



Reg Charity No. 289154



Our Hospice

Quality Account



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Introduction



St Elizabeth Hospice is an independent charity and hospice, which improves life for people in the East Suffolk and Great Yarmouth areas living with a progressive or life-limiting illness.

Established in 1989, the hospice has a reputation for delivering high-level care to patients and the community it services. Through medicine and therapy, they ease pain; give life purpose and make life liveable. Last year, the charity supported over 4, 000 patients and their families.

The hospice's work is centred on the individuals needs and they provide specialist support wherever it is needed; whether that is in the home, another setting in the community, in hospital or in the hospice itself. Support is provided to patients and their families via the Ipswich Inpatient Unit, at Beccles Hospital, the Community Care Unit including outpatient's clinics, home visits from the community nursing, medical or therapy team, the OneCall 24/7 telephone helpline and bereavement support.

In 2023, St Elizabeth Hospice merged with East Coast Hospice to form a collaborative approach to developing achievable and sustainable palliative care services for people living in the Great Yarmouth and Waveney area.

Our CQC rating is

Outstanding ★

Last visit October 2021

Part I: Statement on quality

Update from 'our strategy'

As an independent charity, we are the largest provider of specialist palliative and end-of-life care in Ipswich and East Suffolk, and Great Yarmouth and Waveney.

Our Vision, Mission and Strategic Objectives are as follows:



Statement from the Chief Executive, Judi Newman



It is a privilege to lead St Elizabeth Hospice and bear witness to the commitment and professional dedication of my colleagues in providing outstanding holistic care to patients and their families every day.

In our annual Quality Account, we welcome the opportunity to provide evidence that our assurance processes are robust, safe and that we continue to strive to learn and adopt best practice. We encourage a culture of continuous quality improvement and, in that spirit, this year has seen a thorough review of our clinical governance structure, processes and policies. We thank St Helena Hospice for their collaborative support during this review.

We work in partnership with the two Integrated Care Systems (ICS) that serve our geography: Suffolk and North East Essex (SNEE) ICS and Norfolk and Waveney ICS. In Great Yarmouth and Waveney, we continue to enjoy our partnership with East Coast Community Healthcare (ECCH), who hold the community services contract.

We take our integrated collaboration role seriously and contribute fully to system leadership: in SNEE, we currently chair the SNEE ICS Joint Advisory Group (JAG) and in Norfolk & Waveney, we are members of the Palliative and End of Life Clinical Programme Board. We have led system work on ICS End of Life workforce resilience in SNEE and often represent SNEE at regional and national meetings for palliative and end of life care. Colleagues have engaged with a range of system review programmes, from community services reviews, dementia and inclusion improvements.

At a place level, we are a member of the Ipswich & East Suffolk Alliance Committee and the Great Yarmouth and Waveney Place Board. We work closely with our neighbouring hospices, looking for opportunities to collaborate, share costs and best practice wherever possible, and learn together. We have a Hospice Education collaboration between St Elizabeth Hospice and St Helena Hospice, which we are delighted to confirm that St Nicholas Hospice Care has now also joined.

Each October, our Board has a Strategy away day and actively reviews our Governance Framework to ensure it is still fit for purpose. We review our governance structure and discuss what additional working parties we may need in the year ahead. This provides the oversight and compliance required by our Trustees and our regulatory commitments. This oversight includes our risk registers and Business Assurance Framework, which are overseen by the Governance and Oversight Committee.

Our Statement of Purpose outlines the main shape of our purpose:

St Elizabeth Hospice aims to improve life for people living with a progressive illness by:

- Providing multi-disciplinary holistic, specialist and dedicated palliative care services to patients, their families and carers.
- Working alongside other statutory and voluntary agencies to provide specialist and dedicated palliative care, in a timely manner, where the patient wishes to be.
- Acting as a resource to the local community regarding general and specialist palliative care to increase confidence and competence in improving life for people living with a progressive illness.
- Providing care that respects the choices made by patients and their families so that patients are treated in their preferred place and die in their place of choice where possible.
- Working towards equitable provision of all services, leading to increased use of services by people with non-malignant progressive disease, and those from seldom-heard communities.

Since last year, we have seen the fruits of our investment in business intelligence and we now have greater visibility of our activities and outcomes. This helps with sustainable decision making and ensuring we are operating as efficiently as possible with the best outcomes for patients. Our 18-bed inpatient unit in Ipswich has continued to see high levels of occupancy throughout the past year and we have been able to introduce a refurbishment to some of the shared areas, improving quality and infection prevention. The Community team of Clinical Nurse Specialists has also continued to experience high levels of demand and the Palliative Care Co-ordination Hub has continued to see high levels of calls with over 31,000 incoming calls a year into the OneCall 24/7 telephone advice line from patients, families and other health care professionals seeking specialist advice, guidance or referrals. The virtual ward model is helping to avoid hospital admissions and provide an additional pathway for hospital discharges by delivering domiciliary care in the last 12 weeks of life, with daily visits to patients as needed from healthcare assistants and clinical oversight when necessary.

In Ipswich and East Suffolk Alliance, we are working closely with Integrated Neighbourhood Teams to explore areas of opportunity for closer collaboration where it is in the best interests of patients.

Our partnership with East Coast Community Healthcare (ECCH) has continued to deliver high quality specialist palliative care to the community of Great Yarmouth and Waveney, with six SPC beds in Beccles Hospital, the community team, in-reach into the James Paget University Hospital and the provision of Community Care Unit day services including bereavement support. The Community Care Unit within the Louise Hamilton Centre at the James Paget University Hospital has proved very popular and we have renewed our contract to continue to deliver services from the Centre twice a week.

Our plans to build a second hospice in Gorleston have progressed well, with fully drawn up architects' plans and costings ready for a Section 73 planning variation application. The plans have been developed in partnership with clinical colleagues and stakeholders, and we are grateful for everyone's commitment to making the most of this transformation opportunity to improve equitable access to care for the local population of Great Yarmouth and Waveney.

The Zest transition programme for young adult care continues to be an invaluable service for the young adults and their families who deeply value the nurse-led short break respite care and the weekly social Zest Days. The Zest programme has worked with Norfolk-based hospices and partners to test the need for similar services in Norfolk, with opportunities for local families to meet the team.

Our new three year strategy was launched, with the three strategic objectives of championing the delivery of palliative and end of life care, health equity for all and equipping others professionally and in the community to grow their confidence and skills in supporting end of life care. This final objective includes both the education of healthcare professionals and also the upskilling of the community to equip ourselves as relatives, friends, colleagues and neighbours to better support one another through the experiences of dying and loss. This public health approach to death and dying – known as Compassionate Communities – has enabled us to learn more about death in other cultures, what matters most to communities and forged new relationships through community outreach work, generously funded by the National Lottery. This is invaluable and important work for us as a hospice.

We would not be able to deliver the service we do without our staff, volunteers, donors, stakeholder partners and, of course, our patients and their families. On behalf of our Board of Trustees and Senior Leadership Team, our sincere thanks are extended to all those who are part of the St Elizabeth family and we will continue to champion and deliver outstanding care to the community we serve.

Judi Newman
CEO

Statement from the Board of Trustees

As Chair of the Board of Trustees for St Elizabeth Hospice, I am always mindful of our responsibilities to the Care Quality Commission, the Charity Commission, Companies House and all statutory requirements that are essential considerations for the Board of a charitable hospice. However, we are also mindful of our responsibilities to our local community, the stewardship of public and donated funds and our duty of care to our staff and volunteers as well as all those experiencing our services. Our Governance Framework enables us to hold those parallel responsibilities with transparency and confidence that our care and support services are being delivered to the highest standards.

We maintain a skills matrix of the experiences and professional skill sets of our Trustees so that we can review any gaps that we need to prioritise when recruiting future Trustees. We have recently been through a public recruitment for new Board members, with interviews by the Nominations Committee, and have made some successful appointments to augment the skills of the Board. I am grateful to the Board of Trustees who offer their time and experience freely and generously.

The Board is organised into specific sub-committees which meet regularly with the Executive team and senior colleagues to review current services, future development and the relevant risk register. These meetings are then formally reported to the Board. In addition, the Board approves the formation of working parties as required if there are specific areas the Board feels require additional time and focus. Given the major projects currently underway, the main working group this year has been the Property Working Group who have overseen the commissioning of architects and cost consultants for the Gorleston and Foxhall Road extension projects. We are grateful to the volunteers with specific professional skills who have donated their time and expertise to assist us on this Group.

The Governance and Oversight sub-committee, which also reports directly to the Board, monitors the overall compliance of current practices with written and reviewed policies and procedures. It has overall responsibility for risk management including a formal board assurance framework. The Chairs of all sub-committees attend this governance sub-committee. This year, as best practice, we have commissioned an external governance review which is due to report back to the Board in July 2025. We have also commissioned an internal audit to undertake some periodical review of processes. The Finance and Investment Committee have reviewed our investment strategy, and the wider Board has been exposed to the investment strategies and training to meet their fiduciary responsibilities.

Each October, the Board and Senior Leadership Team meet to discuss ongoing strategy, business planning, governance framework and the subjects requiring separate working party involvement. It is an opportunity to have a deeper discussion into the significant projects underway. In October 2024, we were pleased to welcome Toby Porter, Chief Executive of Hospice UK, to our Strategy Away Day and we discussed the upcoming Terminally Ill Adults (End of Life) private members bill as well as the Gorleston community hospice plans. The Senior Management Team joined the Strategy Away Day for a working lunch. We remain committed to the development of our SMT, as evidenced by the promotion and recruitment to Associate Director roles. As our services grow, we see these AD roles as necessary to effectively manage our Board's desired expansion towards Hospices in both Ipswich and Gorleston along with expanding vital community services.

The Board would like to note that our research work has extended, as both leaders and participants in clinical research, PhD studies and service evaluations. Dr Joe Sawyer, a specialist palliative care consultant in our medical team, is now a Senior Visiting Research Fellow at the University of Suffolk and has initiated a multi-disciplinary Journal Club for staff and volunteers to develop analytical skills in literature reviews. We welcome this development to our long-standing commitment to Education.

