspection team included an inspector, a pharmacy inspector, a specialist nurse in palliative care and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR, previous inspection reports, questionnaire responses and all contacts we had about the service. A notification is important information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern.

Eight people were being cared for when we visited. We spoke with four people and nine relatives. We observed staff interactions with people and looked at five people's care records, and four people's medicine records.

We met with the chief executive, medical director, registered manager and unit manager at St Julia's. We also spoke with 28 other staff including doctors, nurses, healthcare assistants, support staff, education staff and a bereavement counsellor. We looked at five staff records including training, supervision and appraisal records.

We received feedback from 14 staff from the local acute and community NHS trusts, community and specialist palliative care nurses, GP practices and commissioners who worked with the hospice team.

Is the service safe?

Our findings

People felt safe and well cared for at the hospice. One person described the hospice as their "safe haven." Another person said, "I feel safe and cared for now I have come into contact with them." A family were confident they could safely leave the person in the hospice, knowing they were well cared for. A relative said, "To know [person's name] was safe and well cared for took a huge weight off my shoulders." A health professional said, "Excellent service, the service provision and care is fantastic, in terms of safety and outcomes for patients."

People were protected by staff and volunteers who were knowledgeable about the signs of potential abuse and understood how to keep people safe. Staff attended a range of safeguarding training, dependent on their role. They were confident concerns about potential abuse reported would be taken seriously and responded to. Appropriate safeguarding policies were available which included contact details, for the local authority, police and other agencies. This meant staff knew how to report potential abuse to outside agencies.

For example, a member of staff told us about a previous occasion where they had concerns about a person with a very controlling partner who staff thought might be exerting undue influence on them. They discussed these concerns with senior staff who contacted the local authority safeguarding team to report their concerns. The team kept a close eye on the person during their partner's visits and intervened if they thought the person was being coerced. Another staff member told us about their involvement in a difficult family situation about the future custody of a child. No safeguarding notifications were received from the service in past 12 months, we checked with the unit manager who confirmed the examples staff described were not recent.

People were protected because risks for each person were identified and managed. Comprehensive individual risk assessments were completed, in relation to people's risk of falling, malnutrition and dehydration, and about moving and handling risks. Detailed care plans identified measures taken to reduce risks as much as possible. For example, on how to reduce a person's risk of developing pressure sores, including details of pressure relieving equipment, the need for regular repositioning and skin care.

Accidents and incidents were reported and reviewed, to identify ways to further reduce the risks of recurrence. For example, the registered manager notified us about an incident where an oral hygiene mouth swab healthcare product had failed, as the sponge tip had detached when they were providing a person's oral care. The person's family was fully informed about the incident, in accordance with the Duty of Candour regulations. The registered manager notified the Medicines and Healthcare products Regulatory Agency (MHRA), who arranged for a recall of the product. Following the incident, the hospice reviewed their mouth care practices and introduced soft children's toothbrushes for mouth care instead, which they judged safer.

The hospice undertook a falls audit to compare their practice with NICE guidelines on falls prevention. Following the audit they implemented a falls screening and intervention tool and new moving and handling and mobility care plans. These included prompts for staff to reduce falls risks by ensuring people used good

fitting footwear, making sure their call bell was close at hand and by providing good lighting at night to help people find their way around easily. They purchased some new beds, which could be set at a low level for people at risk of falling out of bed. The beds also had sensors, which highlighted to staff when a person was getting out of bed, so staff could go to the person and offer assistance. The service introduced 'falls champions' within the team. These were staff who have had undertaken extra training in the assessment and identification of people more likely to fall. These measures helped reduced falls by introducing early falls prevention measures.

In the provider information return (PIR), the registered manager highlighted St Julia's hospice participated in the Hospice UK benchmarking of patient safety indices. Hospice UK is the national charity for hospice care in the UK. The indices compared data between hospice services of similar sizes on falls, pressure ulcers and medicine errors. The data showed St Julia's recorded lower than average across all three, which showed their risk reduction measures were effective.

Environmental risks were assessed with actions taken to maintain the safety of the hospice and equipment. For example, all risks associated with Control of Substances Hazardous to Health (COSHH) were assessed, and showed all chemical products had to be locked away when not in use. However, on the first day we visited, we found some cleaning products stored on the lower shelf in a sluice room which was not secured, which could pose a risk for visiting children. We raised this with the unit manager, who arranged for them to be removed and stored securely. A notice was made to remind staff to keep these products locked away out of reach, and random spot checks were instigated to monitor staff compliance.

Maintenance staff carried out an ongoing programme of repairs and maintenance. All moving and handling and fire equipment was regularly checked and tested, regular servicing and maintenance of clinical equipment, gas and electrical appliances was carried out. Contingency plans were in place to ensure continuity of the service for people, for example, in the event of staff sickness or the loss of utilities such as water, gas and electricity.

The hospice had robust recruitment and selection processes which ensured staff and volunteers were safe to work with vulnerable people. Staff and volunteers completed application forms and interviews were undertaken. Appropriate pre-employment checks were done, such as Disclosure and Barring Service (DBS) checks which highlighted any criminal convictions and obtained references from previous employers. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

People were cared for by sufficient numbers of skilled and experienced staff, many of whom had worked at the hospice for many years. People said staff spent time with them and responded rapidly to call bells. One person said, "I've used the bell quite a lot when I want to go to the toilet and they come very quickly." Staff confirmed they could spend as much time as people needed offering each person and their relative's assistance, support, comfort and reassurance.

The registered manager had recently reviewed staffing levels and found they were in line with national recommendations. In the morning there were three registered nurses and two healthcare assistants on duty, with two registered nurses and two healthcare assistants in the afternoon. At night, there were two registered nurses and one healthcare assistant. A team of doctors provided 24 hour advice and support. The duty rota was completed six weeks in advance and showed recommended staffing levels were maintained.

