St. Ann's Hospice

St Ann's Hospice Little Hulton

Inspection report

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Date of inspection visit:
19 October 2016
20 October 2016

Date of publication:
06 January 2017

Ratings

Overall rating for this service	Outstanding ☆

Is the service safe?	Good ●
Is the service effective?	Good ●
Is the service caring?	Outstanding ☆
Is the service responsive?	Outstanding ☆
Is the service well-led?	Outstanding ☆

Summary of findings

Overall summary

This inspection took place on 19 and 20 October 2016 and we provided 48 hours' notice of our visit to ensure the registered manager would be available to facilitate our inspection. The service was last inspected in December 2013 and was found to be meeting all the regulations we reviewed at that time.

St Ann's Hospice is situated in the Little Hulton area of Salford, Greater Manchester and is registered as a charity. The hospice provides palliative and supportive care services to people with life limiting illnesses. Services provided include Hospice at Home, day therapy, inpatient care and a CSPCT (Community Specialist Palliative Care Team). An extensive garden area is available for the benefit of patients and visitors. Off street car parking is available and the location is well served by public transport routes.

St Ann's Hospice is registered with the Care Quality Commission (CQC) to provide care for up to 18 people on the inpatient unit. At the time of our inspection there were 12 people being cared for on the inpatient Unit and approximately 250 people receiving care and support in the community. Of these 250 people, the manager told us that provision of personal care was limited.

There was a registered manager employed at the time of the inspection. 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 told us they felt safe when accessing services provided by the hospice. People who used the hospice told us staff would not hesitate to go the extra mile when caring for them. We saw the importance staff at the hospice placed on supporting families and carers of people with life- limiting illnesses in order to improve the well-being of all concerned. This included the provision of carer and bereavement support, complementary therapies and counselling.

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.

All staff had received training in safeguarding adults. In addition the hospice had developed a culture in which staff were supported to report any concerns, no matter how small, to senior staff.

There were sufficient numbers of staff available to provide tailored, individual support to people, both in the hospice and in the community. Staff and volunteers had been safely recruited, such as ensuring DBS (Disclosure Barring Service Checks) were in place.

People received excellent care, based on best practice from an experienced and consistent staff team. Staff were supported through training to develop the knowledge, skills and confidence to be able to meet

people's needs in an individualised manner.

All staff and volunteers completed a comprehensive induction programme. Staff were expected to complete online training to demonstrate knowledge in all the topics covered. A comprehensive training programme was also in place to help ensure staff had the skills they required to communicate effectively with people who used the hospice, families and professionals.

Good systems were in place to ensure the safe handling of medicines. People were cared for in a safe, secure and clean environment. People were protected because risks were identified and managed. The risks of cross infection for people were reduced through training for staff and robust infection control procedures. There were high quality fixtures and fittings throughout the building, ensuring people's comfort and privacy was catered for.

People had access to high quality food and their nutritional and hydration needs were met by excellent catering services. We noted there was a commitment to further improving the range of meal options available to people throughout the day and we saw catering staff asking people for their preferred choice of food and drink.

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

People who used the hospice were supported to make choices and to have as much control as possible about what happened to them both before and after their death. They and their family members were consulted and involved in planning their care. People were also supported to discuss and make decisions on their preferred place of care at the end of their life. Staff were aware of the action to take to uphold a person's rights should they be unable to consent to their care and treatment in the hospice. The skills staff developed through the hospice's innovative communication training programme enabled them to have difficult conversations with people in a sensitive and caring manner.

The hospice was proactive in reaching out to communities who did not traditionally access their services, including people who identified as lesbian, gay, bisexual, transgender and people from minority ethnic communities.

People told us the leadership team in the hospice were excellent in the care and support they offered to staff, volunteers and everyone who accessed the service. We were told there was an open and transparent culture in the hospice which encouraged people to express any concerns or complaints they had.

People received a consistently high quality of care because senior staff led by example and set high expectations about standards of care. Staff and volunteers spoke positively and passionately about working at the hospice. They told us they received excellent support and guidance from all the managers in the service. We saw staff had regular team meetings and other informal opportunities to enable them share good practice.

The leadership team in the hospice demonstrated a commitment to service improvement. Staff, volunteers and people who used the hospice were regularly asked for their views and ideas about improvements which they felt could be made. We saw that action had been taken to respond to ideas and suggestions people had made. This demonstrated people who used the service, their families and carers, staff and volunteers

were all involved in shaping the future of the service.

There were robust systems in place to monitor the quality of care provided in the hospice; these included lessons learned sessions from accidents, incidents or complaints, which were shared across the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People said they felt safe at the hospice, with staff having a good understanding about how to report safeguarding concerns.

We found medication was handled safely.

The premises were clean with appropriate systems in place to reduce the spread of infections.

Is the service effective?

Good

The service was effective.

People said staff were well trained and had good skills.

Staff had access to a wide range of training and received appropriate supervision.

People at the hospice told us about the high standard of food and drink available.

Is the service caring?

Outstanding

The service was exceptionally caring.

People and relatives described the care as outstanding and told us staff were exceptionally kind, caring and compassionate.

The ethos of care was person-centred and valued each person as an individual. Due to the training they received, staff were exceptionally skilled at helping people to express their views and communicated with them in sensitive and caring manner.

People received care and treatment which enabled them to have a dignified and pain free death. Families and those that mattered to the person were supported to spend quality time with them. Relatives were also able to access bereavement support following their family member's death.

Is the service responsive?

Outstanding

The service was highly responsive to people's needs.

People received care that was exceptionally personalised to their individual needs, wishes and requests. Staff worked in partnership with people to develop care plans which enabled them, as far as possible, to fulfil their wishes and goals. Staff were willing to go the extra mile to ensure people received the care and support they wanted at the end of their life.

The hospice was proactive in reaching out to communities who did not traditionally access their services. Innovative methods had been used to inform the local population about the services provided at the hospice in an effort to dispel myths and encourage people to access the support available to them.

People were encouraged to provide feedback about the care they received from the hospice. Records we looked at showed that complaints had been fully investigated. Robust systems were in place to share lessons learned from complaints with staff and ensure any required changes in practice took place.

Is the service well-led?

Outstanding ☆

The service was extremely well-led.

There was a registered manager in place. People and staff told us the quality of leadership in the service was outstanding. The leadership team promoted an open and positive culture that placed people and staff at the centre of the service.

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

The hospice had a range of robust monitoring systems in place in order to review the quality of people's care and the environment. There was a clear commitment to on-going service improvement throughout the hospice.

St Ann's Hospice Little Hulton

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 was planned to check 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 19 and 20 October 2016. We gave 48 hours' notice that we would be visiting the service on these days. This was to ensure the registered manager would be available to facilitate our inspection and to be able to accompany the hospice at home team on visits to people's homes. The inspection was undertaken by two adult social care inspectors, a specialist nurse in palliative care and a pharmacist inspector from the Care Quality Commission (CQC).

Before the inspection we asked the provider to complete 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 what improvements they plan to make. Prior to the inspection we reviewed the PIR and looked at information we held about the service and provider, including notifications the provider had sent us. A notification is information about important events which the provider is required to send us by law.