The Board can attest that St Elizabeth Hospice continues to demonstrate its values in the way it conducts itself, from recruitment of staff through to the experience of care delivered and our approach to responsible, sustainable fundraising and retail. We take our values seriously and see them enacted in both our care and our support services. With significant changes with NHS reform and a new 10 Year Plan on the horizon, we will remain true to our values that are central to our work:

OUR VALUES



stelizabethhospice.org.uk

On behalf of the Board, I would like to take this opportunity to thank the Senior Leadership Team, all the staff and the 1,700 volunteers without whom we could not deliver the care services available today. Many thanks to our stakeholders and supporters who continue to support and encourage us. We remain committed to the ethos of ongoing quality improvement, recognising our value that “Every Moment Matters” and we are the responsible stewards of the trust that our community places in us. The Board fully endorses and approves this Quality Account.

Ian Turner
Chair of the Board of Trustees

This Quality Account
was endorsed by the
St Elizabeth Hospice
Board of Trustees on
29th May 2025

...You are all so special in the way that you care for the people who enter your hospice. Each journey is individual and A said two things on that first Saturday – he wanted to feel safe and he wanted to be free of pain. You all made that happen.

...My mum was given the greatest care, respect and love in the safest haven at St Elizabeth Hospice. There will never be enough words to express our deepest gratitude to you and your beyond remarkable team – oh my goodness you are all in a league of your own ... the magic sprinkled every second of every day is beyond tangible. Mum passed so peacefully with such dignity and grace. ... I remain indebted to you all.

Part 2 - Priorities for improvement

2.1 Priorities for improvement 2025-2026

Areas for improvement for 2025-26 are set out below.

They have been selected because of the impact they will have on patient safety, clinical effectiveness and patient experience.

- Patient Safety
 - Joint working with St Nicholas Hospice
- Clinical Effectiveness
 - End of Life Care plans Minsmere Ward
- Patient Experience
 - Carers Assessment
 - Spiritual Care

Patient safety

Topic – To implement joint quality improvement work with St Nicholas Hospice

How the priority was decided:

Over the past year the two Suffolk Hospices have been discussing their areas of strength and weakness as well as their collective challenges. With the current financial sustainability challenges facing hospices there is a need to work as efficiently and as effectively as possible, making the best use of our precious staff resource. As a result, the Directors of Care brought together key leads from across their respective organisations to discuss how we could more effectively work together to address areas where further quality improvement work was needed. Following the teams carrying out a joint SWOT analysis the following areas were identified:

- Safeguarding, including policy review and work to assure the application of DoLS in the Hospice setting is robust
- Pressure area care and the need to embed the Purpose T tool
- Opportunity for joint audits / peer review across a range of Hospice activities
- Mouthcare and the need for an end-of-life appropriate assessment tool

How the priority will be achieved:

Individual leads from both Hospices for each area have been identified and will liaise with each other outside of the quarterly joint meetings with the following outputs:

- An updated adult safeguarding policy and Mental Capacity and DoLS policy
- An action plan to introduce the Purpose T assessment tool, including templates and care plans for the clinical records system (Systmone)
- At least two jointly agreed audits, with results shared and areas for improvement identified
- Research of a mouthcare assessment tool and update to local policy

A joint Teams channel has been created to support this work

How progress will be monitored and reported:

A joint group has been established which will meet quarterly to report on progress.

Each organisation will provide quarterly updates to their respective organisations via their existing governance processes.

Clinical effectiveness**Topic – To develop and implement an Individualised plan of care for the last days of life in the St Elizabeth Hospice beds on Minsmere Ward****How the priority was decided:**

The 'One Chance to Get it Right' report in 2014, produced by the Leadership Alliance for Care of the Dying after the UK independent review of the Liverpool Care Pathway, recommended the use of an individualised plan of care. This is a personalised care plan for a dying person, designed to ensure they receive the best possible care in their final days, focusing on key priorities like pain management, comfort, communication and respecting their wishes. Healthcare settings providing care to people at the end of life should have such a care plan in place, as the Ipswich IPU has had for several years. East Coast Community Healthcare (ECCH) work in partnership with St Elizabeth Hospice (SEH) to deliver care in Minsmere ward. Members of the ECCH nursing team have previously been tasked with developing the care plan but for a number of reasons, no plan has been forthcoming. SEH medical team in Great Yarmouth & Waveney have agreed to take leadership of this as a clinical priority. The urgency of this has been highlighted recently through a clinical incident which led to patient harm. The risk of this particular incident happening again will be significantly reduced by the introduction of an individualised care plan.

How the priority will be achieved:

- Formation of Task and finish group with SEH and ECCH representation that will:
- Develop a plan for Minsmere ward
- Explore whether plan will be paper or digitalised for Systmone
- Implement the plan with clinical staff including training and integration into business as usual
- Review completion rates and quality through audit and other feedback as decided by group

How progress will be monitored and reported:

- Regular reports from Task and Finish Group
- Updates to Quality Assurance & Improvement Group
- Data collection on completion quantity and quality
- Triangulation with incidents, compliments and complaints.

Patient experience**Topic – To introduce and implement the Carer Assessment Tool****How the priority was decided:**

Carer assessment and / or support is part of the CQC Quality Statement 'we maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them'. Carers play a crucial role in supporting patients, which often may affect their own health. It is important that we acknowledge, assess and address their support needs. At present this may be done on an ad hoc basis and is not standardised throughout the hospice. CSNAT or The Carer Support Needs Assessment Tool Intervention, is an assessment tool designed specifically to enable carers to identify, express and prioritise areas where they feel they need more support. This evidence based tool has been developed for use with carers (family or friend) who are supporting someone with a palliative illness and uses a person centred

approach. The aim is to implement use of the CSNAT tool throughout the hospice both in Ipswich and Great Yarmouth and Waveney

How the priority will be achieved:

- Identify core group of 'champions' throughout the organisations clinical teams who will meet and undertake first stage of CSNAT on line training
- Apply for CSNAT licence to use the assessment tool within the hospice
- Develop leaflet for carers to use outlining the assessment tool
- Ensure system one form in place to record CSNAT tool
- Consider where recording of tool is on system eg patient or carer notes
- Gather information re carers support services available for signposting – have this available throughout the hospice
- Develop policy for carer assessment
- Conduct pilot study of champions using CSNAT over 2 months
- Review pilot and lessons learned
- Develop training plan to roll out training more widely among hospice clinical staff
- Review implementation and take up of carer assessment at regular intervals including audit every 6 months

How progress will be monitored and reported:

- Initial discussion at Care Services Group with regular updates and review
- Trial pilot scheme with review and report
- Regular audits of CSNAT twice yearly with report to patient Services group
- Regular review of policy / procedure as needed

Patient experience

Topic – Increasing awareness of the holistic principles of spiritual care support across all areas of the hospice.

How was the priority decided?

In recognition that patients and carers were not getting equitable access to a spiritual care offer, and in recognition that an organisational response to spiritual care need extended beyond a few spiritual care 'posts', the Emotional Wellbeing and Spiritual Care Team commissioned a proposal to assess the strengths and areas for development of spiritual care across the whole organisation. This proposal was completed in March 2025 and was written by Elizabeth Young (Spiritual Care Development Advisor).

We were also aware we wanted to better achieve Ambition 3: maximising comfort and wellbeing as part of the Ambitions for Palliative and End of Life Care (National Framework 2021-2026)

This priority references

- The proposal for spiritual care conducted between August 2024 and March 2025 entitled 'Putting Spiritual Care 'front and central' of hospice strategy.
- The Emotional Wellbeing Team objective 'To ensure people have access to spiritual support'

How the priority will be achieved:

- Establishing a Steering group for spiritual care across both clinical and non-clinical areas of the hospice.
- Developing a plan for spiritual care delivery within the model of 'Spiritual Care – everybody's business' following the 5 areas outlined in Elizabeth Young's report.

- Strategic spiritual care leadership
- Co-producing innovative person centred spiritual care
- Nourishing the spiritual life of staff and volunteers
- Spiritual care interwoven into community events
- Spiritual curiosity underpinning education evaluation and research

How progress will be monitored and reported

- Progress will be reported to the Quality Assurance and Improvement Group and Care Services Group
- We will update and monitor our Emotional Wellbeing and Spiritual Care Team objectives
- We will report updates to the Hospice Engagement Group
- We will use Power BI to monitor Spiritual Care activity
- We will conduct a staff survey to establish a baseline then complete after one year.

2.2 Achievement of priorities for improvement 2024-25

Patient safety

Priority one

Topic – Equipment Processes

To review and standardise the processes by which we manage supportive equipment. This includes

- Equipment issued via Medequip to patients at home (e.g. beds, commodes)
- Specialist equipment that the Hospice owns which is loaned to patients from time to time (e.g. positioning cushions, TENS machines).
- Stock of small aids which the Hospice purchases and issues to patients as needed (e.g. hand held fans, specialist cutlery, neck collars)

How was the priority decided?

We have realised that within the same organisation we have different processes around who can issue various equipment, processes for doing so, and what equipment is available to loan to patients. There is also no formal database of approved suppliers for small stock aids, meaning there can be variability in quality provided.

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There has been a significant growth in clinical services, particularly in Great Yarmouth and Waveney, and within the Community Health Care Assistant team in Ipswich. It has been challenging to keep up-to-date with ensuring all new staff understand their roles and responsibilities around management of equipment.

A recent MHRA alert around appropriate issue and monitoring of bed rails and bed levers within organisations has highlighted the significant safety concerns which can arise if equipment is not appropriately assessed for and monitored.

How the priority will be achieved

- Development of a working party within the therapy team, but with representatives from and liaison with other teams as appropriate, to:
 - Review current equipment processes and provision.
 - Amend processes to try to standardise what we are doing across teams and geographical areas.
 - Update the policy on equipment management.

- Develop an approved suppliers list for small aids, and ensure equity across sites on what is available.
 - Establish whether there is a need to develop any competencies around equipment.
- Develop and roll-out an appropriate training programme for all clinical staff regarding appropriate use of bed levers and bed rails, to ensure we are compliant with MHRA guidance on this.
- Provide training to the CHCA team on equipment to raise awareness on roles and responsibilities – as well as safety things to be aware of.