The hospice used a dependency tool, known as the 'Inpatient unit case management tool.' This used a red, amber and green scoring system to identify people's individual support needs. For example, a person in the

terminal phase of their lives scored red, because of their high level of need and those of relatives/carers. Other people having particular therapies such as a blood transfusion or who needed two staff to meet their moving and handling needs were scored amber. From this, a visual 'traffic light' dependency assessment was developed each day, so the service could ensure they had the right skills and staffing levels on duty to meet people's needs. The unit manager said, from experience, staff could judge how many people at different dependency levels they could safely manage on the unit. Where a person needed one to one care because of their complex needs, this was provided. The hospice had been very busy over the previous weekend, so existing staff and bank staff did extra shifts, and no agency staff were used, which meant everyone received the skilled support they needed.

People received their medicines on time and in a safe way, and were kept comfortable and pain free. There were effective systems in place for obtaining medicines from two hospital pharmacies for inpatient use and for people to take home. Staff checked and recorded the medicines people were taking when they first came to the hospice, and when they went home, and offered them advice and support about medicines. People could administer their own medicines if they wished to and staff assessed they were able to do so safely. No one was doing this at the time of our inspection. A pharmacist from the Clinical Commissioning Group (CCG) visited the hospice and provided staff with advice on managing medicines safely. Where 'over the counter' or alternative remedies were brought into the hospice, they were checked with the pharmacist to ensure they were suitable for the person before adding them to their prescription chart. There was a medicines training package, new and existing registered nurses undertook annual medicines training and competency assessments, including medicines calculations.

Doctors prescribed and legibly signed people's medicines on prescription and administration charts, and allergies and sensitivities were clearly recorded. Some people were prescribed a number of 'when required' medicines. It was very clear when these medicines should be administered and there were clear instructions about the maximum safe dosage and frequency. Staff recorded the medicines they had given or clearly recorded the reasons for any omitted doses.

A detailed pain assessment chart was used to assess and record people's pain and other symptoms, including what made it better or worse. This meant staff were continually checking and adjusting people's pain relief to ensure it was meeting their needs. Regular pain relief was offered, for example, nursing staff said they often gave pain relief before they repositioned a person to make sure they were kept comfortable. A separate prescription record was used to prescribe medicines to be given by subcutaneous injection via a syringe driver, which is good practice. A syringe driver helps control symptoms by delivering a steady flow of liquid medication under the skin. Nurses checked syringe drivers at regular intervals to make sure the equipment was running safely and correctly and documented these checks.

Medicines were stored safely within a secure treatment room or in locked cupboards in people's rooms, as were prescription pads. However, currently there was no system to keep a record of the prescription forms used, which would further strengthen security. Controlled drugs, which need additional security because of their potential for abuse, were stored securely and records showed they were looked after safely. The hospice had an 'Accountable Officer' who investigated and reported any incidents involving controlled drugs, in accordance with national guidance. Emergency drugs and equipment were available and checked by staff weekly.

A medicines refrigerator was available and staff recorded the fridge temperature daily to check it was in the safe range for storing medicines. However, staff recorded the maximum temperature for over twelve months as 18°C, in excess of recommended levels. When we checked we found the actual temperature of the refrigerator was within the safe range for storing medicines (2-8°C). This occurred because staff did not know

how to reset the fridge thermometer. The registered manager has confirmed staff contacted the manufacturers the next day and reset the thermometer. All staff were shown how to do this and written instructions have been made available in the temperature recording folder. This meant staff were aware of the safe range of temperatures, and what to do if the fridge temperature is out of this range, and this is being monitored regularly.

Comprehensive policies and procedures and up to date information and references were available for staff on the safe use of medicines. Staff reported any medicines errors and near misses. Medicine errors and near misses were audited, and showed nine errors in total occurred in a twelve month period. For example, where an incident occurred in relation to the use of a pain relief patch, improvements were made in checking and documentation procedures. This included the introduction of twice daily checks to ensure people's pain patches remained in place. This was because patches can sometimes fall off and need to be checked and replaced earlier than planned. Some incidents related to prescribing errors which were noticed by nursing staff and returned to medical staff for correction. Other improvements included emphasising the importance of legibility when prescribing. Current medicine records showed these improvements were being sustained.

People were cared for in a clean and hygienic environment. Housekeeping staff had suitable cleaning materials and equipment and followed a cleaning schedule. Colour coded mops and cleaning cloths were used in designated areas to prevent any cross infection. All visitors to the hospice were provided with hand disinfection gels and staff used hand washing facilities, gloves and aprons appropriately. The service had infection control policies and procedures and received infection control advice from a designated infection control lead in the NHS. Regular audits of infection control were carried out. For example, audit results showed staff had good hand hygiene practices and staff followed daily/weekly and monthly cleaning schedules, which reduced people's risk of cross infection. The most recent environmental health visit to the hospice kitchen had awarded the kitchen a top rating of five stars.

Is the service effective?

Our findings

People, relatives and healthcare professionals consistently praised the excellent standards of care, treatment and support provided by hospice staff. One person said, "If it wasn't for hospice staff, I wouldn't still be here. That I am is down to the excellent care." Another family said, "His significant improvement is entirely down to the professional medical treatment and constant attention to his wellbeing." Another person said staff had recently undertaken a medical procedure to help alleviate their nausea and vomiting symptoms. The person said the results were "fantastic," they were feeling a lot better and had managed to eat lunch.

Staff had developed an innovative specialist pain relief service for people with intractable pain that was not relieved by other methods. An intrathecal catheter was inserted into the person's spinal area, and used to administer pain relief. This meant people could go home and the spinal catheter could remain in place for up to a year. Staff said this was the first service of its kind to be offered in a hospice. They told us about a person who benefitted from this service, whose cancer was causing them a lot of pain. Other pain relief methods weren't adequately controlling it and were causing unpleasant side effects. The person's feedback showed this treatment changed their outlook on life and gave them something to look forward to again. In 2015 the Royal Society of Medicine awarded the hospice a prize in the research category for this pioneering treatment. Because of the small number of people receiving this service (seven people in 2015), staff kept up to date by networking with other centres offering this service. Staff taught district nurses staff how to manage each person's spinal catheter safely and effectively in the community. People living at home with a spinal catheter were closely monitored through a weekly outpatient pain clinic.