We also contacted the Clinical Commissioning Group (CCG), the local Healthwatch organisation, environmental health, infection control and various other professionals based at Salford Royal hospital, which the provider had told us they worked closely with. We received positive feedback from all the professionals who responded with their comments.

At the time of our inspection, there were 12 people on the inpatient unit at St Ann's Hospice. During the two days of our inspection, we spoke with six people who used the hospice services and five relatives on the inpatient unit. We also spoke with one person who used the community service and three health care professionals.

We spoke to a wide range of staff involved in the running of the hospice. This included the registered manager, chief executive officer (CEO), director of clinical services, health and safety lead, quality and audit lead, bereavement coordinator, practice development manager, ward manager, head of housekeeping, a dietician, the volunteer group coordinator and the catering manager. Additionally, we spoke with six care assistants and seven staff nurses. This helped us to gather information about the service and inform our judgements.

During the inspection we looked at the care records for eight people using the inpatient unit and six Medication Administration Records (MAR). In addition we reviewed a range of records relating to how the service was managed; these included three staff recruitment files, training records, quality assurance processes and policies and procedures.

Good

Is the service safe?

Our findings

All the people we spoke with during the inspection told us they felt safe when they received care and treatment from hospice staff. One person said; "I'd actually describe the safety as outstanding. The security is good and I have my call bell. I've fallen from bed in the past and they are there instantly". Another person said; "In terms of security, it's really impressive. Nobody could just wander in off the street. I'm not worried at all". Another person added; "Absolutely. If you look like you are falling from bed, they will assist you. They always seem to be keeping an eye on people".

We looked at the systems in place to safeguard people from the risk of abuse, within the service. There were appropriate policies and procedures in place with regards to safeguarding and whistleblowing. This told staff how they would be supported if they reported poor practice or other issues of concern. Staff we spoke with were familiar with the policy and knew how to escalate concerns within the service. They also knew they could contact people outside the service if they felt their concerns would not be listened to. The staff we spoke with during the inspection displayed a good understanding of safeguarding vulnerable people. One member of staff said; "Aggressive behaviour towards people, bruising or belittling people could all be signs of abuse". Another member of staff added; "Physical abuse could be things such as overdosing medication or noticing marks on a person's body. Financial irregularities could also indicate people's money wasn't being looked after properly". Staff having this knowledge and understanding meant people would be protected from the risks of abuse.

Our pharmacist inspector looked at the way medicines were prescribed and managed at the hospice. We watched two nurses administering medicines and saw that a safe procedure was followed. We looked at the medicine charts of six out of the twelve patients currently in the hospice. They spoke to the Clinical Services Manager(who was also the controlled drugs accountable officer), one of the palliative care consultants, the ward manager, another nurse and one patient. The accountable officer is the person who has a legal responsibility to ensure that controlled drugs (drugs liable to misuse) are properly managed. Our pharmacist also met the specialist palliative care pharmacist from a local NHS trust who spends 26 hours a week at the hospice.

Medicines were ordered from the local NHS hospital pharmacy. The palliative care specialist pharmacist provided a clinical service that included checking prescription charts, reconciling patients' medicines and reviewing medicine policies. Medicines reconciliation is the process of checking that a patient continues to receive the medicines they were prescribed immediately before admission unless a medicine is stopped for medical reasons. The hospice consultant told us that the pharmacist was very helpful.

Medicines and equipment that might be needed in an emergency were easily accessible and regularly checked to make sure they were ready to use. Medicines were stored securely and in a tidy and well organised way. The temperature at which medicines were kept was monitored in the right way. Staff were encouraged to report medicine errors. Incidents were analysed to identify any underlying cause so the use of medicines could be made safer. No incidents causing harm to patients had occurred this year. The hospice had carried out a detailed medicines audit (known as the medicines safety thermometer) from January to

March.

There was a clearly written medicines policy covering the different aspects of medicines management. The policy was currently being reviewed. Standard operating procedures were in place for obtaining, prescribing and handling controlled drugs and we saw evidence to show that nurses were aware of these procedures. Controlled drugs (CDs) were stored in cupboards that met legal requirements. The stock balances of the four controlled drugs we checked were correct. Nurses regularly checked stocks of controlled drugs and additional checks were carried out by the pharmacist who visited the hospice. The hospice's accountable officer carried out their role of oversight of controlled drugs use in the hospice and attended local intelligence network (LIN) meetings. (LINs are the forum where different organisations share information in order to reduce drug misuse in a locality).

We checked to see if there were sufficient numbers of staff available to meet people's needs across all the services provided by the hospice. People and relatives we spoke with in the inpatient unit told us they did not have to wait to receive assistance from staff and that call bells were always responded to in a prompt manner; this was confirmed by our observations during the inspection. One person said; "Since I have been here they have always answered my call bell very quickly. There always seems to be enough staff around". Another person said; "There really are enough staff. It would be nice as always if there were more but it always seems well staffed". A third person also added; "There seems to be an unbelievable amount of staff available. They are busy but are always around for you when you need them. If I am in pain, they are quick to respond". The staff we spoke with told us they felt staffing levels were adequate to care for people safely. Staff also told us they were able to spend time with people, which was important to them. One member of staff said; "We are usually staffed pretty well really. Staff will pick up extra hours where needed and things are well covered". Another member of staff said; "I would say there are enough. As anywhere there are busy periods, but I think we have enough and they are all of good quality". When asked about current staffing levels, another member of staff added; "Staffing levels are adequate at the minute".

Our review of staff rotas confirmed there were sufficient numbers of staff on duty to provide the care people required. The registered manager told us that any staff absences were covered by hospice staff and that agency staff were never used; this helped to ensure people received safe and consistent care. We noted there was also a team of trained volunteers who undertook a range of non-clinical roles throughout the hospice. By having enough staff working at the hospice, this meant people's needs could me met safely.

We looked at the staff personnel files for three staff and found a robust system of recruitment was in place. All the staff files were well organised and included a checklist to confirm the required checks and documentation were in place. The staff files contained proof of identity, application forms that documented a full employment history, a medical questionnaire, job description and at least two professional references. Checks had also been undertaken to ensure that all the nurses who worked at the hospice had a current registration with the Nursing and Midwifery Council (NMC). All the staff files we reviewed showed checks had been carried out with the Disclosure and Barring Service (DBS).The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. We saw that volunteers were required to complete an application form and provide the hospice with two references. DBS checks were also carried out in relation to volunteers who might have access to vulnerable adults in the course of their role within the hospice. These checks help to prevent unsuitable people from working with people who use care and support services.

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. We saw care plans had been put into place to help

reduce or eliminate the identified risks. There was a clear process in place for clinical and non-clinical incident reporting. Records we reviewed showed that all incidents were logged and discussed at clinical governance meetings. The registered manager told us the hospice maintained robust incident reporting procedures within a no blame culture. There was a system which aimed to ensure that outcomes and actions from incidents were used as a learning tool to improve or change practice if required. The manager gave us an example of how practice had been changed as a result of staff being interrupted when in the medication treatment room. As a result, only two members of staff were allowed in the room when medication administration was in progress. These systems meant accidents, incident and risks could be prevented from happening again, increasing people's safety.