How progress will be monitored and reported

- Updates through therapy team meetings and one to ones.
- Relevant policies and processes will be updated.
- Training will have been provided to CHCA staff as part of their training days.
- Training will have been rolled out to all clinical staff and completed by March 2025 on use of bed rails and bed levers.
- We will have developed an approved list of suppliers for purchasing to use for purchase of small aids.

In 2024-25

What we did:

- Initial meeting was held virtually with Ipswich and Great Yarmouth Therapy teams to discuss and agree plan and actions for the project.
- TEAMS group was set up to allow central location for project work with relevant staff added to aid communication/information sharing.
- Further meetings were held with relevant teams in the Hospice as appropriate across the year.
- Therapy equipment loans policy has been reviewed and added to the currently in development Therapy Standard Operating Procedure.
- The main focus of the equipment group has been on ensuring the Hospice is up to date with new MHRA Guidance on use of bed levers and bed rails.
- The policy for use of bed rails and levers has been amended and includes updates requirements for staff within Ipswich to complete a bed rail assessment for every admission to IPU or for a Zest Young Adult Short break stay.
- Adjustments have been made to the SystmOne Templates to ensure robust documentation and risk assessment has occurred when staff use bed rails within the Hospice site.
- Training videos for safe use of bed levers/rails has been recorded and included in mandatory training programmes for all staff, with a plan for staff refreshers every two years to be co-ordinated by the Hospice Education team. Different videos were required for Mid and East Suffolk and Great Yarmouth and Waveney due to different community equipment providers, as well as Ipswich IPU beds being managed by St Elizabeth Hospice, but the Beccles beds are managed by East Coast Community Healthcare (ECCH) so we needed to comply with local policies relevant to ECCH in Great Yarmouth and Waveney.
- The Great Yarmouth and Waveney therapy team have been working closely with colleagues in ECCH and Medequip to review current process around equipment competencies and process around this. Good progress has been made with this, but there is more work to be completed in the coming year. There are plans in the therapy team strategy for 2025/26 for this to be completed and then reviewed and adopted as appropriate for the team in Mid and East Suffolk.
- There has been some progress with small aids – we now complete regular stock checks and have confirmed which items should be sourced regularly. However, this needs further review within the therapy team and has been carried forward to next year's therapy objectives.

- The therapy team have provided training on common equipment items and troubleshooting to the Health Care Assistant teams this year. This was as part of their planned training days throughout the year.
- Training has been completed with the care co-ordinators to help them troubleshoot and manage OneCalls that come in around bed levers and rails.
- An audit tool has been developed for monitoring compliance with use of bed rails within Ipswich. Audit has been planned to occur three monthly within IPU and Zest services and this has been added to the planned audit programme.

Did we achieve these improvements?

- We are now compliant with the MHRA alert on bed levers and bed rails.
- We have updated policies relating to
 - Equipment processes, and
 - Bed levers and rails

Patient effectiveness

Priority one

Topic – Patient related outcome measures and further implementation of OACC suite.

How the priority was decided?

The OACC suite of measures (iPOS, Phase of Illness and Australian Karnofsky Performance status (AKPS)) has been previously introduced in the hospice. These measures are used to help evaluate priorities for patients and also to demonstrate effectiveness of interventions, for example by reduction in severity of iPOS scores or by improvement in AKPS. The suite of measures are used to different extents within different services, for a number of reasons which include staff mix, types of patient and service changes since the pandemic. Review of use of the measures will identify any necessary support and changes required.

Until now, the results have largely been considered on a patient by patient basis – the next phase of implementation is to consider the potential for reporting by service area, team or as a wider hospice using the tool PCOM360 (Patient Centred Outcome Measure). Consideration will be given as to how this improves understanding of patients' needs, effectiveness of interventions and how this may be reported on a wider basis to help meet internal and external reporting requirements.

How the priority will be achieved

- Review of data inputting options and any required SystemOne changes with business intelligence/information management team
- Feedback from service area leads about current use of OACC measures
- Development of desired plan for outcome measures in conjunction with service leads/Senior Management Team and Director of Care, taking into account e.g. Multi-Disciplinary Team meetings, caseloads, goals of care and any other clinical impact.
- Consideration of staffing requirements for implementation e.g. admin support and patient facing support which may be via volunteers.
- Agreement of reporting framework.
- Implementation with clinical staff including training and integration into business as usual
- Review of completion rates of source data and of impact of the reports – process to be determined but likely audit and feedback.

How progress will be monitored and reported

- Initial discussion at Patient Services Group with regular review
- Trial reporting process and review with feedback

- Training plan according to the needs of staff/teams
- Policy and procedures to be updated as required

In 2024-25:

We established there was a need to develop our use of the OACC suite of measures to demonstrate the effectiveness of the hospice's clinical services at improving patients symptoms and quality of life.

What we did:

- We worked with individual teams and key stakeholders to map their current and potential future use of AKPS, phase of illness and IPOS
- Clinicians worked with the business intelligence team to develop new methods of data capture and to develop a suite of data reports using power BI to be displayed alongside each team's activity data
- We piloted regular use of ipos in one service area – extended support CCU in Ipswich – for 3 months to trial data capture and reporting, identifying learning and key adjustments to processes
- We agreed a roll out plan for each service area, tailored to each area's needs and patient populations

Did we achieve these improvements?

- Teams have already reported using ipos more regularly, knowledge and confidence has improved
- Systematic power BI reporting has been developed
- Full roll out is on track for 1st April 2025
- Further integration into the community transformation project and related processes such as referral and discharge are in development.

Patient experience

Priority one

Topic – Improving end of life care experiences and support provided to people who are homeless, refugees or asylum seekers or part of Gypsy, Roma, Traveller communities.

How was the priority decided?

- This priority aligns with our strategic objective 'To Drive Health Equity for All'
- The above groups of people are identified in national reports as communities who experience an inequality of palliative care support and end of life care experiences (CQC, 2016, and Hospice UK, 2021).

How the priority will be achieved

- Working with providers with established trust and service provision to these communities eg The Marginalised and Vulnerable Adults Outreach Team, and the Suffolk County Council Gypsy, Roma, Travellers Welfare Officer to enable learning and co-production
- Working in co-production with those who have lived experience, including seeking advice from the Hospice Engagement Group.
- Taking a Compassionate Communities approach to equip and empower communities in end of life care and bereavement support
- We will develop resources to enable staff to have greater awareness of the needs of these communities.
- We will consider how we can adapt our services to ensure improved access based on the above.

How progress will be monitored and reported

- Progress will be reported to the Quality Assurance and Improvement Group, Care Services Group and Inclusion Steering Group.

- We will report updates to the Hospice Engagement Group.
- Further facilitator training provided for No Barriers Here including with community partners, and first programme booked for January 2025 with Emmaus (local organisation working with people who are homeless, enabling advance care planning and early engagement with palliative care).
- Positive case example of hospice provide support and End of Life Care for patient from a travelling community.
- As part of Community Transformation Project, a CNS has been identified to be link for supporting people who are homeless, with plans to identify a link for travelling communities also.

In 2024-25:

What we did:

- We have established knowledge and links with local providers who work with people who are homeless, Gypsy, Roma and travelling communities, refugees and asylum seekers, including The Marginalised and Vulnerable Adults Outreach Team, and the Suffolk County Council Gypsy, Roma, Travellers Welfare Officer. We continue to seek to build our relationships with communities working more closely with these providers who have established relationships of trust.
- We have successfully gained a grant from the National Lottery to fund our Compassionate Communities work with diverse communities, including the employment of two Community Connectors to work across Ipswich and East Suffolk, Great Yarmouth and Waveney. This enables us to invest time in relationship building and seek opportunities to listen, learn and co-produce ways we can improve death literacy and access to palliative care when needed.
- As part of the Compassionate Communities approach we have facilitated the No Barriers Here project with organisations who support people who are homeless EG Emmaus in Ipswich, and those who are refugees and asylum seekers EG Gyros in Great Yarmouth and Waveney.
- We have joined relevant professional networks to enhance our knowledge and skills in providing palliative care for people who experience homelessness, this has included Marie Curie Homeless and Hospice UK networks. This enables us to develop resources, learn about good models of practice from other services and have greater awareness of the needs of these communities.
- We have had positive example of our community team supporting a patient through palliative care and end of life within a travelling community.
- We now have a community CNS who has a link role for people experiencing homelessness.

Did we achieve these improvements?

This will continue to be a work in progress as we build trust and relationships with these communities.

Priority two

Topic – To improve our ability to provide equitable compassionate care and support for patients and families who are trans and gender diverse

How was the priority decided?

The publication of the 'I just want to be me' report (2023) and the subsequent 'Being Ready' project initiated by Hospice UK has raised our awareness. Several members of the clinical team also attended LGBTQ+ awareness training, including on care considerations for those who are transgender. We then recognised and agreed as clinical team that we to undertake learning and review our ability to provide equitable compassionate care and support for people who are gender diverse and non-binary, including those who are transgender.

How the priority will be achieved

- A working party group for trans and gender diverse care formed of representatives from the nursing, therapy and medical team will lead the progress.
- Members of the working group will attend further training provided by the 'Being Ready' project which aims to disseminate evidence based learning to support palliative care practice development.
- A new policy and procedure will be produced to provide information and guidance for staff to ensure we are providing equitable compassionate care to those who are trans and gender diverse. It will also ensure staff are aware of the legal requirements associated with the rights of people who are transgender. The policy will also direct staff to further learning and resources available.
- Learning resources and research evidence will be collated and made accessible for staff on our intranet.
- There will be a new training session added to the annual nursing update days accessed by all hospice nurses on transgender care.
- We will seek opportunities to co-produce the project with people who have lived experience of being trans and gender diverse.
- We will establish the use of a 'safe space' sign (recognised by the LGBTQ+ community) for our clinical care buildings to provide awareness of that our care and support is inclusive of those who are trans and gender diverse.

How progress will be monitored and reported

- Progress will be reported to the Care Services Group and Inclusion Steering Group.
- In addition updates will be provided the staff LGBTQ+ working group which includes non-clinical staff.