People received effective end of life care based on best practice evidence. Staff followed best practice guidance such as 'One Chance to Get it Right' (the five priorities for the care of the dying), Ambitions for Palliative and End of Life care and recent NICE guidelines on end of life care. Staff worked closely with local NHS trusts, care homes and nursing homes and with Exeter and Plymouth Universities to provide a programme of education and training for health and social professionals, in accordance with NICE guidelines. They trained 130 registered general nurses in palliative and end of life care, including in the use of medicines and syringe drivers in the past 12 months. This ensured people could receive high quality end of life care at their preferred location, which avoided people having admissions to hospital.

Each person admitted to the hospice had an individual assessment of their care needs when they were admitted. The hospice used the St Christopher's index of Patient Priorities (SKiPP), a nationally validated tool which explored people's individual symptoms and quality of life. People were asked to complete the questionnaires on day 3 and day 10 of their admission to the hospice. Staff also used a holistic 'Distress Thermometer Tool' developed by the National Comprehensive Cancer Network. This used a 0–10 scoring system to check people's level of distress each day, and identified whether they were related to physical symptoms, practical or family worries, emotional or spiritual/religious concerns a person might be experiencing. From this, staff developed an individualised care plan to provide the right support for each person. They discussed the risks and benefits of treatment options and explored any practical, psychological and spiritual support the person needed.

People's care was reviewed daily or more often by nursing and medical staff and treatment plans updated as their needs changed. A weekly multidisciplinary meeting was held to discuss the care of people being cared for at the hospice, which we attended. Participants included three medical staff, the registered manager, unit manager, two nursing staff, an occupational therapist, physiotherapist, bereavement counsellor and ward clerk. The SKiPP and 'Distress Thermometer Tool' was used to help staff evaluate the impact of their care and treatment on each person's quality of life. Each person's care plan was adjusted accordingly so their care and treatment was proactively managed, in accordance with the recommendations of 'One Chance to Get it Right.' This improved people's experience of care in the last few days and hours of life. One person, referring to their SKiPP quality of life score said, "When I came in nine days ago I was on a one (score), now I'm 15+. They have changed my whole outlook ...it's been life changing." Staff also reviewed the care of five people who had died at the hospice over the previous week, and discussed what had gone well and not so well. This showed the service was committed to continuously reviewing and improving the quality of people's care.

Staff ensured people experienced an optimum quality of life through the use of link roles to champion best practice. For example, staff had lead roles to champion care for people with motor neurone disease, for counselling and bereavement support, foot care, moving and handling, falls prevention and infection control. Staff had done additional training, in their area of interest, and compiled a resources folder to update other staff. The unit manager said staff were passionate about their link roles, and the approach worked particularly well in practice. For example, by reducing people's risks of falls through falls prevention measures. Two staff had link roles for moving and handling and completed a three day accredited 'train the trainer' course. They taught and assessed the competencies of other staff to use approved moving and handling techniques. They used a competency framework to ensure staff were using moving and handling techniques and equipment correctly. Link role staff said this was particularly valuable as they could address people's individual moving and handling needs as they arose. They were also consulted in the purchase of equipment, before a purchase decision was made.

Staff had a range of skills and experience, and received excellent training, updating and opportunities for ongoing professional development. They had access to books, journals, and other online resources to keep up to date with best practice. A training matrix was used to monitor staff were up to date with their required training, and showed 100% attendance rates for the previous 12 months. A training needs analysis used information from the annual staff appraisals and audit findings to identify further staff training and development opportunities for career progression. For example, one nurse had undertaken a further qualification in leadership in palliative care at Dundee University and another nurse started work in the hospice as a healthcare assistant and had gone on to do their registered nurse training.

All new staff and volunteers underwent a thorough induction, which gave them the skills and confidence to carry out their roles. Staff undertook a three day statutory and mandatory update training each year, which included moving and handling, safeguarding, infection control and fire safety training. The third day was used flexibly to provide updates on topical areas, for example, in 2016 staff had an update on palliative care legislation, the CQC Fundamental Standards, advanced care planning and the use of de-escalation techniques for managing challenging behaviour. Health related training included diabetes, catheter care, managing nausea and vomiting as well as nutrition and hydration. Other training specific to people's end of life care needs included managing breathlessness, chronic oedema (swelling) and blood transfusion. Therapy staff used case studies to promote and share learning with other professional colleagues. This included researching the evidence base for the techniques used, evaluating the impact on the person and reflecting on their practice to further improve their care.

Staff received support with their practice through regular supervision. A confidential counselling service was

provided for staff, which some staff said they had accessed and really appreciated. Regular checks were made to ensure people were cared for by nursing and medical staff whose registrations were up to date with their professional bodies. The hospice provided training placements for medical students, GP trainees and junior doctors. Feedback included, "Fantastic placement and amazing consultants" and "Really supportive team ... everyone really keen to teach." Feedback from the Peninsular Medical School and the Deanery was similarly positive.

A physiotherapist taught people techniques to manage breathlessness and fatigue management, which helped them control their own symptoms. They helped people remain independent for longer through teaching exercises and providing advice about mobility aids. They used acupuncture, which some people found really helpful for symptoms and pain relief. A specialist nurse worked with hospice staff to provide a person at the hospice with a treatment to alleviate their symptoms. They explained to nursing staff the side effects to look out for, the person recovered well and went home, which gave them precious extra time with their partner and family.