We looked at the systems in place with regards to infection control. The premises were clean and well maintained reducing the risk of infection. We visited the laundry because the service did their own laundry. We saw that there were two washing machines with sluice wash to reduce the risk of infection. Contaminated laundry was put straight into red disposable bags which meant that staff were not handling it. There was a good dirty to clean flow in the laundry with a separate room for storage of clean items such as towels and all staff had access to PPE (Personal Protective Equipment). This helped protect people from the risk of the spread of infection. One person said; "I've noticed staff always use soap and wash their hands before assisting me".

There were safety signs where there was any risk to people's safety. We saw signs advising parents that children should be supervised at all times. Equipment was stored safely to prevent accidental injuries. There was an ironing press with appropriate safety features in the laundry. The service was being decorated systematically and equipment was put safely into unused rooms whilst the work was carried out.

We looked around all areas of the building. The car parking areas were well laid out with very clear signage and clearly defined parking areas for disabled visitors. During the daytime hours, up to 5pm, people were able to enter the hospice via the front door and be greeted at the reception desk by staff or volunteers. Out of hours these doors were locked and people needed to ring the front door bell to be let in by staff. CCTV was operational in the reception area and also outside the building. The provision of CCTV enabled staff on the inpatient unit to see who required admission to the building out of hours. This helped to keep people safe by ensuring the risk of entry into the building by unauthorised persons was reduced. Inpatient staff were also able to alert a security company who monitored the site out of hours should they have any concerns about intruders or breaches in security.

We looked at the documents which showed equipment and services within the hospice had been serviced and maintained in accordance with the manufacturers' instructions. These included checks in areas such as gas safety, legionella, portable appliance testing, hoisting equipment and the fire and call bell system. These checks help to ensure the safety and wellbeing of people who used the hospice, staff and visitors. Our inspection of records showed that a fire risk assessment was in place and regular in-house fire safety checks had been carried out to ensure that the fire alarm, emergency lighting and fire extinguishers were in good working order and that the fire exits were kept clear. We were told that regular table top evacuation exercises took place to help ensure staff were aware of the action to take in the event of a fire at the hospice, without distressing people who used the service.

We noted that contingency plans were in place to ensure the continuity of the service in the event of staff sickness, IT failure or the loss of utilities such as water, gas and electricity. The hospice at home team and other community based staff had security arrangements in place when lone working. This meant that in the event that staff encountered difficulties whilst out in the community, they had access to relevant support.

Good

Is the service effective?

Our findings

People who used the service and relatives consistently told us they felt staff were well trained and had the correct skills to provide effective care. One person said; "Absolutely. The staff are well trained and know what they are doing. I really can't find anything to criticise them about". Another person said; "The staff really do seem competent and I have never had any problems".

We looked at how staff were supported to develop their knowledge and skills. We looked at the induction programme that newly appointed staff had to undertake on commencement of their employment. Induction programmes help staff to understand what is expected of them and what needs to be done to ensure the safety of the staff and the people using the service. The induction training programme included topics such as: health and safety; principles of end of life care; safeguarding; communication; moving and handling; infection control; and equality and diversity. A member of staff commented; "The induction gave me the skills and knowledge to be able to do the job".

We saw staff had access to a range of training as part of their on-going development and received a range other training courses, specific to caring for people with palliative care needs. The staff we spoke with told us they received enough training to support them in their role. One member of staff said; "They provide enough training and we are offered a broad spectrum. There is always more available". Another member of staff said; "They always keep us up to date with mandatory training. There is a lot of good in-house training available and there is an education department we can access as well". Another member of staff added; "I think we get very good training in all areas. The nurses are very good at helping with anything we are unsure of as well so we all learn from each other". Due to staff receiving thorough training and robust induction meant people benefited from receiving care from staff who had the necessary skills to provide effective care.

Staff said they had access to supervision and appraisal as part of their role. Staff supervision enables managers to monitor the work of staff and offer support and guidance to help them develop in their role. One member of staff told us; "They happen on a regular basis, but we get a chance to speak with the manager and Clinical Services Manager most days". Another member of staff said; "We do get clinical supervision. It ties in with our NMC revalidation as well which is important". Another member of staff told us; "I've had a few since working here, but they are available on request as well or on the back of specific incidents".

We noted that the hospice provided training to its own staff and other professionals in areas such as bereavement support, family work and the Six Steps programme. This programme aims to guarantee that all possible support is made available to people in order to facilitate a private, comfortable, dignified and pain free death. Supporting staff to receive this training within a number of community based settings such as care homes and nursing homes helped to ensure people could receive high quality end of life care at their preferred place of care, which avoided people having unnecessary admissions to hospital.

The hospice also provided placements to a variety of healthcare professionals, with in-house mentorship and training. This included GP trainees, medical students and student nurses. We were told the placements

were always highly valued by students. We spoke with one student nurse who told us they had enjoyed their placement at the hospice so much they now worked there on a sessional basis.

We asked the registered manager to tell us what they understood about the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA 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 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 in care homes, hospices and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At the time of the inspection there was nobody subject to a DoLS order, although the manager told us 'urgent' applications would be made when needed.

The staff we spoke with had a good understanding of DoLS and MCA. One member of staff said; "I think a DoLS would be required if people are deemed to lack capacity to consent to their own decisions". Another member of staff said; "If we feel someone lacks capacity, I would request for a DoLS to be done. Where people have had a DoLS in the past we have to contact the coroner when they pass away". Another member of staff added; "I've been provided with training in this area. Capacity is in relation to people being able to make decisions themselves. If a person was struggling with this a DoLS would be required".

People at the hospice said staff always sought their consent before they received care and treatment. This meant people were given choice by staff about decisions impacting on their life. One person said; "They always ask me what I want and talk me through the process. Another person said; "I'm always asked for my impressions and contribution before any decisions are made. In the past I have discussed my medication and was able to give feedback before I started taking it". Another person added; "They will always ask you and they never just assume".

Teams providing hospice services engaged proactively with other professionals to achieve good outcomes for people. Multi-disciplinary team (MDT) meetings took place every week for in patient and community services. In addition the specialist palliative care team held handover meetings every Monday and Friday to update staff and review the care of people receiving support in the community. The social worker, physiotherapist, occupational therapist and consultant attended the meetings. The social worker was employed by St Anne's and worked part time with the community teams and the rest of the time in IPU (In patient unit). The team had specialist registrars on rotation for six months. The team visited people at home and the support they provided was based on holistic assessment, emotional support and linked in with other services such as district nurses, OTs (Occupation Therapists) and dieticians.