In 2024-25:

What we did:

- A working party group for trans and gender diverse care was formed of representatives from the nursing, therapy and medical team. The group members attended training by the 'Being Ready' project which enabled learning to support best practice within palliative care for people who are trans and gender diverse. The members include representation across both Ipswich and East Suffolk, Great Yarmouth and Waveney, community and in-patient teams. Thus allowing every year to have a key person to enable dissemination and support the wider teams.
- A new policy and procedure has been drafted to provide information and guidance for staff to ensure we are providing equitable compassionate care to those who are trans and gender diverse. It will ensure staff are aware of the legal requirements associated with the rights of people who are transgender. The policy directs staff to further learning and resources available. The publication of the policy was paused when the government proposed a change in legal position for bed allocation within clinical care settings for people who are gender diverse. We continue to await resolution to enable publication of the policy. Alongside this in March 2025 Hospice UK published the new guidance for hospices 'Trans and Gender Diverse Inclusion Handbook' which will also enhance the final version of the policy.
- We now have an area for LGBTQ+ resources on our staff and volunteer intranet, with new additions highlighted in our weekly updates, as well as a focus on LGBTQ+ awareness raising and resource sharing during July (Pride month).
- Throughout 2024/2025 a new inclusion training session including transgender care was added to the annual nursing update days attended by all hospice registered nurses.
- During the year we attempted to hold an opportunity for co-production with the LGBTQ+ community. Our staff working group, including those with lived experience, supported the idea of a breakfast meeting and invited those we had existing relationships with and other local organisations. Unfortunately, we did not have anyone attend. We have reflected on this and recognised the need to focus on outreach and building trust going forward.

- A 'safe space' sign (recognised by the LGBTQ+ community) was developed by our Marketing and Communications team as part of the wider Inclusion Steering Group. The aim being to have this displayed in our clinical care buildings to provide awareness of that our care and support is inclusive of those who are trans and gender diverse. We have also planned to incorporate this within our new website. We await final decisions around the location and display of the safe space signage.

Did we achieve these improvements?

Significant progress has been made but further work is required on final version of policy before dissemination to staff in light of recent legislative changes and published national guidance.

Priority three

Topic – Improving the accessibility and equitable opportunities for patients and families to provide feedback on our services.

How was the priority decided?

The need was co-produced through different inclusion projects eg Hospice For All (working with multi-ethnic communities) and the No Barriers Here project (working with people with learning disabilities). We recognised that our patient and family feedback mechanism were limited to sending written English surveys, therefore excluding anyone who didn't speak/write English, those who have limited or no literacy skills. We therefore do not gather feedback and evaluate patient experience inclusively. We are also unable to evaluate the impact of our inclusion projects and how they are seeking to improve patient experience.

How the priority will be achieved

- Working with other provider organisations within the SNEE ICB we will seek to collaborate efforts in seeking solutions for inclusive feedback.
- Working in co-production with those who have lived experience, including seeking advice from the Hospice Engagement Group.
- We will review if our current systems of gathering feedback are inclusive eg timing of requesting feedback following episodes of care.
- We will pilot adapted feedback approaches with those who have limited English literacy (which can include multi-ethnic communities, people who have a learning disability, dementia or other cognitive impairment, those who use British Sign Language).
- We will seek to enable digital solutions that enable us to adapt our feedback questionnaires.
- We will establish a system that enables staff to identify patients and families who will require accessible feedback opportunities.
- We will establish understanding of the budget requirements to support inclusive feedback to support future delivery.

How progress will be monitored and reported

- Progress will be reported to the Quality Assurance and Improvement Group, Care Services Group and Inclusion Steering Group.
- We will report updates to the Hospice Engagement Group.

In 2024-25:

What we did:

- We have worked with other provider organisations within the SNEE ICB and regional Strategic Clinical Network for Palliative Care to seek collaborative solutions to enable inclusive feedback. We have discovered that this is shared challenge across the system with no working example of a solution.

- We have worked in co-production with those who have lived experience, through our Hospice for All project and local learning disability organisations, as well as seeking advice from the Hospice Engagement Group.
- For people we support with a learning disability we have learnt that we need to provide brief and timely of gathering feedback including the use of pictorial rating as well as verbal dialogue where possible preferably immediately after the care experience or at most the next day. As part of our Easy Read procurement we have included a generic feedback form that can be used across the services. Staff can then add additional comments from further dialogue or observation or carer feedback (depending on level of mental capacity). This approach can also be used with others who have limited literacy skills for a variety of reasons eg Dementia, limited English language etc.
- We have explored, with limited success to date, the digital options of sharing translated feedback forms and receiving these back into English, with the ability to collate into our overall findings. The cost of translating current feedback forms into other languages and back into English individually is prohibitive. It has been identified that using AI assistance within electronic survey and then using Microsoft Co-pilot to translate back into English and collate on a spreadsheet with other feedback is possible. The IT team plan to purchase a co-pilot license to enable this to be trialled. In the meantime it is more practical and cost-effective to use paid interpreter to call the patient and/or family to complete a feedback form over the telephone.
- For those who are ethnically diverse and for whom English is a second language we have co-produced an introduction to our hospice services to be interpreted which now includes the patient and/or family's consent to be contacted post-care for feedback using an interpreter.
- Staff are advised to inform our governance coordinator of the need for interpreter phone call for feedback on an individual basis.
- Whilst piloting the above approaches we are working to establish understanding of the budget requirements to support inclusive feedback to support future delivery in 2026/2027.

Did we achieve these improvements?

This continues to be a work in progress and will form part of the wider digitalisation of patient and family feedback.

Priority four

Topic – Advanced Clinical Practice

To increase staffing skills across the hospice to allow us to safely support patients with complex respiratory needs.

How was the priority decided?

Advanced Practice (AP) is part of the strategy for workforce development within the NHS Long Term Workforce Plan (2023). The aim is to have 5000 new practitioners a year commencing ACP pathways by 2028.

Currently, within STEH there is not a clinician in an AP role. However, there is a clinician who has completed the e-portfolio route and there are 2 clinicians who are undertaking training and 2 who are requesting training. Of the 2 clinicians training 1 has an identified AP role to fulfil once training completed that encompasses the AP definition and pillars of practice.

The clinical workforce at present for nursing and therapy teams has a range of Band 4-8b roles from Nurse Associate to Nurse Consultant roles. The majority of roles sit within Band 5-7 roles. The Band 6-7 roles would be the people and roles considered for ACP training which comprise of CNS and senior therapy clinicians.

The other two Hospices within the ICS do have AP roles but we do not have the information (although has been requested) to see how they align to the true scope of AP as defined against the Job specification agreed in the SNEE wide oversight group.

Presently, there are opportunities to develop the workforce to AP level with funding options available. However, this is not aligned to a workforce strategy for STEH or across the ICS to the scope of workforce development against identified need.

Developing the AP workforce would support system wide working for enhanced patient care particularly in the community setting enabling clinical assessment, physical assessment, diagnosis and actions including prescribing if needed.

Health Education England have developed a specification for Palliative and end of Life care AP which sets out the requirements for the AP role in this speciality. This also captures the roles required for young adults in addition to adult services. Developing the AP workforce supports the requirements of the role for organisations but would also contribute to evidence when commissioning of the scope of practice and contribution to system wide working.

How the priority will be achieved

- Review the current workforce roles/job specifications and identify where Advanced Practitioners would be utilised within service provision
- Review service demand and identify where AP roles would benefit patient care
- Work with the local Advanced Practice Faculty to secure funding to support development of the roles
- Link with the other SNEE Hospice's to align and standardise the AP role across SNEE to ensure a more robust and flexible workforce across the system
- Create a working party to scope the workforce plan and propose further actions as identified

How progress will be monitored and reported

- Complete the maturity matrix used for organisations that are scoping AP
- Monitor the progress monthly with the matrix as the tool to enable this
- Report to the East of England Advanced Practice faculty at monthly meeting
- Regular oversight AP meetings with representation from SNEE Hospices and Hospitals
- Utilise an action and decision log to record the outcome of the SNEE AP oversight group
- Keep a record of AP's within the SNEE and trainee AP's to demonstrate the role in practice
- Policies and procedures to be updated if required
- Audit feedback from staff participating on the ACP course with qualitative and quantitative data
- Review patient feedback from patient surveys

In 2024 -2025:

We established we needed a framework to support the Advanced Practice Workforce and identify the current roles that exist and what we propose as a workforce strategy.

What we did:

- An interim lead Advanced Practice Lead was established to lead the work
- We mapped Staff currently at STEH working towards AP qualification and due to begin
- We applied for funding to support two AP training roles
- We created a SNEE wide oversight group to create a framework for the AP role in palliative and end of life care with agreed outcomes to complete:
 - o Agreed job specification and scope of practice for P&EOLC AP
 - o Suggested Banding for job role
 - o A draft SOP to oversee AP practice
 - o AP Maturity Matrix

- o Ongoing action/decision log
- o Create a community of practice to enable ongoing AP development
- We identified that we needed to have a register of practitioners that can take the role of education supervisor so that training can be facilitated
- We plan to feedback to clinical and operational leads for St Elizabeth, St Helena and St Nicholas to inform the strategy for AP practice moving forward.

Did we achieve these improvements?

- We established an oversight group that met regularly
- The oversight group agreed / enabled the following outcomes:
 - o Created a maturity matrix and the progress towards governance of AP roles
 - o Agreed a job specification and scope of practice for P&EOLC AP
 - o Created a draft SOP to oversee AP practice
 - o Utilise an action/decision log to demonstrate work to date and outstanding tasks
- An Interim Advanced Practice Lead is in place which links into the East of England AP faculty
- Secured funding of £10,200 per financial year per trainee for two AP trainees with one more to be applied for in the forthcoming financial year
- Meeting planned to feedback to clinical and operational leads the work to date. Thereafter, to agree a planned strategy for the work moving forward

Priority five

Topic – Patient Wishes

To review the process by which we help to achieve meaningful experiences for patients accessing Hospice services. Develop an equitable process for this.

How was the priority decided?

Historically as an organisation, we have tried where possible to find ways to support patients and their families to achieve meaningful experiences which logistically it would be difficult for them to arrange without support. Examples include a visit to a meaningful place, e.g. river or beach, being able to attend a wedding, being able to visit home, facilitating a trip to watch football, celebrating an anniversary etc.