People's consent to care and treatment was sought in line with legislation and guidance. The Mental Capacity Act (MCA) 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People were asked for their consent for day to day care and were consulted and involved in all care and treatment decisions. When staff were using bed rails, or monitoring equipment, these were discussed with the person and their consent sought. Staff received training on the MCA, and DoLS and had supporting policies and procedures. Each person's mental capacity to make their own decisions and consent to their care was regularly reviewed, as their condition changed. Where people lacked capacity, staff respected people's wishes, set out in advanced care plans, even when the person was no longer well enough to communicate them. Staff also consulted relatives, staff and other professionals in 'best interest' decisions about the person's care and treatment. For example, a person was seriously ill and receiving end of life care at the hospice. The person's family wanted to take them home but staff did not think this was in the person's best interest due to their complex symptoms. So, a best interest meeting was held, involving family, other professionals and took account of the person's stated wishes about their preferred place of care.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and found they were. Staff had undertaken relevant training and used pocket guides to help them make decisions about deprivation of liberty. To date, staff did not make any applications to deprive people of their liberty, but were confident to do so, if needed.

People praised the quality of food and were supported to eat and drink what they wanted for as long as they wished. One person said, "The food here is very good, I get a good choice, if there is something I don't want, they will cook something like cheese on toast for me." Another person said particularly appreciated being able to get food and drink at night. They said, "I have put on weight, I'm eating and feeling really good." Catering staff were passionate about the food they produced, people chose their meals from a menu which showed photographs of small portions presented in an appetising way to tempt them. Staff received training on nutrition and hydration and how to manage people with swallowing difficulties or choking risks.

People's individual needs were met by the environment of care at the hospice. The building was light and airy, with high ceilings and lots of light. There were facilities for people with disabilities such as wide corridors suitable for wheelchair access, a height adjustable Jacuzzi bath and wet room facilities. People had spacious individual rooms with quiet areas where people and families could talk in privacy. A central courtyard garden provided a safe and welcome outside space for people and families and meant people confined to bed could access the outdoors. A relative's room was available so family members could take a break and make a drink and a snack. Staff explained many people in Cornwall had an affinity with the sea, and this theme resonated in the artwork, pictures and the calm, relaxing colour schemes used.

Is the service caring?

Our findings

People said they received outstanding care because hospice staff were exceptionally caring and compassionate towards them. Comments included, "Staff are amazing, they go that extra mile" and "The team at St Julia's are true professionals and the hospice is a beacon of excellence in every way." One person said, "You helped us through all the difficult times with grace, kindness and care." Another said, "Its brilliant in here, the staff are fantastic."

A family said, "We were touched by the kindness, compassion, care and dignity you showed." Another family said, "The calm environment is second to none but it is also nice to hear music and laughter and the chatter of everyday life." A relative said they were really struggling to come to terms with the fact the person was so ill. They really appreciated the unlimited time staff had for the person and for them and described staff as "angels." Others said, "They continue to give support to the family ...and that is priceless." A GP said, "I have visited St Julia's and the level of care and compassion is humbling to see." Another professional said, "They look at the whole person, they don't leave out any aspect."

The service had an open and positive culture that placed people at the heart of everything they did. Staff had a shared ethos, of caring compassion and respect. One staff said, "We are all working here for the same purpose, to make things better for people, whatever that means for them." Another said, "Although we can't make people better, we can make them feel better and improve their quality of life." The chaplain said, "People come in wounded and in pain, we can supply the love, care and peace that they want."

Most people were referred to the hospice for care towards the end of their life, as end of life community services were provided by other organisations in Cornwall. This meant staff had a short time frame in which to get to know people. Hospice staff had exceptional interpersonal and communication skills, and quickly established a rapport with people, were familiar with their circumstances and what mattered to them. We witnessed many kind and gentle interactions and observed staff used gentle touch to comfort people and relatives, offering a reassuring hand or a hug to when they became anxious or upset. They spent time with people, chatting to them in an unhurried and relaxed way. Care included personal touches, such as making a flower arrangement to brighten each person's day and arranging a surprise party for a person's 80th birthday. The person was overjoyed, loved the whole experience and had nothing but praise for their care.

Some people were very frightened when they first knew they were coming to the hospice, but soon settled in once they arrived. One person said, "It felt like the end." They described how friends and family were initially reluctant to come and visit them but said the welcome atmosphere and caring attitudes of staff soon overcame those obstacles. A young person's story in the most recent hospice booklet highlighted this issue. The person said, 'The hospice went from being the scariest word you could hear in the world, to being something that was just safe.' Their relative's feedback was that staff and volunteers cared for the person 'as if she was one of their own which was amazing.' They particularly appreciated that when the young person's friends turned up late one evening to drop off cards and balloons, nursing staff invited them in. They said, 'There was a lot of hugging, it was lovely and meant so much to everyone.' This care inspired family members to participate in the London marathon to raise money so the service can continue for others.

People said the hospice was a happy place, in which they felt supported and cared for. The relative of a person said, "She fell in love with the hospice because as well as the care, everyone was so friendly." Relatives described how they felt a sense of relief when the person was admitted to the hospice. They felt they could relinquish their carer role to staff and spent precious time being with their loved one, knowing all their care needs were being met. One family said, "We were able to transition away from being her carers to be her daughters once again, you are all angels, you are inspirational." Others appreciated simple touches like being offered a hot meal, when they were with a person for long periods.

Staff cared for the whole family, they supported people to visit home and go out on trips with family or friends. People were able to have visits from much loved family pets, which comforted them. When we visited staff were doing painting with three young children, so family members could be with the person, who was receiving end of life care. A person's relative said, "The place feels so right." A community palliative nurse said people had really positive experiences at the hospice, and appreciated the peace and quiet and non- medical environment. They said hospice staff focused on what was important to each person and tried to fulfil their wishes. Another professional said, "The best thing about the hospice is the holistic care of the patient and the family, diagnosis can be sudden and time is short. Staff give families precious time together to make memories." Another said, "Hospice staff are very good at preparing people and families for death and giving them support."

People confirmed hospice staff consulted and involved them in planning their care. Staff excelled at giving people information and explanations in a skilled way. All staff and volunteers undertook communication training to support them to have difficult and challenging conversation with people and families. This included awareness of verbal and non-verbal communication and active listening, which meant they felt confident to comfort and reassure people and those close to them. A wide range of 'plain English' literature and information leaflets were available to help provide information to support decision making. For example, treatments available for various types of cancers; information for carers and about complementary therapies. Where a person needed support to express their views, this was provided. For example, a deaf interpreter was arranged to support a deaf person to participate fully in a multidisciplinary meeting about plans for their child's future.