The hospice at home team attended gold standard framework (GSF) meetings and MDT (Multi-Disciplinary Team) meetings with one of the Clinical Commissioning Groups (CCG) they worked with. The Gold Standards Framework gives training to all those providing end of life care to ensure better lives for people. They also attended community matron meetings. They had daily tele-conferences with the district nurses in order to identify those people who required more urgent support. They also had meetings with staff in the day care unit as some of their community patients attended. This ensured that they were able to react to people's needs in a timely fashion. There was a clear referral pathway for hospice at home showing that health and social care professionals as well as families and carers could refer to the hospice at home team. When we visited one person in their home their discussions with the clinical nurse specialist demonstrated the involvement they had had in their healthcare. The clinical nurse specialist gave them facts and explanations but left them to make their own choices.

There were five social workers employed by the hospice. They liaised with local authorities and CCGs in relation to discharge, family dynamics, bereavement work and supporting children. The social workers were responsible for making alerts to the local authority when any suggestion of harm. They delivered all safeguarding training in house. The training had been ratified and signed off by CCG. The team leader was the head of safeguarding in the organisation. There was a safeguarding strategy and part of that was to keep safeguarding training up to date. Volunteers completed eLearning and there was a plan for them to do face to face training in future.

People who used the hospice were protected from the risks of poor nutrition. A nutrition assessment was completed, which outlined the person's nutritional support needs clearly. If a special diet was required kitchen staff were informed by nurses and it was clearly identified on a whiteboard used for this purpose. We saw one special diet identified and one person with an allergy and this was clear for all kitchen staff to see.

Each person had a care plan with regards to eating and drinking. These were used when patients had been identified as requiring support to improve their nutritional status, for example if they needed food to be given via a peg tube (a tube inserted into the stomach which nutritional feeds are drip fed into. This is done when people were unable to swallow for physical reasons), or those patients who simply needed to have nourishing food or supplements to help improve their diet.

The staff told us that the peg tube feeds were recorded on the Emis (the internal electronic patient record tool used by the hospice) system, however there were also paper charts kept at the bedside to support and reassure the patient and their relatives relating to the feeds and fluids taken. People approaching the end of their life, often do not feel hungry and may need to have smaller portions of food served to them on small side plates rather than on normal sized dinner plates. They may also prefer small meals often rather than three meals per day. We asked the staff what they did when this was the case and we were told people were given their food on red trays to remind staff that they needed assistance when eating and had charts that required completion such as fluid and hydration charts. We saw one care plan for a person who required thickening agent to be added to fluids to assist with swallowing. We saw this being provided for this person during the inspection which would help keep them safe by helping to prevent them choking when drinking.

All the people we spoke with gave positive feedback about the meals provided in the hospice and told us staff always went out of their way to meet their preferences. One person said; "The food is really nice. If there is something I don't like, they always make me something else". Another person said; "The food is phenomenal and is all locally sourced. I never used to like pies, but because they are so good here, I like them now". Another person added; "The food is very good. Alternatives are always available and the selection available is impressive. It's almost like a la carte. You say what you want and they will provide it for you". A fourth person also told us; "You really can't fault the food".

People's individual needs were met by the environment at the hospice. The building was light and airy, with high ceilings and lots of light. People had spacious individual en-suite room and could also be in rooms with other people if they wanted. Several people had expressed an interest to be in shared rooms with people and this had been provided for them due them becoming close whilst in the hospice. We saw that when one person wanted to have some time alone they were moved to a single room All bedrooms had patio doors which opened onto a courtyard/garden area. This area provided a safe and welcome outside space for people and families and meant people cared for in bed could access the outdoors. We saw that there was a room available on the inpatient unit where relatives could stay overnight; pull out beds were also available for use in people's individual bedrooms. The registered manager told us they had recently recognised that doorways were not wide enough to enable people to sit outside in their bed when the weather was nice if this was what they wanted. This demonstrated the hospice considered creative ways of improving people's

quality of life and promoting their well-being. The registered manager told us these building changes were in the process of being implemented.

Outstanding ☆

Is the service caring?

Our findings

All the people we spoke with during the inspection who used the service at St Ann's Hospice told us they received outstanding care. Without exception people told us staff were always extremely kind and compassionate and were dedicated to providing high quality care and support. One person said to us; "Fantastic is one of the many positive words I'd use to describe it here. It is outstanding without a doubt and I could not have asked for more in the time I have been here". Another person said; "It's absolutely outstanding and I have been amazed. It's mind boggling really. I knew they had a good reputation and being here has been really special. It sounds strange but I don't want to leave. It feels like a hotel, but with all the medical support as well. I pinch myself sometimes and ask myself if this is real". Another person also told us; "It's been absolutely unbelievable, it's so good. It's amazing the way they care for people here". One person who received hospice at home services who had previously been an inpatient told us, "I wouldn't be here without the hospice. It is like a five star hotel". When we asked a fifth person about the care at St Ann's Hospice, we were told; "It's absolutely excellent. All of the staff from top to bottom have been brilliant. I feel very well cared for here".

As part of the inspection, we also asked relatives and family members for their views of the care provided at St Ann's Hospice. Each relative we spoke also said the hospice provided an outstanding service. One relative told us; "It really is fantastic here and the staff are all so caring. I feel I can talk to them about anything. They provide an outstanding level of care. I've never been a fan of the care in hospitals, but here it has been sublime. My overall experience of the hospice and the level of care provided has been outstanding and I would recommend it to other people". Another relative told us; "From what I have seen here the care is outstanding. The staff will fall over themselves to help you, but that is just their nature". A third relative also added; "I would definitely describe the care here as outstanding. They really make an effort to get to know people and find out what is important to them. Nothing seems to be too much trouble and all the staff here have a very calm, gentle and caring manner about them. The ethos of the whole place is lovely".

Everybody we spoke with at St Ann's Hospice, including people who used the service and their relatives, praised the staff for the kind, caring and thoughtful approach they displayed. One person said to us; "The staff are friendly, approachable and will do anything for you. They treat me just like a human being and that's how it should be". Another person said; "The staff are all very unique and are wonderful carers. They all have lovely personalities and I find it very easy to relate to them and get to know them". Another person added; "Everyone here is so cheerful. All of the staff are marvellous and they all do their job with a smile on their face. They really do care".

During the inspection, we observed staff to have an extremely caring approach towards people at the hospice. For example, when observing the handover between night and day staff, one person had received some bad news about their condition, which a nurse shared with the rest of the staff team. The mood in the room instantly changed, with staff visibly upset by what they had heard and that this person did not have long left to live. The staff we spoke with told us that despite people living at the Hospice for short periods, they developed caring relationships with people and always found it difficult when people died. Our own observations of staff confirmed that staff were exceptionally caring.

Another person told us about how they had being talking to a member of staff about the comedian Peter Kay. This person told us that within a couple of hours, a member of staff had been out and bought them some Peter Kay DVDs, which we were told was a 'lovely touch'. This person told us; "They didn't have to do that for me and I was quite taken aback. I find the staff to be just like family". Two members of staff we spoke with told us they had wanted to work at the hospice because they had been so impressed by the level of care provided to their family members in previous years. One member of staff said; "Quite a few staff have lost partners here, but I know they all appreciated the level of care that was provided. All of the staff from nurses to care assistants are like angels".