There is currently no formal process in place for this. If a request is made, it depends on who it is mentioned to, and whether clinicians can find the time on top of their busy workloads to provide the appropriate support as to whether it is something we can help achieve. This leads to a potentially inequitable service. In addition, high clinical caseloads are making it more difficult for staff to find the time for achievement of these important experiences. There is desire across hospice teams to improve the current situation.

How the priority will be achieved

- Discussion and consultation with the Hospice Engagement Group for advice.
- Development of processes for clinicians to be able to refer a patient for a wish.
- Development of appropriate Inclusion criteria, Risk Assessment and Process documents.
- Recruitment of a volunteer to support organisation of wish achievement following referral.
- Development of a group of interested clinical and support staff who can support the volunteer. Set up and organise appropriate communication channels.
- Development and management of a budget to support patient wishes – and processes for accessing this.

- Develop a database of organisations external to the hospice who may be able to help support with facilitation of wishes, and make and develop contacts with these organisations (e.g. taxi firms, concert venues).
- Liaise with fundraising regarding the possibility of sourcing a Trust Fund for purchase of two VR headsets (one for Ipswich and one for Great Yarmouth and Waveney).
- Communicate new processes and referral forms to hospice teams.

How progress will be monitored and reported

- A database will be developed to be able to track how many referrals are made to the service, as well as recording whether we were able to support with wish achievement.
- Patients and families who have wishes supported will be asked, where appropriate, whether they would be happy for their 'story' to be used for marketing purposes.
- Budget management will be tracked appropriately.
- Feedback will be provided to the Hospice Engagement Group.
- Service will be audited after a year to identify demand, use, and appropriateness.

In 2024-25:

We established there was a need to develop the process by which we help to achieve meaningful experiences for patients accessing Hospice services, to ensure a more equitable process.

What we did:

- Staff interested in this project met with the Hospice Engagement Group for advice.
- There is now a group of clinical and non-clinical staff who are happy to support with wish achievements. They are all connected via a group E-mail.
- There is a volunteer in place who has been recruited to support with this project.
- Risk Assessment documents, inclusion criteria, and referral forms have all been developed, as well as a database of resources which continues to be added to.
- This project, and the referral process for it has now been officially introduced via the Hospice weekly update. This has been followed up with E-mails to clinical staff to inform them of the referral process.
- We have sourced a cash tin for the ward staff to be able to access to help with celebrations/ events for patients on the ward that have to happen at short notice, as well as developed the processes for accessing, topping up and monitoring the use of this tin.
- We have liaised with the Data Intelligence team to develop a tracker spreadsheet which can be linked to Power BI to report on activity.
- The Hospice has purchased one VR headset. The therapy team are liaising with IT to develop a step-by-step process for set-up and will also develop appropriate guidance on use. It was agreed that it would be good to review functionality of one headset for use across both sites, and then a second one could be purchased if there is high demand.
- Staff have made appropriate referrals, and the volunteer is collecting all relevant information and making appropriate connections with external organisations that support.

Did we achieve these improvements?

- The hospice wish project is now fully operational. The processes put in place mean that there is a clear and equitable process for referral for support for wish achievement.
- Wishes facilitated through the Wish Group have included:
 - Patient was able to go and observe her daughter at a riding lesson. The volunteer was able to make links with a transport company and with a riding school. The riding school kindly provided a free lesson, and the Hospice funded transport for the patient
 - Purchased memory soft teddy bears for a patient's younger siblings

- Taking a patient on the in-patient unit in Ipswich to his son's sports day at school
- Taking a patient for a day trip to Felixstowe with his daughter
- Many ward celebrations of events such as anniversaries and birthdays, including room decorations, cakes, flowers etc.
- Some other referrals have been made, and work progressed to facilitate these wishes, but due to a change in patient condition have not been possible to achieve. This highlights the need for swift processes and actions once a wish has been identified.
- Outstanding actions which will be completed in the coming months:
 - Staff are due to trial the VR headset and develop further guidance on use, considering contra-indications to use. Once this has been completed, we will update staff on availability.
 - Audit on use of the service.

2.3 Statement of assurance

2.3.1 Review of services

During 2024-2025 St Elizabeth Hospice provided the following services:

- Inpatient Unit (18 bed)
- Community Care Unit
- Community Clinical Nurse Specialists/Registered Nurses and Healthcare Assistants
- Virtual Ward service provided by Community Health Care Assistants
- OneCall advice line
- Emotional wellbeing services, including bereavement service and spiritual care team
- Therapy services, including, physiotherapy and occupational therapy
- Medical consultant led outpatient appointments and domiciliary visits
- Zest Young Adult Services
- Co-ordination Hub
- Specialist Palliative Care Services to the Great Yarmouth and Waveney area under subcontract from ECCH.

Our work is centred on the individual's needs and we provide specialist support wherever it is needed.

In-patient unit

The Inpatient Unit (IPU) provides specialist palliative care for the relief of pain and other distressing symptoms, as well as psychological and spiritual distress, or end-of-life care at all times aiming to maintain the patient's dignity and choice.

The IPU is a short stay unit made up of bays and single rooms, there are several reasons why patients are admitted to the IPU, including end-of-life care. There are 18 beds on IPU in Ipswich and there are a further 6 beds in Beccles Hospital. 10% of patients need to use one of the hospice beds.

As well as expert medical and nursing care, a variety of therapies are offered.

Inpatients and their families and carers can access emotional wellbeing support services such as bereavement support and spiritual care.

We accept patients from East and Mid Suffolk, Great Yarmouth and Waveney, and further afield if this is the patient's choice.

Community care unit (CCU)

The majority of patients want to be supported in the community; this can be in one of our Community Care Unit locations. The Community Care Unit supports patients with complex needs. This service supports symptom control, improves ease of access to professionals and provides social integration.

It is aimed at those suffering from a progressive or life-limiting illness requiring the input of several of our professionals and would benefit from having their appointments on the same day. This includes rehabilitation and enablement support by physiotherapists and occupational therapists as well as nursing, medical and emotional wellbeing support. We offer group support to patients, relatives and carers.

At St Elizabeth Hospice Ipswich, the service includes:

- Pre-booked appointments available Monday – Friday with all members of the multidisciplinary team
- Fully equipped gym for assessment and rehabilitation available 5 days a week
- Access to our Ridley's Café Tuesday, Wednesday and Thursday 10-3pm. This allows patients and their families to have somewhere to purchase light snacks and beverages whilst attending appointments
- Patient care will be booked depending on individual needs
- A range of support groups and rehabilitation programmes (Breathlessness Management Group and Exercise Groups (Seated, Circuit and Drop-in exercise groups)
- Volunteer led hairdressing, complementary therapy and beauty therapy available,

In Great Yarmouth and Waveney, in partnership with East Coast Community Healthcare (ECCH), the service includes:

- Support offered throughout the region – currently at Louise Hamilton Centre, Martham Medical Centre and Beccles Hospital.
- Pre-booked appointments will be available for patients to receive multi-professional input
- Patients booked in with the relevant professionals will have the option to stay on the day of the visit
- Patient care will be booked depending on individual needs

Each patient is assessed before they first attend the CCU service to identify their needs and to determine what support is required before a tailored plan of care is created to meet these needs.

Community service

Community nursing team

Our team of Clinical Nurse Specialists (CNS), Registered Nurses (RNs), Hospice Paramedic (in Gt Yarmouth & Waveney only), Community Healthcare Assistants (CHCA) and therapists work in people's homes to help manage difficult symptoms and care for patients at the end-of-life. Support is available 24/7.

Around 70% of our clinical care is provided in patients' place of residence whether that be at home or in a care home.

The team also operate a Virtual Ward, meaning that patients can remain at home and receive care from Healthcare Assistants, Clinical Nurse Specialists, Physiotherapists and Occupational Therapists. This enables patients to have choice over their place of care and receive clinical support.

The community team supports education across the area with specialist sessions as well as enhancing student education.

Community Clinical Nurse Specialists (CNS) & Registered Nurses

Our community clinical nurse specialists have advanced knowledge and experience of palliative and end-of-life care. The CNS work alongside care providers, such as a GP or district nurse to help manage symptoms.

They support patients and families at home with symptom control, pain management, advice on difficult emotional and spiritual issues and understanding what is happening. This may include support from one of our healthcare professionals, GP or district nurse or another health professional.

Virtual Ward with care provided by Community Health Care Assistants (CHCAs)

We work closely with Ipswich Hospital and other organisations to help patients, known to be nearing the end-of-life, to leave hospital to go home to die, or remain at home if that is their wish.

For patients being discharged from hospital, we can react quickly to make sure the patient has the quickest possible discharge home and ensure that good quality care is in place. Our CHCAs can provide personal care and specialist nursing support is available to manage pain and other difficult symptoms.

OneCall clinical and medical advice line

OneCall is a specialist 24/7 telephone helpline and provides quick and appropriate advice to members of the public, patients, relatives, carers, medical professionals and health and social care workers.

- 30,000 calls per year answered by OneCall from families, patients and healthcare professionals
- Currently have 2,600 calls a month

Having one phone number for anyone who wants advice or information about our hospice and palliative care issues will help us to reach out to the whole of the local community.

Most callers can be helped over the phone, however in some instances a caller may be offered a visit due to urgency and need.

Emotional support team

The Emotional and Spiritual wellbeing team is here to support patients and families facing illness and bereavement. Contact can be made through OneCall which is a specialist 24/7 telephone helpline. We are also here to co-ordinate bereavement care across Ipswich and East Suffolk – working with our partners to support anyone facing a bereavement.

A range of services can be accessed through our emotional support team:

- Telephone advice and enquiries
- Counselling
- Family support
- Art therapy
- Music therapy
- Support groups
- Children's specialist support
- Bereavement services

Our highly skilled team is able to:

- Support both patients and families with their emotional, spiritual and social needs
- Offer counselling
- Offer advice on support groups available

We work with families as a group to:

- Enable couples and families to talk about what they are facing and gain support from one another
- Help families to make important decisions

- Prepare children, in partnership with their parents, for loss or support with their bereavement
- Negotiate and liaise with teachers and employers

LivingGrief is the St Elizabeth Hospice bereavement service. As of April 2020, the hospice's bereavement services have been available to everyone, even those who have not previously been under the hospice's care. However, in Great Yarmouth and Waveney, LivingGrief counselling services are only available to people who have received care from the hospice previously.