One person particularly appreciated that staff always told them the truth and discussed realistically the pros and cons of their care and treatment options. A professional described how hospice medical staff responded to their request to visit a person who was dying. They said the doctor explained to their family how they knew the person was dying. They said, "They went through it step by step in a way we can't, they were brilliant at breaking bad news sensitively." A specialist nurse told us about a person they referred to the hospice who was angry and very frightened, and said hospice staff built up a good rapport and dealt skilfully with them. They said, "They consulted and involved her, whenever she phoned them with a problem, they always knew who she was, she trusted them."

People said staff and volunteers always treated them with the utmost dignity and respect. Curtains were fitted inside the door of each bedroom, which provided complete privacy for care. One person said, "I like my door left open, so staff pull the curtain across so no one can see in." A relative said, "There is a lot of respect and support. Dignity is key. Consideration of all the family, not just the patient, is without bounds." Volunteers understood confidentiality. One said, "We never talk outside people's rooms or about anyone we might know outside of the hospice, even when we are asked."

The hospice had a volunteer led service known as, "Look good, feel good." This offered one to one appointments with people who had experienced hair loss secondary to their treatment. They provided a selection of hats, scarves and turbans people could buy and taught people how to wear and style their

headwear. They recommended suitable items for special occasions, such as weddings. This helped restore people's confidence and self-esteem.

Staff were knowledgeable about how to meet people's spiritual, religious and cultural needs and had done multifaith training. The unit manager said the hospice had a focus of people's spirituality, so staff could support people with whatever spirituality meant to the individual. A volunteer chaplain visited people and families at the hospice regularly and in response to specific requests. They were available to all, with any belief or none and provided spiritual guidance. They had extensive contacts with local ministers and other faith groups, so had contacts to meet people's religious needs. The chaplain said their role was "a privilege," because they could support people in their final days and hours. They described themselves as, "A friendly face with time to listen." A non-denominational room known as 'The Sanctuary' was available for anyone to spend quiet time in.

The chaplain assisted some people who wished liked to plan their funeral. They also organised a range of other events in response to people's needs, such as baptisms and blessings. One staff told us about a wedding ceremony staff organised for a couple who wanted to get married. Staff bought the flowers and made the bouquets, to make the couple's day as special as possible. Another person was too ill to attend their daughter's wedding, so the chaplain organised for the couple to have a blessing in 'The Sanctuary.' Staff helped the person with their hair and make-up so they felt special, this meant the person could participate in this family event.

People were supported to have a comfortable, dignified and pain free death. One person said, "They give me pain relief as soon as I needed it." A relative said, "You kept him safe, comfortable and out of pain, he had suffered so much and that meant everything to us." When we visited, a person had just died, and looked at peace. Staff had performed the last offices to a high standard, and lovingly placed a flower on the person's pillow and a vase of flowers by their bedside. As we entered their room, the staff member spoke gently to the person and treated them with the utmost dignity and respect. Staff had worked with a local undertaker to follow a person's journey after they left the hospice. This helped them make sure they were following best practice in caring for people following their death. As there were no mortuary facilities at the hospice, the undertaker worked with staff to introduce the use of a 'cool blanket.' This meant people could remain in their room at the hospice a little longer, which meant relatives, friends and family had more time to say their goodbyes and so staff could support them.

The hospice had a trained bereavement counsellor who supported people receiving end of life care, and family members. They were working with a young person to make a memory box about their grandad who was in the hospice. Following a person's death, the counsellor sent bereaved relatives a 'Thinking of you card' with their contact details. When a relative contacted them, they outlined the counselling services available. Following an initial assessment, they were offered six to eight sessions, depending on need. This meant bereaved relatives had ongoing support following their loved one's death. The counsellor signposted people to other specialist services, such as Penhaligon's Friends, which is a Cornish charity supporting bereaved children. A link member of staff had undertaken additional training in bereavement and counselling and provided invaluable support to people, families and other staff in the hospice. For example, by helping staff find the right words or approach to deal with difficult conversations or a particular situation.

There were regular memorial services held, known as 'Light Up a Life Service' to remember people that had died. This provided an opportunity for friends and relatives to come together and remember loved ones. At Christmas in 'The Sanctuary,' relatives wrote a message to their loved one and put it on the Christmas tree and share their memories of the person in a memory book. This provided comfort and solace to the bereaved.

Is the service responsive?

Our findings

People received exceptionally personalised care that responded to their individual needs. One person said, "They make things feel better and look at you as a whole." Another said, "It's a real comfort blanket to know it is there for me and my family." A relative said the hospice was "outstanding" and described staff as "fantastic, really person centred." Professionals consistently gave us exceptional feedback about the services provided by the hospice. Comments included; "Hospice staff are at the forefront of pioneering services" and, "The service given to dying patients at St Julia's hospice is second to none. The staff are a great team, nothing is too much trouble and they are a huge resource of advice."

Hospice staff worked closely with other health professionals and services providing end of life care in Cornwall in innovative ways to meet people's needs and provide co-ordinated care for them. This was particularly important because of the rurality of the county and long travelling distances for people accessing services. Hospice staff worked with local hospitals, nursing and care homes, and with community staff to ensure people receiving end of life care in all settings were supported to receive personalised high quality care. For example, hospice staff undertook a project to support NHS staff working in a specialist dementia care unit in Bodmin to provide end of life care for people with complex mental health needs. This meant people could remain in the specialist unit and receive care from staff who knew and understood them. This avoided unnecessary distress and was in accordance with best practice recommendations in the National Dementia Strategy.