People who used the service told us staff treated them with dignity, respect and gave them privacy at the times they needed it. One person said; "I'm treated exceptionally all the time. I use a urine bottle and the staff are all very discreet when I am using it and always close the curtains when delivering my care". Another person said; "One thing I have noticed here is the level of respect people are treated with and they have been so consistently good with that. My privacy is protected and that is so important to me. They always go to great length to make sure that happens". Another person told us; "I'm always treated with respect. As you can see I am in a shared room and personal or intimate care is never delivered without these curtains being closed".

The hospice had a range of strategies in place to facilitate communication. These included contracts with local interpreters and sign language services. The hospice also had access to a telephone translation line where a 'Dial in' is requested which then turns into a three way conversation (between the patient, staff member and telephone). The manager also told us about a range of translation cards which were used to communicate with Polish and Lithuanian people for example. IPad's were also available, which could feed into amplified hearing systems if people had problems with their hearing. We spoke with one person during the inspection who was using a hearing system; "This thing is brilliant. I would be completely in the dark without it and would struggle to know what was going on and be able to understand what the doctors and nurses were telling me".

The hospice had also introduced collaborative training with Central Manchester Foundation Trust, including 'Sage & Thyme' communication skills training. This was available to all grades of staff, informing them how to listen and respond to patients/clients or carers who are distressed or concerned. It places published research evidence about effective communication skills within a structure for clinical practice. One of the main benefits of this training was to guide staff into and out of a conversation with someone who is distressed or concerned. It also provided structure to psychological support by encouraging staff to hold back with advice and prompting the concerned person to consider their own solutions.

During the inspection, it became apparent that people were offered choice and control about all aspects of the care received, approaching the end of their life. People reported this was regards to food, how they spent their day and the clothes they wore. One person said; "We definitely get choice here. They help you do what you want to do and it is all centred around what I need". Another person said; "I have a choice over everything I do whilst being here. I am always asked about what I would like and I find it is all totally down to the individual. I don't have to do anything I don't want to do. I've noticed that nothing ever happens that I don't know about". Another person added; "Absolutely. What astonishes me is that there is choice about absolutely anything and from my point of view with not having long left. If you are a male and wanted to wear a pink dress, then that would be absolutely fine".

People told us staff promoted their independence all the time and allowed them to keep doing as much for themselves as possible. One person said; "They are constantly encouraging me to get up and out of bed as I haven't walked in a long while. As a result, I walked for the first time today due to staff not giving up with me

and I feel that has been a real achievement". Another person said; "Amazingly so. Each day the staff offer me the opportunity to have a walk around with my stick. It's not something they have to do, but they tell me they don't want to lose my living skills. It has really helped to keep me moving and mobile".

During the inspection we spent time on the inpatient unit. We observed staff to be very person centred in all their interactions with people. Staff were completely focussed on asking people what they wanted to do, how they were feeling, if they wanted anything and what they would like to achieve that day. In each person's room was a notice board where staff had approached people each day and asked them what they would like to achieve on that day in particular. The people we spoke with said these may have only seemed like small milestones, but for them were huge accomplishments and achievements. One person said; "I've been bedbound for a long time now and I didn't ever think I would be able to sit in this chair but as a result of the care I have received here I am able to do it each day". Another person said; "The prospect of being able to go back home is a reality now, even if it's just for a short period. I'd made it clear to staff that was what I wanted to do and with regular physio, I'm nearly ready".

All the staff we spoke with demonstrated a commitment to offer support to the whole family during a person's illness and after their death, if required. Relatives and carers were able to access the complementary therapies offered at the hospice. The hospice also employed a bereavement support officer. Additionally, there was a team of bereavement support volunteers that could be accessed by anyone linked to a person using the hospice (in the hospice or at home). There was a counselling service coordinator plus one other counsellor. They had a team of volunteer counsellors and visited people to provide both pre and post bereavement support. The first contact was made within one week of referral, with a telephone service also available. This meant people had access to advice and guidance to be able to deal with any sensitive situations, linked to their loved ones.

There was also a chaplaincy co-ordinator who had access to a team of volunteers from all denominations. The focus was on people's spirituality and what was important for them. The hospice had consulted with patients and carers to look at how to make the original chapel more accessible and had gone on to develop 'The Haven', a spiritual space. The chaplain had conducted weddings, christenings and blessings at the hospice and one person's wedding was featured on the hospice web site spearheading a 'fund raising campaign'.

There were also regular remembrance services for the families and friends of people who had died and were often attended by up to 50 people. The registered manager told us these services were very well attended by families and were supported by staff and volunteers from the hospice. We noted there was a service planned for Christmas 2016 in which people would be able to light a candle to remember their family member and would receive a card dedicated to their loved one. We were told a Light Up A Life Book of Remembrance would be available at the hospice following the event.

There was an advocacy service available for people if they needed it. The majority of advocacy afforded by the hospice was from the Social Workers. The hospice also routinely supported people to access information and advice form a range of specialist organisations/teams in relation to benefit entitlement, immigration, housing, care in the community and funding for care. During the inspection we were told of an example where a patient was supported to appeal a Personal Independence Payment (PIP) award. The Social Worker challenged the decision and the individual's application was re-assessed. The patient was subsequently awarded the higher rate of entitlement.

In another example, following the death of a relative, a son, who was in his early 20's and had lived with his father was served with an eviction notice. The son had struggled to effectively communicate with the

housing department as he had limited spoken or written English. The reason for eviction was because the tenancy had been in the father's name. The Social Worker liaised with the relevant agencies and was able to secure the tenancy for the son and support with accessing English language classes. This meant people could be involved in decisions about their lives, explore choices and options and defend and promote their rights and responsibilities with the support of the staff at the hospice.

There was also a patient and carers' group. The group meet every two months and has a current membership of five patients and seven carers who have all had experience of services provided by St Ann's. The group continued to provide an invaluable contribution to the on-going development of the services provided. The feedback from this group included updating St Ann's Resuscitation leaflet, to re-look design and content of the inpatient information leaflet and to potentially redesign the St Ann's website. We were told some of this feedback was in the process of being implemented.

Outstanding ☆

Is the service responsive?

Our findings

All the people we spoke with during the inspection told us the hospice had been extremely responsive to their needs, providing them with an excellent service. One person said; "They have developed my living skills such as getting me back walking again. Everybody thought I was going to die last week but they have really pulled me round". Another person said; "They have provided me with all the care I need and the entire care package is so good. I'm always warm and am certainly well fed". Another person added; "My condition is terminal, but I am getting everything I need here and have been made to feel very comfortable".

Professionals consistently gave us exceptional feedback about the services provided by the hospice. One professional told us; "I believe the care St Ann's deliver to be outstanding. Their role is pivotal to providing palliative and end of life care in the community". Another professional added; "I believe we have a great working relationship with our community colleagues at the hospice. They respond very well to our referrals and as both of our teams work at weekends I believe that we communicate very well with each other during this very busy time. It is particularly useful when a patient who is in the community is being admitted to hospital. They are so good at keeping us informed and it means that as a team we can meet the patient ahead of the referral. This can sometimes mean that the patient has more timely care and prevents anything unnecessary, particularly if such a patient is end of life care and their wish is to be at home". Another professional commented; "The care here is phenomenal. People are well looked after, as are their families".