LivingGrief provides:

- LivingGrief sessions – group support and information for anyone who has experienced a bereavement
- Closed bereavement groups
- Leaflets and resources
- Counselling support – individual and family work, information and resources (on-line resources <https://www.livinggriefhub.co.uk/>)
- Walk On - walking group for people who are bereaved

565 Service

Provides Emotional support to children, young people and families living with a family member with a progressive illness. The service also provides bereavement support following the loss of a loved one via family meetings, one-to-one counselling and group work.

There are also resources for professionals working with young people and parents to access online. The Dying to Talk programme educates school staff about supporting children and young people living with someone who is unwell and in bereavement.

Spiritual support

Provides help to the patient to manage feelings about what is happening to them and explore experience in the light of what gives meaning to that individual. Coping with illness, loss and change isn't easy for anyone. We can help the patient/family and carers to deal with a range of feelings that they might experience. The spiritual support we provide is not based on any particular faith and addresses everyone's individual and unique spiritual needs.

Art therapy and music therapy

People often find expressing themselves through art and music is easier than talking. We are able to offer art and music therapy to patients and relatives.

Our therapists can provide individual or group sessions in a variety of settings such as at the patient's bedside or in a family member's home.

Therapy team

Our team consists of physiotherapists, occupational therapists and therapy assistants.

Physiotherapy

Physiotherapy aims to help maintain a patient's movement, function and independence. Our physiotherapists assess each patient and a treatment plan is agreed according to the individual's needs.

Physiotherapy can help with:

- Provision of specialist palliative rehabilitation to allow patients with complex disease to exercise safely.
- Assessing whether a patient would benefit from appropriate walking aids or orthotics/supports, and providing these as appropriate.
- Reducing pain through movement, positioning and use of a TENS machine (a small battery operated unit which reduces pain by stimulating sensory nerves), or acupuncture.
- Supporting with symptoms such as pain, nausea and breathlessness through provision of acupuncture.
- Treating and managing breathlessness symptoms through tailored support. The hospice also offers a specialist education session to help those experiencing breathlessness.

- Provision of respiratory physiotherapy to help patients who have weak cough and/or difficulty with respiratory secretion clearance. This can involve provision of respiratory exercises, assessment for and issue of suction machines, and teaching various techniques which can help with cough augmentation.
- General fitness through exercise groups.

Occupational therapy

Occupational therapy (OT) focuses on maintaining independence and quality of life in all aspects of a patient's daily routine. Our occupational therapists work with patients, carers and families to assess a patient's ability to perform activities. They then draw up a treatment programme which aims to increase the patient's capability to tackle difficulties and adapt with independence, confidence and control.

Occupational therapy can be important in ensuring a patient is safely discharged home from the hospice with appropriate equipment and support services. The team also supports patients in the community, including those who wish to remain at home during the final stages of their illness.

Occupational therapists can help with:

- Providing equipment to aid independent living and improve comfort and positioning
- Relaxation techniques to alleviate stress and anxiety
- Techniques to cope with fatigue and loss of energy
- Advice on how to promote independence
- Assessing the patient's home environment
- Practical strategies to help families/carers support the patient at home
- The hospice Occupational therapists also offers a specialist service to support people with lymphoedema, in collaboration with the Hospital team.

Zest transition and young adult care services

Young people with incurable conditions are now living longer and needing adult hospice services. Working alongside local healthcare providers and children's services, St Elizabeth Hospice accepts referrals from the age of 14 years old, living in Suffolk and North East Essex, to support the transition into adult hospice care.

Zest is our young adult care service that provides a developmentally appropriate approach for young adults who are transitioning from children's services or diagnosed with a life-limiting or life-threatening conditions.

We offer palliative and supportive care for the whole family including:

- Zest X-Change - a monthly evening social group
- Parent support group
- Monthly Saturday family drop-in
- Transition coordination support
- Zest Days - a service which gives young adults, aged 18 and upwards living the opportunity to enjoy socialising and inclusive engaging activities on Fridays, at Zest in Ipswich.
- Zest short breaks - respite provision
- Regular clinical reviews and access to the hospice multi-disciplinary team

Our specialist team work with young people and support them to minimise the impact of their conditions and maximise their potential. This care enables young adults with challenging conditions to manage their symptoms, access fun activities with their friends and fulfil their aspirations.

Medical led out-patient/clinics & domiciliary visits

Team of Medical Consultants, Nurse Consultants, Specialty Doctors and Registrars provide 24/7 support to all clinical teams across the hospice.

- Direct medical care to all inpatients in the 24 beds across the patch, with Palliative Medicine Consultant oversight. 7 day admissions, complex symptom control, meeting Preferred Place of Death wishes, avoiding unwanted hospital admissions

- Approx. 379 outpatient appointments or domiciliary visits per month to support patients in the community – 220 in East Suffolk and 159 in Great Yarmouth and Waveney
- Consultant support to OneCall 24/7 and direct advice to GPs
- Key role in delivering medical reviews, support for Advance Care Planning, managing complex co-morbidities
- Medical support for Zest – the hospice young adult services
- Cross site working for all consultants, improving co-ordination and collaboration with other providers including East Suffolk and North Essex Foundation Trust (ESNEFT), James Paget University Hospital (JPUH) and East Coast Community Healthcare (ECCH)

Multiple strategic roles in driving forward quality improvement within the organisation and across Integrated Care Systems (ICS) and Sustainability and Transformation Partnership (STP) – clinical leadership, quality assurance, education delivery e.g. palliative care conferences and masterclass sessions, audit and research.

Co-ordination hub

Commissioned by the Suffolk and North East Essex Integrated Care System (ICS) and working with health care partners, the Hub includes OneCall, a team of multi-disciplinary staff working across 24/7 which provides a range of responses to calls, education and support of other providers, emotional and bereavement support, support to care homes and GPs.

Working with our clinical partners, we are coordinating communication and care by:

- Providing and coordinating care in people's homes
- Providing advice on how to manage symptoms and administration of drugs
- Arranging admissions to hospice
- Providing psychological and bereavement advice
- Arranging practical help to get equipment and medication



Specialist Palliative Care Services Commissioned by East Coast Community Healthcare

We are working in partnership with East Coast Community Healthcare (ECCH) to deliver specialist palliative care services in the area. The aim for this joint initiative is to ensure greater parity in the levels and range of care available to the communities of Great Yarmouth and Waveney in comparison to the rest of the region.

The services we provide in this area are:

- Specialist consultant support to six palliative care beds at Beccles Hospital
- In reach specialist palliative care support into James Paget University Hospital
- Access to our 24-hour specialist palliative care advice line, OneCall, for patients, relatives and healthcare professionals – 0800 567 0111
- A community nursing specialist palliative care service during working hours including weekends
- Community Care Unit and outpatients from Beccles Hospital, Louise Hamilton Centre, Hamilton and Martham Medical Centre, including counselling and therapies

2.3.2 Service development

On 1 March 2023, we merged with another charity called East Coast Hospice (ECH).

East Coast Hospice has been fundraising to build an adult inpatient hospice with a day centre and respite care for the people of the Waveney & Great Yarmouth area. The charity believed that it was essential to open a hospice for inpatient and day care to support these communities and provide greater parity of end of life services.

They have a rural seven acre site on Sidegate Road in Gorleston. We are working with Norwich based architects, LSI, to design and build a community Hospice building. We have a fundraising presence and retail outlets throughout the patch to support income generation.

Both organisations have a shared ambition to develop an achievable and sustainable palliative and end-of-life care service for the communities of Great Yarmouth and Waveney.

With St Elizabeth Hospice already providing services in the area and with East Coast Hospice running a capital appeal, it made sense for us to join forces to seek a solution faster with a single call to action for the community.

This partnership allows all parties to share expertise and work together to create and grow end-of-life care services which will support the communities of Great Yarmouth and Waveney in the most effective way.

A full feasibility study was conducted in early 2024 to help us decide the best way to progress and provide a building or service that is adequate for the demand and financially sustainable for the area.

As a result, we are beginning the process of a phased approach to constructing a hospice services building on our land in Gorleston.

We will update hospice staff, volunteers and supporters, as well as the local community as the project progresses

2.3.3 Funding of services

The work of St Elizabeth Hospice is supported by a grant from the Ipswich and East Suffolk Alliance, part of the Suffolk and North East Essex Integrated Care Board. The hospice also receives funding from Norfolk and Waveney Integrated Care Board, via a subcontract from East Coast Community Healthcare (ECCH).

The income received in relation to services reviewed in April 2024 - March 2025 represents 35%, all NHS funding.

2.3.4 Participation in clinical audit

As a provider of specialist palliative care, St Elizabeth Hospice is not eligible to participate in any of the national clinical audits or national confidential enquiries as they did not relate to specialist palliative care. We will also not be participating in them next year for the same reason. (Mandatory statement).

2.3.5 Participation in local audits

Our Quality Assurance and Improvement Group (QAIG) meets bi monthly to monitor our annual programme of audits, quality improvement, and patient experience. We continue to submit data to Hospice UK for falls, pressure ulcers and medication management.

In the year 2024-25 the following audits were carried out: -

- Lymphoedema Audit
- Acupuncture Audit
- Inpatient Drug Administration Audit
- Inpatient Unit Aspects of Care
- Weekend Working Audit
- Goal Attainment Audit
- ReSPECT Audit
- OneCall call handling Audit
- Documentation of new referrals Audit (GtY&W)
- Drop-in Exercise Audit
- Mouthcare Audit
- Hospice UK CDAO Management of Controlled Drugs
- Hospice UK CDAO Self-Assessment for Controlled Drugs
- FPI0 Audit
- Documentation Review of Falls Audit
- Documentation of New Pressure Ulcers
- Community Team Documentation Audit (East Suffolk)
- Viewing Room Access Audit
- Antimicrobial Stewardship Audit
- Community HCA Documentation Audit
- Inpatient Observational Audit of Patient Care
- Infection Control Audits
 - Hand Hygiene
 - Uniform
 - Commode Cleaning
 - Catheter Care
 - Infection Surveillance
 - PVAD & CVAD Care
 - Cleaning Frequencies
 - Contact Plate Suppling
 - Mattress Checks

Below is a summary of a few clinical audits carried out throughout the audit year.