Hospice clinical staff did training sessions on end of life care for NHS staff, which included practical training about keeping people comfortable and pain free. This meant those staff developed the skills and confidence to meet people's end of life care needs. A consultant said they particularly appreciated their help with developing end of life protocols and prescribing guidelines suitable for their patients. They also said a member of hospice staff was particularly helpful to them in managing a challenging family situation, to make a 'best interest' decision about the withdrawal of treatment for a person. Staff in the dementia unit used the hospice helpline regularly for advice and reassurance, for example, when a person experienced breakthrough pain. People benefitted because staff in both services shared their skills and expertise. Staff from the dementia unit delivered training sessions for hospice staff on caring for people living with dementia. They said this gave them a greater awareness of how best to support people with dementia in an unfamiliar environment. It increased their awareness of the need to use a variety of communication methods, to enable people living with dementia to make as many decisions as possible about their care and treatment. The work done with the specialist dementia team has been incorporated into the countywide joint work on end of life education and care planning.

The hospice provided a 24 hour, 7 day a week palliative care advice line for people and their carers and for health professionals such as GP's, district nurses and hospital staff. Staff provided advice on symptom control, management of pain relief and identified people who benefitted from admission to the hospice to manage their pain and other complex symptoms. A recent survey of GPs showed they found the support and advice from the hospice extremely helpful. A local GP commented, "This is a fantastically helpful service ... I have used it on several occasions. Thank you to the doctors who provide this ... it makes dealing with

palliative care in the community much easier ... especially out-of-hours." The 2014-15 quality account showed the service had been used on more than 800 occasions last year and has continued to grow. It has since been extended to provide an email advice service, which provides a written response within 24 hours. Professionals said this service was particularly helpful with complex patients where multiple professionals were involved. This was because the e mail advice received could quickly be shared.

Hospice staff worked closely together with the palliative care team at the Royal Cornwall Hospital Trust (RCHT), at Treliske. A hospice consultant did regular ward rounds at the hospital and provided hospital staff with expert advice on pain relief and complex symptom control. Hospice staff also provided specialist advice and support to 23 NHS specialist community palliative care nurses. They attended their weekly multidisciplinary team meetings, in East, West and Central Cornwall. We went to one of these meetings at RCHT, and met six community specialist palliative care nurses and two GP's. The meeting included discussion of people in the community newly diagnosed as end of life and reviewed the continuing care of people with challenging/complex symptoms. Hospice medical staff did joint community visits to people with complex needs with specialist nurses and GP's to undertake a palliative care review and provide advice on their future management. This supported people to remain at home to receive end of life care.

Hospice consultants participated in weekly joint oncology and pain out-patient clinics at the RCHT. The clinics enabled people to have prompt access to expert individualised pain and symptom control, which included medication, physiotherapy and innovative interventional treatments such as nerve blocks. It meant people received the most expert care at all stages of their illness as well as emotional, social and family support at one outpatient appointment. A relative of a person who attended one of these joint clinics praised the continuity of care and communication between consultants. They said medical staff knew the person's history, which saved them from continually having to repeat themselves when they attended an outpatient appointment. Hospice staff also saw people at the hospice and at local community hospitals, so they received care nearer their home for their convenience. Similarly, staff from RCHT visited people at the hospice to provide hospice staff with specialist advice regarding their care.

Staff exceeded the expectations of their role to provide people with an exceptional service. A member of staff undertook a two year course to gain a podiatry qualification. They explained people often experienced difficulties with their toenails due to the side effects of chemotherapy. Although there was a high demand for chiropody services, people in the hospice couldn't always access these services quickly, so this staff member provided people with foot care, such as trimming their nails, and advice on foot skin care. This initiative filled a gap in local service provision and helped people to keep their feet in good condition, which in turn helped them maintain their mobility and independence. A person told us about the help they received with their ingrowing toe nails. They said the staff member showed their wife how to cut their toenails and stayed with them whilst they did this. They said, "I was really impressed." Another member of staff gained a qualification in use of massage and aromatherapy, so they could offer people relaxation through complementary therapies. They often worked flexibly in the evening, so people were offered a treatment before bed time, which helped them sleep.

Staff worked with people and those close to them to develop individualised care plans that reflected how each person wanted to receive their care, treatment and support. They supported each person, if they wanted to, to develop an advanced care plan, so people's wishes about preferred place of end of life care were documented. These captured in detail people's views about resuscitation and any withdrawal of treatment. This meant the person's wishes were known so staff could carry them out.

All medical, nursing and therapy staff recorded their assessments in one record, which communicated changes in people's care needs quickly and effectively between the staff team. A symptom observation chart

showed staff monitored and responded quickly to any symptoms people experienced such as breakthrough pain, nausea and vomiting, shortness of breath, and respiratory secretions. They helped people change their position regularly for their comfort and to prevent pressure sores. People were offered regular food and drink, and frequent mouth care if they were too ill to drink. A patient status board in the staff office used symbols to communicate confidential information rapidly between ward staff when people's needs changed. For example, it used a red, amber, green system to highlight if a person's condition was changing or deteriorating, so medical staff could prioritise seeing that person next.

A person admitted to the hospice two weeks ago with uncontrolled pain said this had quickly been resolved. The relative of another person said they were quite agitated when they were first admitted, but staff soon got their symptoms under control. Another family had been trying for months with other services to get the person's pain controlled. Eventually, they rang the hospice for advice, and staff arranged for the person to be admitted and changed their pain medication. They said, "He is now lovely and settled." This showed the person's quality of life had significantly improved, and meant their family could relax and enjoy spending precious time with them.

Therapy staff working at the hospice included a physiotherapist, occupational therapist and lymphoedema nurse, who saw people in the inpatient unit and at outpatient appointments. They used a rehabilitation approach to help people to achieve as good a quality of life as possible and restore their sense of wellbeing. For example, an occupational therapist prompted a talented guitarist through music therapy to resume playing their guitar, which gave the person a lot of pleasure. A case study showed how physiotherapy helped another person with shoulder pain and restricted movement following a mastectomy (surgical removal of the breast to treat breast cancer) and reconstructive surgery. The physiotherapist taught the person exercises to improve their posture and used a specialist treatment, to stretch scarred tissues. The person reported a significant improvement and was able to sleep at night and start gardening again. A lymphoedema nurse helped about 200 people each year to manage their condition. For example, a person with a swollen arm and discomfort following surgery was taught massage techniques and fitted with a compression sleeve to help encourage good lymph drainage and reduce swelling. This meant the person was able to return to work. The breast specialist nurse said the service was prompt, and said "The nurse communicates well with the team and always gives us written feedback."