People we spoke with told us staff had been exceptional in enabling them to achieve symptom and pain management control, either through pain relief medicines or other therapies. Each person told us this was as a result of the high quality care they received at the hospice. One person said; "One of the main reasons for coming here was for pain relief and due to what they have done for me, I'm now pain free. I was in agony previously". Another person said; "They have managed my pain really well. I do have a particular sore spot but they always respond very quickly. They provide very good care with regards to pain management".

People told us staff encouraged them to pursue hobbies and interests whilst living at the hospice. One person said; "I really enjoy doing the adult colouring books. The staff knew I enjoyed doing this as my dad was an artist and they had taken this into account". Another person said; "I really enjoy doing crosswords, going on the internet and reading. The staff don't just leave you be here, they want you to do things you did previously". A third member of staff added; "They certainly don't push you but through speaking with me, they know I was very active previously, so they always encourage me to keep moving".

The staff we spoke with told us about how they provided care that was person centred, based on what people wanted and in line with people's wishes. One member of staff said; "We ask people all of the time what they would like to do that day. The admission process is always very geared towards finding this information out. We try and accommodate people wherever possible". Another member of staff said; "The admission process focusses on this very much so we can see what people want. If people don't want to wake up until 11am and just sleep then that is fine by me". Another member of staff added; "I find it useful speaking to families to establish their likes, dislikes and preferences. I always ask people what they want and make sure they have choice as well".

Whilst speaking with staff and people who used the service were told about a number of occasions staff at the hospice had gone above and beyond and also 'Gone the extra mile' for people. People said staff at the hospice were outstanding when delivering care that was person centred. This had enabled people to fulfil their ambitions towards the end of their life. We were informed of when a hen party had been hosted by staff at the hospice. This person's daughter was getting married and they had been unable to attend due to their illness. Staff from the hospice had brought a rail of clothing in for this person to choose from so they could dress themselves up and feel part of the occasion. Another person's granddaughter was due to get married at the week end following our inspection which we were told this person was looking forward to very much, due to being able to watch it over the internet via Skype. This person's relative said to us; "The hospice staff have definitely gone above and beyond with this one. The bed is going to be brought into the main lounge so it will be more comfortable and all the staff are going the extra mile. It will make all the difference to mum as she was extremely disappointed at the thought of missing out on it due to coming here".

Another person previously had a passion for horse riding and wanted to say farewell to their own personal horse. The staff at the hospice had arranged for the horse to visit the hospice and place its head through the window onto the persons pillow, giving them great comfort and enjoyment. Another person was particularly interested in tattoos and had expressed a wish to have one final tattoo, detailing their grandson's name. Staff had supported this person to attend the tattoo parlour and fulfil the request made by this person. A recent patient at the hospice was from the Ukraine and spoke very little English. Through the use of interpreters, it had been determined this person liked animals and dogs in particular, stating they found it helped keep them calm. The staff at the hospice had immediately arranged for a dog to be brought into the hospice, which slept on this person's bed and gave them a great deal of enjoyment and happiness.

During the inspection, we were told of many other occasions where staff had gone the extra mile to respond to requests from people who used the service included arranging for an Elvis Presley impersonator to visit the hospice, as one of this persons last requests had been to hear their music. Another person at the hospice was from Lithuania and staff had gone to Manchester city centre to a shop specialising in Lithuanian produce to source food this person liked following a request in their latter days of life. Another person had requested to have a strawberry milkshake before they died and staff had gone straight to the McDonalds drive through to purchase this. People had also been able to renew their wedding vows if this was something they wanted to do before they died. These examples demonstrated willingness of staff to meet people's individual requests wherever possible, providing high quality care to people at the end of their life.

Two people, who were patients at the hospice during the inspection, told us they had wanted to experience a night out in Manchester and had gone out the weekend prior to our inspection. One of the people told us they wanted to get very drunk and have a nice Chinese meal, thinking it could be one of the last weekends they would be alive. In advance, staff had ensured these people had any necessary medication with them, as well as any emergency contact information. One of these people told us; "We were able to go out with some of our friends and family which was nice. I got drunk and just acted like everybody else. It was brilliant and what a great feeling it was. It really was an amazing night. I don't want to be defined by cancer, I just want to be able to have a good time. If I get the chance I would love to do it again. I can't think of any other place that would promote that kind of thing but they do here, but are safety conscious as well".

The registered manager told us the staff team worked hard to promote the hospice as being a service that catered for people not just at the end of their life. The registered manager told us they had recognised that people were often unaware of the range of services the hospice provided and were often of the opinion that it was used only by people at the end stages of their illness. In order to ensure people had accurate information the hospice had recently produced a short video, which they hoped would encourage people to contact the hospice to find out more about the support available.

The hospice had been extremely proactive in reaching out to 'Hard to reach' groups such as Black Minority, Asian and Ethnic (BAME) groups and people living in homeless shelters or those that had drug and alcohol problems. The hospice offered a placement for trained staff to understand more about the specific complex needs of homeless people. A member of staff had visited Manchester's gay community in their own time to speak with people, share information and provide them with information about how they could best access their services if required.

The practice development manager chaired a meeting with a local transgender group in the area on a Saturday evening. We were told some of the concerns and anxieties people had, included end of life medication, hormone replacement, body image, family complexities and documentation. In response the registered manager had provided people with advice and guidance in these areas. The group expressed an interest to look round the hospice and were interested in volunteering opportunities on offer. This enabled the hospice to build links with other services, with the lead for the project also offering to provide training on transgender people at the end of their life and also transgender people living with Dementia.

Innovative methods, including the use of social media and video messaging, had also been used to inform the local population about the services provided at the hospice in an effort to dispel myths and encourage people to access the support available to them. The hospice had Twitter, Facebook, Instagram and YouTube accounts with followers from other local charities and organisations that work with people from homeless, LGBT (Lesbian, Gay, Bi-sexual and Transgender), and different religious communities. The hospice aimed to share relevant posts that they produced and would 'tag' these groups into any appropriate news stories promoted on social media. This ensured a wider audience could hear more about St Ann's and the breadth of services on offer.

The staff we spoke with had a good understanding of equality, diversity and human rights. During the inspection we were shown a letter from a family member of a patient who was Jewish. The letter thanked all the staff at the hospice for being so considerate and respectful about their religious needs and that staff went out of their way to accommodate the family during their time with the hospice. One member of staff said; "We have had people from Muslim origins in the past who don't speak the language so we have immediately requested an interpreter. We have also ordered in special kosher meals to ensure Jewish people can be catered for. We've gone out to a local Polish shop as well to cater for different peoples requests".