Hospice UK Self-assessment Audit for the Controlled Drugs Accountable Officer (CDAO)

This is the first audit carried out using a Hospice UK audit tool to ensure that the appointment of the CDAO and the discharge of their responsibilities in the management of controlled drugs (CDs) meets the requirements of the Misuse of Drugs Regulations (2001) (as amended 2007), The Health Act (2006), and the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

The audit had four sub-topics: Appointment of the CDAO, Role and Responsibilities of the CDAO, Annual Review by the CDAO, and Continuous Quality Monitoring.

The audit scored 78% overall and re-audit will be in one year.

Resulted in:

- The new CDAO carried out a review of processes following the audit.

Hospice UK management of controlled drugs

This is the first audit using a Hospice UK tool carried out to ensure that the management of controlled drugs meets the requirements of the Misuse of Drugs Regulations (2001) (as amended 2007), The Health Act (2006) and the Controlled Drugs (Supervision of Management and Use) Regulations 2006.

The audit had seven sub-topics: Adequacy of Premises/Security, Procurement, Examination of Stock Held, CD Register, Records and Audit; Prescribing of CDs, Administration of CDs, and Destruction of CDs.

The audit scored 95% overall and re-audit will be in one year.

Resulted in:

- Review of process for approved signatories

Controlled drug prescribing audit (benchmarked)

This audit is to establish if there is evidence of high quality, safe prescribing that meets NICE Guidance

The NICE guideline 'Controlled drugs: safe use and management' published 12 April 2016 recommends developing standard operating procedures for risk assessing the use of controlled drugs in organisations that includes record keeping.

The aim of the audit is to review opioid prescribing within inpatient units for St Elizabeth Hospice, St Helena Hospice and St Nicholas Hospice.

The audit had six sub-topics:

1. The Morphine Equivalent Daily Dose (MEDD) prescribed at St Elizabeth Hospice, calculated using the agreed opioid conversion chart, and should be similar to St Helena and St Nicholas Hospices.
2. The PRN opioid, when prescribed for uncontrolled background pain, should be the same as the regularly scheduled opioid.
3. The PRN opioid, equates to 1/6th of the background dose. Or justified if not
4. Morphine prescribed first line
5. The MEDD for each hospice range comparable as prescribing benchmark
6. The MEDD mean for each hospice is comparable as a prescribing benchmark

Standard 1 – Achieved

Standard 2 – Achieved

Standard 3 – Mostly Achieved

Standard 4 – Partially Achieved

Standard 5 - Partially Achieved

Standard 6 - Achieved

Resulted in:

- Where the standard was not completely met there was reasonable rationale to demonstrate the additional context to the prescribing variance/difference.
- The audit demonstrated prescribing across the three organisations appeared to be consistent with no significant differences in opioid prescribing across organisations
- Compared to the previous audit there is no significant difference in MEDD across organisations. The MEDD for St Elizabeth has changed the most reducing from 96.5 to 88.1 mg.
- Updating prescribers to check PRN doses are calculated at 1/6 MEDD and if not rationale is documented. Remembering to check when increasing background dose that PRN dose remains correct
- St Elizabeth data did not include Beccles site and to include this as separate data set for next audit

Documentation review of falls

An audit to ensure all patients who attend the Hospice have a Moving and Handling Patient Assessment and Care plan completed within six hours of admission or during first attendance within the In Patient Unit, as per local policy. Those identified as having mobility problems/history of previous falls or other significant medical conditions are to have a Falls Prevention Care plan completed on SystmOne.

The audit had 8 standards: Patients had a Moving and Handling care plan completed on admission, patients had their mobility choices / ability documented, patients had their mobility and transfers documented each shift, patients had a falls risk assessment and care plan completed and updated post fall, patients had a description of

their fall documented, patients had a medical review following their fall, 60% of patients had a medication review post fall, patient's Next of Kin were documented to have been informed of a fall either by staff or patient had capacity to inform them

The audit scored 86% overall and re-audit will be in one year.

Resulted in:

- Highlighting to In-patient Unit staff the need that all patients should have falls prevention implementations pre / post fall documented or rationale for not taking action.
- Highlighting to In-patient Unit staff that all patients identified as a falls risk on admission should have a therapy referral
- Highlighting to In-patient Unit staff that all patients should receive falls prevention leaflets as part of admission packs. This needs documenting and noting where patients are too poorly or cognitively impaired.
- Highlighting to In-patient Unit staff that post fall, if there is evidence of a head injury or head injury cannot be excluded, neurological observations should be performed and recorded.

IPU patient documentation of new pressure ulcers

An audit of practice against the procedure for prevention and management of pressure ulcers.

The audit had 14 standards; Skin assessment and completion of Waterlow risk assessment within 6 hours of admission; Waterlow updated every 7 days or as indicated, i.e when changes have been noted to skin integrity; Information on risk factors recorded; Patient given information/advice; Patient repositioned as per plan; Patient/NOK informed of pressure ulcer; Number of mattress recorded; Category and of pressure ulcer recorded; Size of pressure ulcer recorded; Relevant care plans in place, Rationale for dressing choice recorded; Review date recorded; Photograph taken; Consent for photo recorded;

The audit scored 69% overall and re-audit will be in one year.

Resulted in:

- Amendment of care plans to clearly identify:
 - Size of ulcer
 - Rationale for dressing choice
 - Review date
- Some elements listed on patients' electronic documentation moved to care plan to enable clearer identification e.g. patient repositioning plan, pressure areas checked each shift, daily mattress settings and Patient/NoK informed of Pressure Ulcer.
- Ensuring staff were made aware of what was being documented well, and what could be improved on, and the plan to enable this via Team Meetings

Audit of antimicrobial stewardship

An audit to review whether the antibiotics prescribed for hospice inpatients during the reference period were correctly chosen, including route and duration, in line with the relevant antibiotic policy from the local trust.

The audit had 7 standards: All patients should have a documented drug allergy history; Antibiotics are prescribed if clinically indicated according to the patient's clinical signs/symptoms; The indication, route and expected duration for the antibiotic is recorded in the patient record; Appropriate microbiological cultures have been sent before commencing treatment; Microbiology results and sensitivities have been reviewed and actioned if required; Antibiotic treatment has been reviewed within 72 hours or less or in light of clinical change; Antibiotic treatment is prescribed in line with local antibiotic policy

The audit scored 87% overall and will be monitored monthly through the Infection Prevention Control Group.

Resulted in:

- Reminder to all medical team that an allergy history must be documented for all inpatients
- Request to IPU team leaders to share in next 'drug memo' for staff administering medication that they are encouraged to prompt prescribers if they find that an appropriate allergy history is not recorded and would be best practice to delay administration of antibiotic until allergy history is confirmed for that patient. Also to request reminder to include allergy history in all admission assessments.
- Reminder to medical team to consider use of relevant cultures and to document if this is either desirable or not appropriate.
- Presented audit at medical team governance/education half day, to discuss learning points and identify further actions on their part.
- Disseminated findings to hospice's Infection Control strategy group and quality audit group.

ReSPECT audit Gt Yarmouth & Waveney

Recommended Summary Plan for Emergency Care and Treatment (ReSPECT), serves as a comprehensive approach for discussing, formulating, and documenting recommendations related to future care and treatment. While it encompasses various aspects, including cardiopulmonary resuscitation (CPR), its primary purpose is to guide emergency care decisions.

The audit had two standards: All compulsory fields of the ReSPECT form should be completed; ReSPECT document should be uploaded and recorded in SystemOne.

The audit scored 74% overall and re-audit will be one year.

Resulted in:

- Highlighting the need of education and training on the importance of complete documentation, form uploads, and endorsements.
- Re-audit of ReSPECT documentation and form uploads to monitor improvement.
- Consider use of Leverage electronic health record (EHR) systems to set reminders and automate parts of the documentation process.
- Providing feedback to staff to improve compliance and address any barriers.

Documentation audit on referrals made to Community Team

An audit to ensure that we are responding to referrals in a timely manner and that these new patients are being seen in the most appropriate clinical setting.

The audit had 5 standards: We have a clear team standard of when contact will be made with every new referral and when they will have a HNA to ensure all patients have equitable and fair access to the service ; Every member of the team is using the HNA template to ensure there is evidence of a personalised approach to care and that notes are written in a consistent way; Patients are being seen in the most appropriate place for them, ensuring we are prioritising CCU to support community capacity to support the most unwell patients in a timely manner; Each patient is fully discussed by the assessing clinician at MDT to ensure there is a high level of clinical oversight of every patient as they enter the service; There is a clear plan following the HNA intervention consisting of planned action, date of next assessment and that actions within the plan have been completed; All patients known the service have clearly recorded next of kin (NOK) details that are recorded in the appropriate place ensuring all staff know where to access them.

The audit scored 95% and re-audit will be in one year.

Resulted in:

- Discussion at Quality Improvement & Assurance Group in regard to inconsistency in documentation ie needing clear domains including headers (presenting problem, physical, social, psychological/spiritual, clinical impression, plan). Will be part of the Community Transformation Project 2025
- Review of abbreviations used in patient documentation.

...Thank you so so much for your attentiveness, kindness, understanding and humour through such a very difficult and traumatic time for us. Thanks to you all, mum's life had the best closure any of us could hope for given the circumstances. It meant the world to us and it meant everything to mum.



The Quality Assurance and Improvement Group has a rolling audit programme as well as the ability to prioritise new audits if this response is required.