At the weekly multidisciplinary meeting staff discussed two people with complex symptoms and prioritised them for admission later that day. Another person had improved, and staff made plans for their discharge. They contacted the specialist community palliative care nurse to visit them at home to provide ongoing support. Physiotherapy and occupational therapy staff did home visits to help people manage their condition at home. For example, by teaching people relaxation and breathing techniques to manage breathlessness and advising people on any equipment needed, such as mobility equipment or moving and handling equipment. This meant people were discharged home or to another service, with the right support, once their acute symptoms were stabilised. Hospice staff communicated regularly with other professionals providing care for the person and wrote detailed treatment plans in discharge letters. One person was really looking forward to going home and said, "I have a package of care waiting for me when I get home, I have a Macmillan nurse coming plus a carer, and the council has provided me with a special bed, which has been delivered." Macmillan nurses are specialists in cancer related palliative care. A health professional said, "They do a good job, they can get people home as soon as they have improved because of all the expertise around them."

The service had a policy and procedure for managing complaints which outlined the arrangements for investigating and responding to complaints. Information about complaints was included in the Patient's Guide, which each person received when they were first admitted. No complaints had been received in the

past 12 months. In the previous year, feedback about a staff attitude issue had been robustly dealt with. A professional said, "I have never heard anything negative about the hospice."

Is the service well-led?

Our findings

People, staff and external professionals consistently gave us exceptionally positive feedback about the excellent quality of end of life care at the hospice. One person said, "It's fantastic here, it's been life changing ... a very powerful experience. It's given me renewed hope for the future, turned my life around and given me something to look forward to." Other written feedback comments included; 'The kindness of staff helps no end when I feel in pain;' and 'It has been marvellous at the hospice;' 'I had fantastic care.' Professional feedback included, "St Julia's is a well led, patient centred facility, providing excellent and compassionate care. It is held in great esteem by patients and their families and clinicians." Other comments included, "The hospice delivers a platinum standard, gold plated service;" and "The hospice is the best service we interface with, the most prompt, humane and pragmatic, exemplar practice and outstanding colleagues."

The leadership team promoted strong values of person-centred care and worked in partnership with other organisations providing end of life care for the people of Cornwall to achieve best practice. Feedback from professionals showed hospice staff took a lead role in improving the quality of end of life care. In January 2015, Healthwatch Cornwall published a report 'Place of Dying' which recommended local organisations providing end of life care worked together to develop better information for people on end of life planning, choices and support available.

On 29 January 2016 Healthwatch held 'A Good Death' End-of-Life Conference to bring all interested parties together and drive forward the improvements needed. Hospice staff contributed and highlighted that St Julia's had already developed the facilities needed to offer more local outpatient services to people. They invited specialist healthcare professionals to work with them to refer people to the hospice earlier, and asked commissioners to provide additional funding so they could expand and develop more local services for people. For example, providing people with chemotherapy and blood transfusions locally for symptom control. This would mean more people could receive treatments nearer their home. The chief executive of Healthwatch said, "Hospice staff were passionate about influencing change for the better, they were highly motivated and energetic practitioners, committed to collaborative working and a seamless service that plugs the gaps."

Between February 2015 and February 2016 hospice staff participated in a Health Education South West (HESW) project to develop Anticipatory Prescribing Guidance across Cornwall. Anticipatory prescribing is designed to enable prompt symptom relief at whatever time the person develops distressing symptoms. The project won first prize in the Royal Cornwall Hospitals' Trusts (RCHT) Audit and quality improvement initiative. It was recognised by HESW as an exemplar of cross sector working and was accepted for presentation at The European Association of Palliative Medicine (EAPC) conference.

This initiative was developed in response to the recommendations of a (VOICES) national survey of the bereaved in 2015, about inadequate pain and symptom relief, which recommended people's medicines are prescribed in advance, so people don't have to wait. Hospice staff developed guidance on anticipatory prescribing, and introduced a best practice policy framework for use by healthcare professionals across Cornwall. They worked with a local GP lead to introduce the use of a "Just in Case Box." These are

medicines kept in the person's home or in a care home 'just in case' they are needed to provide quick and effective relief of symptoms. They trained 900 health professionals over a 10 month period, which meant people receiving end of life care in all settings across Cornwall had prompt access to better pain relief and symptom control. The lead GP said, "They are fantastic clinicians and colleagues, a great ethos and approach. They are key innovators and leaders of change."

Hospice staff worked with the continuing health (CHC) care team to ensure people who needed it had rapid access to specialist palliative care. They agreed criteria to identify people needing specialist palliative care. This meant people were rapidly referred to the hospice by CHC staff without waiting for NHS funding approval. A pilot of this initiative, using four beds at Mount Edgcumbe hospice was underway, and if successful, will be extended to St Julia's hospice. This initiative will increase NHS funding so more hospice inpatient beds can be opened to provide more sustainable high quality end of life care in Cornwall. It will also avoid unnecessary admissions to hospital for end of life care for people.

Hospice staff contributed to the ongoing planning, development and review of end of life services in Cornwall through participation in the Cornwall Clinical Forum. They participated in the Penrith Living Well initiative who were undertaking a mapping exercise to identify existing services and highlight gaps in local service provision. The data was used to inform and influence commissioning decisions so end of life services are commissioned which meet the needs of local people. The hospice chief executive said more progress had been made in organisations working together to improve end of life care in Cornwall during the last six months, than had previously been achieved over many years.