The hospice used a variety of different methods to seek, listen and take action based on feedback received. One of these was known as the 'Comments scheme'. This enabled visitors, patients, volunteers and staff to make suggestions for improvement they had about the services. The Lead for Quality and Audit was responsible for managing the scheme and sending any comments received to the appropriate manager for consideration and ensuring a response. The responses were collated and approved at an organisational meeting, posted on the hospice intranet and monthly summaries of the comments are distributed across the whole organisation every month. A total of 139 comments or suggestions were posted in 2015/2016 and suggestions made included the reintroduction of patient laundry bags and an extension of the Wi-Fi access, both of which had been acted upon.

The hospice had developed creative ways to seek feedback from people who did not necessarily work in a hospice or caring environment. This initiative was known as the Patient-Led Assessments of the Care Environment (PLACE). The purpose of PLACE was to provide a snapshot of how an organisation was performing against a range of non-clinical activities which impacted on the patient experience of care. The non-clinical activities of concern were cleanliness, food/hydration, the premises, privacy, dignity and respect. The criteria included in PLACE were not standards, but represented aspects of care which patients

and the public had identified as important. It also represented good practice as identified by professional organisations whose members were responsible for the delivery of these services.

In response to the findings from the PLACE, staff had taken action to address these issues in a timely manner. For example, additional disabled parking spaces to the car park, toilet seats had been upgraded to ensure they had more contrasting colours to promote continence in people living with dementia and various dirt and debris was cleared from gutters and garden areas by volunteers. This showed staff were committed to listening and responding to feedback from different walks of life in order to continually improve the quality of service provided to people.

The hospice had a positive approach to using complaints and concerns to improve the quality of the service. The service had a policy and procedure for managing complaints which outlined the arrangements for investigating and responding to complaints. Information about the complaints procedure was on display throughout the hospice. The registered manager told us any complaints received were dealt with quickly and people received a written response.

We noted that any concerns had been taken seriously, investigated, action taken and lessons learned. We saw that outcomes from complaints were linked to change of practice when necessary. A regular report was produced for the Board of Trustees detailing any complaints received; this enabled the Trustees to ensure lessons were learned from complaints in order to improve people's experience at the hospice. We also saw a summary of the lessons learned and actions taken from risks and complaints which helped the service learn. For example, the hospice used 'Reflective sessions', where any complaints from people who used the service or relatives were disseminated to staff, enabling them to learn from any mistakes. This demonstrated the commitment of the hospice to service improvement.

People could access services provided by the hospice at home team if they wished to remain at home. On the day of our inspection the district nurses had referred a person to hospice at home who had a rapid discharge from hospital. A member of staff went out immediately after the call to assess this person and their wife's needs. The hospice at home team provided a sitting service to support carers and pop in visits at least once a week to check people's wellbeing and build up relationships and telephone calls as often as the person wished. The hospice at home team leader told us that people often chose this option as they wished to retain links with the hospice but did not want any more people visiting them. As part of the home visits the hospice at home team sometimes assisted people with their personal care needs but most people had separate carers to carry out this role, not linked with the hospice.

Outstanding ☆

Is the service well-led?

Our findings

There was a registered manager in place at the time of the inspection which is a requirement of the provider's registration with CQC. The registered manager had legal responsibility for the day to day running of the hospice. 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.

The purpose of St Ann's Hospice was to, "To provide excellent care and support to people living with or affected by life limiting illnesses." In order to do so the service had embedded the values of compassion, professionalism, respectfulness and inclusiveness in every area of the service. They had clear strategic objectives which included putting patients and their carers first. The hospice used the "Ambitions for Palliative and End of Life care: A framework for Action to inform their future strategic plans. This framework was aimed at local health and social care and community leaders. It built on the Department of Health's 2008 Strategy for End of Life Care and responded to an increased emphasis on local decision making in the delivery of palliative and end of life care services since the introduction of the Health and Social Care Act. The chief executive officer spoke to us about their proposed plans to work with other hospices in the area in order to engage with commissioners more effectively. They were clearly passionate about their role at St Ann's.

Staff and volunteers spoke positively and passionately about working at the hospice, telling us they enjoyed their jobs and that there was a positive culture amongst staff that was person centred, open, inclusive and empowering. One member of staff said; "I like working here. I came here as a student and I haven't looked back since. There is a good culture and it is a supportive environment". Another member of staff said; "It's great here. The support and training opportunities and the amount of quality time we get to spend with people make it a good place to work". Another member of staff added; "I've really enjoyed my time here and you are given the time to care for people. It's a nice laidback atmosphere. I've worked here for a year now and hope to have many more". A fourth member of staff also added; "It's a nice place to work. We make a difference to people's lives and there is a lot of job satisfaction".

The staff we spoke with told us they felt the management, leadership and support systems in place were outstanding. One member of staff said; "I find them [Managers] extremely supportive and they always try to accommodate as best as possible. They are down to earth, approachable and I would say it's outstanding". Another member of staff said; "Leadership here is definitely outstanding. The support is good and it is a really well organised place. There are a lot of experienced nurses and doctors available to give advice". We get good guidance from them and they are very good role models". Another member of staff added; "Management certainly is very, very good here. We get clear tasks for the day and everybody knows what they are doing".

People who used the service and their relatives also spoke of the outstanding leadership and management at St Ann's Hospice. One person said; "All of the managers seem to be very good. They make an effort to

come in and see me each day and see how I am". Another person said; "The management here is sensational and it seems to filter down to all the other staff. The managers and all the staff in fact are passionate and professional". A third person commented; "The excellent standard of care and treatment we are receiving must come down from the top". A relative also said to us; "I've found management to be fantastic. They come in quite often and check I am ok and not too upset".

The registered manager was visible throughout the inspection. One member of staff said; "The [Registered] manager's door is always open. She prioritises us. There was an incident where all the phones went down and had to be redirected to the manager's phone. I had a problem and she still made time to see me despite having to answer all the phones". It was clear that staff and volunteers worked closely together and had shared values with the hospice. People who used the service described them as caring and staff told us they enjoyed working at the service.

The hospice had clear links with the community, one of which had been with the Myriad Foundation. The Myriad Foundation were a local Islamic charity and provided volunteers whose main role was to spend time with patients of all faiths or no faith, providing emotional and moral support through simple gestures like having a chat, going for a walk in the gardens, playing games or simply sitting and keeping them company. The programme is called 'My Hospice Buddy', but as St Ann's cared for patients with any life-limiting illness, the service was not restricted to only those with cancer. The service was originally set up in partnership with Macmillan Cancer Support, who also train the volunteers. The project aimed to bring greater social inclusion and provide companionship to people at difficult times in their lives. Another aim of this project was to break down barriers and open up pathways for more Muslim people to access the services provided by St Ann's. Often in the Muslim community, a person who was ill was only cared for by their family and there could be a lack of knowledge about what hospices can do for people. This initiative helped to raise awareness and ensure that people were getting the care they required.

In addition we met a member of the pat dog scheme and their dog at the hospice. They visited patients regularly. For dog lovers this was a source of support and we saw that people responded positively to their visit. The provider had a total of fourteen charity shops within the communities that surrounded their locations. One such shop was in Little Hulton serving the local community. There were many fundraising events. The next planned event was a Halloween dog walk.

The hospice had also developed links with other countries in Europe. The registered manager told us about a recent conference they had attended with the medical director in Lithuania. The purpose of this had been to educate other countries about palliative care. Staff from the hospice in Lithuania had also visited St Ann's earlier in the year on a 'Fact finding mission', to learn more about the services on offer and also visit other services in the area such as Salford Royal. This presented both learning and networking opportunities about how palliative care could be improved in both countries, to the benefit of people using their services.

During the inspection, we were told about the 'Exchange programme', implemented by hospice staff. This was a creative and innovative method of management used to develop the knowledge and expertise of their staff. The exchange programme worked in partnership with the Central Manchester Foundation Trust, offering nurses a five day placement on haematology, gastroenterology, respiratory or cardiac wards. Nurses from Central Manchester Foundation Trust had also been invited to take up a placement at St Ann's which enabled both sets of staff to learn new skills and experience what is what like to work in the different care settings and what peoples illnesses consisted of. We spoke with a nurse who had participated in the programme. We were told; "It has been a huge benefit to me and my personal development. I've really enjoyed it and it is really good to see the journeys people have been on and the care they receive. It has really helped with referrals and I've learnt things I had never encountered here which can only be a good

thing".

St Ann's continued to further develop the skills and knowledge of staff, whilst at the same time involving patients, by participating in the PEP (Personal Excellence Pathway) scheme for medical students. The PEP allowed medical students to focus on particular topics during their medical degree, creating a personalised learning experience.Their involvement includes audit activity and production of documents such as gaining the views of patients. One of two projects included the production of a patient information leaflet titled 'Are you taking a lot of medicines' which included the views of patients in its design. This was part of a larger polypharmacy quality improvement project. The leaflet was accepted for poster presentation at a Palliative Care Congress in Glasgow in March 2016.

The second project included the views of patients and healthcare staff regarding weighing patients in a hospice setting. This project also included an audit of the practice of weighing patients, highlighting whether patients who are prescribed weight dependant medicines are weighed and their dose altered if necessary. Findings reinforced the introduction of routine weighing of patients with the option of recording the clinical reason for not doing so. This project meant people benefited from having accurate weight records when being prescribed new end of life medication.

Over the last 12 months a comprehensive leadership and management development programme for all directors, managers and team leaders had been provided called 'Inspire'. The purpose of the programme was to ensure St Ann's leaders were leading and managing staff consistently and effectively. The programme ran over a 12 month period and included group and individual elements. The programme had a strong emphasis on development planning aimed at improving performance and leadership capability. The courses was broken down into six modules consisting of and introduction to leadership and management development ,managing people, managing self, interacting with others, strategic and financial awareness and reflection/ evaluation. The modules themselves were supported a masterclass in recruitment and selection, individual performance reviews, managing poor performance and incident reporting.

The hospice had won several awards and were accredited with several different programmes, one of which was the Queens Award for Volunteers. The Queen's Award for Voluntary Service is the highest award given to local volunteer groups across the UK to recognise outstanding work done in their own communities. Each group is assessed on the benefit it brings to the local community and its standing within that community. The hospice had also been awarded a Level 2 (Highest award) Certificate in the Palliative Care program. The aim of this course is to introduce care staff to the end of life care principle, which will enable them to understand the delivery of palliative care to assist a person to live well until the end of their life.

The hospice had been creative and innovative in submitting two abstracts to Hospice UK in order to support the ongoing research of palliative care. One of these was called ITASC (Improving Timely Access to Specialist Palliative Care), with the authors including the registered manager and medical director. The rationale behind the project was due to data indicating an increasing demand on specialist palliative care beds. There was also evidence of the impact delayed discharges caused on achieving timely access to the inpatient unit, with staff feeling there was a need to educate society about the changing role of specialist palliative care. The aim of the project was to enable more people who are triaged as appropriate for admission by the Multi-Disciplinary Team, to be admitted to the hospice and receive timely specialist in-patient palliative care. The aim was to increase the number of appropriate admissions from 70% to 75%.

The hospice was skilled in communicating with staff, people who used the service, their families and other professionals. The patient and family support team leader told us that they were looking at improving accessibility by conforming with NHS guidance. From 31 July 2016, all organisations that provide NHS care

or adult social care are legally required to follow the Accessible Information Standard. The team were looking at the use of language to make their written communications more accessible. There was a sensory action plan in place and this looked at how to improve communication. In addition they were developing a more effective communication care plan to make staff aware of where there was a need for additional support. One social worker was trained in British Sign Language (BSL) level 3 and where necessary translators could be accessed.

The service was also introducing Schwartz rounds to start in early 2017. Schwartz Rounds provide a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare. The patient and family support team leader told us that there was clear evidence that supported staff provide improved care and support and so this was seen as an investment in the staff by the hospice.

St Ann's Little Hulton presented quarterly reports to the nine clinical commissioning groups they worked with. These looked at overall improvements in healthcare and resulted in better patient experience and outcomes. There was a quality and audit lead for the service and audits had been completed across the service. A prescribing audit had been completed and the report from this audit had been accepted to be presented at the Association of Palliative Medicine in Norway. This identified where there had been departures from the prescribing policy before a clinical incident occurred. It is now used as an educational tool for new doctors. They complete an audit when they start and then repeat within months in order to show them where they need to improve when prescribing. All training doctors have a chance to participate in audits when on rotation at the hospice as part of their training. There were quarterly audit meetings and these were monitored through clinical governance meetings.

Haelo, a hosted body of Salford Royal NHS Foundation Trust ran training courses for quality improvement in healthcare. They had developed a reputation nationally and internationally in the fields of innovation and improvement science. Following a project looking at polypharmacy [the use of four or more medications by a patient] the hospice was invited to Improving Timely Access to specialist palliative care (ITAC We were told five members of staff were trained in quality improvement methodology. The medical director told us; "The science behind quality improvement is the way forward". The hospice had a report accepted for presentation at Hospice UK. The report was completed using the skills developed following this training to help identify trends. The hospice also engaged with and had representation with a number of organisations. They were represented on groups such as North West Palliative care physicians for CPD and networking, had a portfolio champion on the North West education board, was represented at Hospice UK, Association of palliative medicine, universities of Salford and Manchester, the North West audit group and the Myriad foundation.

We saw evidence of regular clinical audits, for example of medicines management, safeguarding concerns raised as well as the health and safety of the care environment. These resulted in action plans to improve where appropriate. Reports from these audits were submitted to the relevant governance committee for review. There were also regular 'Leadership walkarounds'. These were done monthly by senior managers at the hospice and provided them with re-assurance that the service was safe and that the hospice was operating at high standards.

The staff we spoke with told us that team meetings were regular and were encouraged to share their views and opinions about their work. One member of staff said; "They are regular and they make every effort to accommodate both day and night staff. We feel listened to and things always get sorted out and nobody is ever made to feel intimidated". Another member of staff said; "They are every few months or so and the minutes are always fed back to people who can't attend. I feel we can be pretty open with management

about concerns and their door is always open". A third member of staff also added; "The agenda for the meetings usually goes up on the wall and we always feel listened to. There is a good system in place as well where points can be raised for people who can't attend".