Hospice staff worked closely with Marie Curie, a national end of life charity, by providing advice to Marie Curie staff doing night sitting services locally for people having end of life care at home. They also worked with the Motor Neurone Disease (MND) co-ordinator, consultants, and therapists to provide a co-ordinated local service for people with MND. This meant those people received all their care at one clinic, rather than attending separate appointments with each specialist. Professionals developed shared documentation, so each person had all their advice in one record.

Although professional feedback about multidisciplinary working with staff in other organisations was overwhelmingly positive, at the trust weekly multidisciplinary meeting, we picked up some tensions. This was between hospice consultants and some (but not all) community specialist palliative care nurses. This related to historical professional differences between staff about the current model of end of life care commissioned in Cornwall. The registered manager and medical director acknowledged these issues and outlined steps they were taking to improve these working relationships. For example, newly appointed specialist nurses undertook part of their induction in the hospice which they said was improving understanding of their respective roles in providing end of life care. Two external professionals, commenting on these issues, confirmed they felt hospice staff were proactively trying to further improve these relationships for the benefit of people.

The service was committed to excellence through research to identify new ways to further improve their service. Hospice staff supported fourth year medical students to identify better ways to get feedback from people who were too unwell to complete the St Christopher's index of Patient Priorities (SKiPP) questionnaire. Medical students undertook verbal interviews with 185 people to identify key factors they considered important when rating their quality of life. Analysis of the data showed people's concerns were mainly about pain, nausea, breathlessness and feeling unwell, as well as reduced mobility. This data was used at multidisciplinary meetings to help staff identify further ways to improve those people's symptoms and quality of life.

The registered manager was the Director of Patient Services and managed both hospice sites. At St Julia's they were supported by a unit manager, who was an experienced nurse. The Medical Director managed the medical staff team of consultants, specialist registrars and GP trainees. Staff worked together as multidisciplinary team, and respected and supported one another's contribution, and felt valued by the leadership team. Commenting on leadership, a staff member said, "We have strong support, standards are kept high;" other staff said, "There are clear communication lines and a culture of openness;" and "We get brilliant support, we feel valued and empowered to thrive."

Staff meeting minutes showed ideas and suggestions for improving practice were discussed and staff were consulted and involved in decision making about the service through a staff and a volunteer council. Issues discussed included shortfalls in funding was delaying the opening of a newly developed outpatient facility and extra inpatient beds. Following questions from volunteers about how money raised was used, pocket guides were developed to communicate this information in an open and transparent way.

Cornwall Hospice Care Limited (the provider) was managed by a board of trustees. The executive team met with the board of trustees every three months, and in between met regularly with the trustee chairs of various committees. Trustees did an unannounced provider visit to the hospice each year using the Care Quality Commission's five key questions as their framework. Trustees spoke with people, a range of staff, looked at the environment of care, at staff training and at some records. They reported their findings in a report to the board. The findings were very positive and highlighted minor areas for the board's attention, such as the need to review the role and support for the unit manager, following the semi - retirement of the medical director. The registered manager planned to introduce regular informal 'walkabouts' with the chief executive in the near future as a way to get more ongoing feedback from people, relatives and staff.

People and relatives views and experiences were sought in a variety of ways. The hospice used a national questionnaire 'I want great care' which asked respondents to rate their care using five key questions about dignity/respect, involvement, information, caring, support from staff and whether they would recommend the service to others. The hospice had received 639 reviews, almost all of which awarded the service a top five star rating. A comments and suggestion box was used to seek feedback and suggestions from people, relatives and staff. A feedback board showed the actions taken in response, such as fitting a soft door closure mechanism to the microwave in the relative's room to reduce noise levels. Following a recent donation for use in 'The Sanctuary' non- denominational room, people and staff were consulted about how to make this room more accessible to all. In response, sofas and attractive soft furnishings were purchased to make the space more accessible, cosy and inviting for all to relax and spend time in.

12 staff had undertaken leadership and management development training to prepare them for future medical and nursing leadership roles. There were plans for nursing staff to deputise in the unit manager's absence. The registered manager had recruited a hotel services manager to free up the unit manager to focus more of their time on clinical leadership, audit and quality monitoring. The hospice had robust governance and quality monitoring arrangements. They continuously improved the quality of care through clinical governance and a clinical service committee and an education strategy group. Minutes of the April 2016 clinical governance committee included audit plans for the forthcoming year and plans to further improve advanced care planning. Patient services, facilities, health and safety, volunteers and therapies were discussed and reported on at the Clinical Services Committee.

A range of audits were undertaken, such as audits of falls, drug errors, pressure area care with recommendations for improvement implemented. Other audits included the advice line, community team referrals, an antibiotic prescribing audit and a joint audit of intrathecal (spinal) catheters. Clinical and environmental risks and accidents/incidents were monitored to identify themes and trends with actions

taken to reduce risks. Senior management had identified financial sustainability as one of the biggest risks to maintaining and developing services. The unit manager and registered manager attended various Hospice UK network meetings to keep up to date and share good practice ideas. Benchmarking data for year ending April 2016 showed bed occupancy was high than average at St Julia's compared to similar sized hospices but they had lower than average incidents reported for falls, pressure ulcers and medication errors which demonstrated the hospice had robust risk management systems.

Following a review of governance arrangements, the registered manager planned to set up a new Quality Assurance meeting to meet alternate months, from June 2016. This was to dedicate more time to analysing incidents, focus on medicines management, and benchmark audit findings with other similar services to identify further areas for improvement. They also had plans to explore the use of technology further, so the service could provide the best care for the greatest number of people, by overcoming some of the geographical challenges. An annual quality account highlighted the priorities for improvement for 2015-16 which included a pilot to offer a volunteer sitting service for people with life limiting illnesses in the local area, so carers could have a break. This showed the service was committed to continuous improvements.

The registered manager sent us regular notifications, as required by the regulations. People's care records were kept securely and confidentially, and in accordance with the legislative requirements. All record systems relevant to the running of the service were well organised and reviewed regularly. A newsletter kept people and supporters of the hospice up to date with developments. This included fundraising events planned, and stories about people's care.