The schedule below shows the local audits that St Elizabeth Hospice will carry out in 2025-26

Audit Programme

Monthly

- Infection Prevention audits

3 Monthly

- Bed Lever Compliance IPU
- Bed Lever Compliance Zest
- Pharmacy Controlled Drug Audit
- OneCall Advice Line (Call Handling)
- Falls – Assessment and Management
- Medical Device Alerts
- Medicines Alerts

6 Monthly

- Mouthcare
- Zest Disdat Tool
- Zest Capacity Audit
- Safeguarding – Documentation and mental capacity and best interest
- Safeguarding – knowledge spot check audit of staff
- Drugs – omitted medications
- Pressure Ulcer Assessment and Management
- Viewing Room Access Report
- Methadone Prescribing
- Ketamine Prescribing
- Administration of Drugs
- PGD Audit

Annual

- Audit of Exercise Groups (seated, circuit)
- Lymphoedema
- Nutrition
- Safeguarding Supervision Drop in
- Admission Avoidance (IES Community)
- Lidocaine Infusions
- Opiate Prescribing
- Opiate Benchmarking
- Use of Sedatives during last days of life
- Non-Medical Prescribing
- PGD Audit
- Medical FPI0 use
- Blood Transfusions
- ReSPECT
- Hospice UK – Controlled Drug Arrangements
- Hospice UK – Role of CDAO
- Bereavement Care Services
- MyMop Outcome Measure Trial
- Acupuncture
- Aspects of Care
- Family Administration of Medicines
- Corticosteroid Management
- Therapy Notes
- Virtual Ward Unit
- Complaints
- Carers Support
- Paracentesis
- Community Documentation

Some feedback received:

Feedback from relatives/carers of patients looked after by Community Nursing Services

86% felt we met their expectations

98% felt the service helped with advice

92% felt the service helped with symptom control

91% felt the service helped with enabling their relative to remain at home.

80% stating they had no problems contacting Hospice Community Service.

72% reported their relative died at home with 85% dying where they wished to be and 86% of relatives agreed with their relative's choice.

100% felt the Hospice Community Nursing Service cared with respect.

97% felt team were helpful

98% felt team cared with dignity

92% felt confidence in the professional.

77% felt extremely satisfied with the service they received

82% felt extremely likely to recommend our services to family and friends if they needed similar care/treatment.

Relatives highly rated our overall care at 96%.

Feedback from Emotional Wellbeing Team Clients

96% of clients who responded were satisfied with the overall Service.

68% found the response time to the referral just right. 25% too long.

87% described the environment in which they were seen as excellent/good.

90% felt the sessions had helped them deal with the situation that brought the Service.

94% said the therapist showed warmth and empathy towards them.

87% said the number of sessions offered to them was just right. The majority having between 7-12 sessions (66%)

2.3.6 Research

Hospice patients have participated in the following research projects during 2024/25:

- A Cluster Randomised Trial of Clinically Assisted Hydration in patients in the last days of life; Surrey Clinical Trials Unit/ NIHR Royal Surrey Clinical Research Facility

2.3.6.1 Use of CQUIN payment framework

Use of the CQUIN Payment Framework St Elizabeth income in 2024-25 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because we are not party to any NHS National Standard Contracts

2.3.7 Goals agreed with commissioners

St Elizabeth Hospice's income in 2024-2025 was not conditional on achieving quality improvement and innovation goals through the commissioning for quality and innovation payment framework because it is a third sector organisation. It was therefore not eligible to take part. (Mandatory statement).

2.3.8 Clinical coding

St Elizabeth Hospice was not subject to the payment by results clinical coding audit during 2024-2025 by the audit commission. (Mandatory statement).

2.3.9 Data quality

St Elizabeth Hospice did not submit records during 2024-2025 to the secondary uses service for inclusion in the hospital episode statistics which are included in the latest published data. (Mandatory statement).



..... So kind and patient, nothing was every too much trouble and we all feel so well cared for by such a wonderful team of people. Dad has back the twinkle in his eye and we have been enjoying seeing him laughing again.

Part 3 Review of quality performance

3.1 Overall referrals

We aim to improve life for people living with progressive illness and life-limiting conditions, and their families in the East and Mid-Suffolk and Great Yarmouth and Waveney areas.

Last year over 4,000 patients and their families received care from St Elizabeth Hospice.

In 2024/25 the majority of people we supported were living with cancer (49%). However, patients we cared for with neurological conditions (12%) and other chronic disease (9%) are increasing – adding to complexities and increasing the need for an appropriate level of skill diversity within staff teams.

In 2024/25:

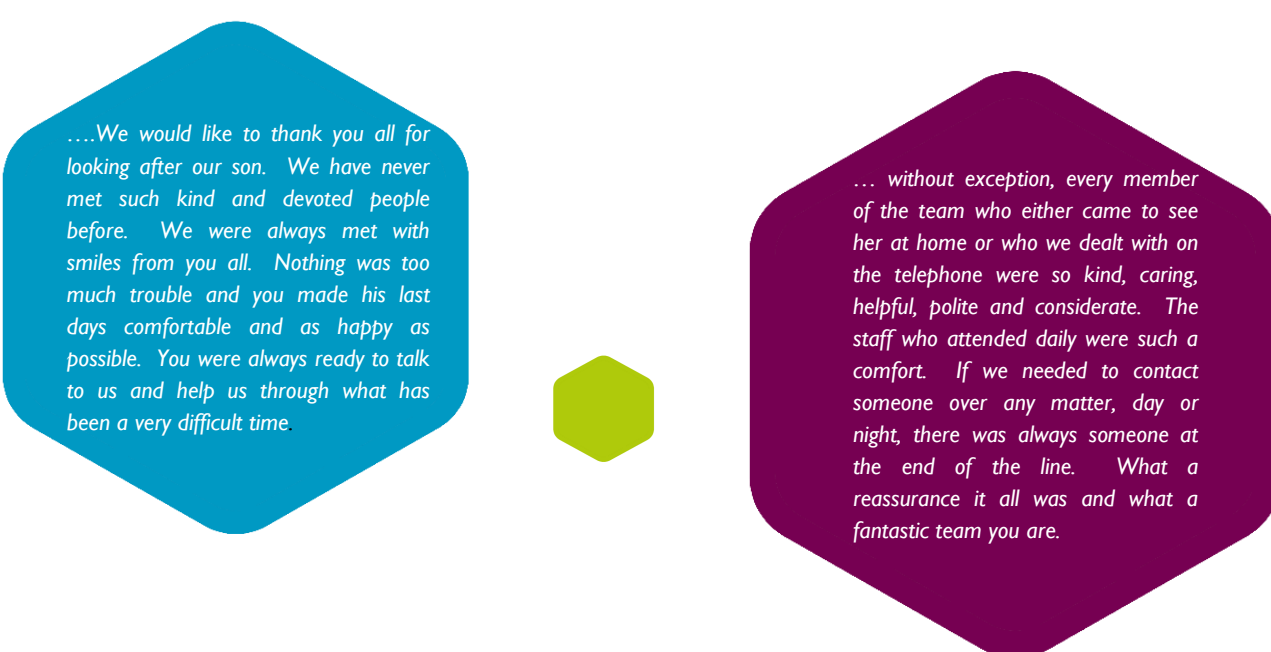
- 4,025 individuals were supported in the community
- In total 4,131 people were supported in East & Mid-Suffolk and Great Yarmouth and Waveney – 24/25
- 251 people admitted onto the Inpatient Unit at Foxhall Road
- 95 people admitted onto the Inpatient Unit at Beccles Hospital
- 1,254 people received emotional wellbeing and/or bereavement support

The illustration below shows how many referrals received and where they come from.

The majority of people we support are aged 60-80 years, as below:

Age	Community	Hospice	Emotional wellbeing & Bereavement support
Under 40	7.26%	0.07%	5.76%
41-60	12.92%	0.65%	8.06%
61-80	41.27%	1.21%	12.51%
81+	35.97%	0.36%	4.01%

St Elizabeth Hospice is constantly aiming to improve quality of care and services to patients and their families. It demonstrates this through its governance structure. It has a culture of openness and learning by its mistakes and not apportioning blame.



....We would like to thank you all for looking after our son. We have never met such kind and devoted people before. We were always met with smiles from you all. Nothing was too much trouble and you made his last days comfortable and as happy as possible. You were always ready to talk to us and help us through what has been a very difficult time.

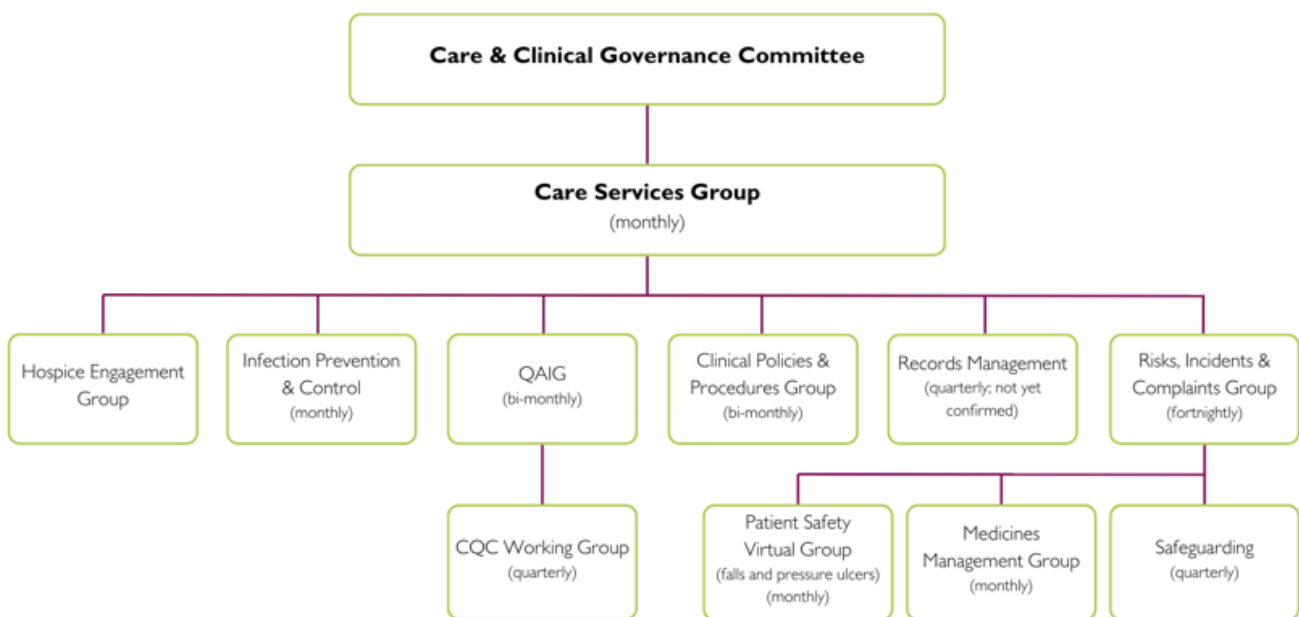
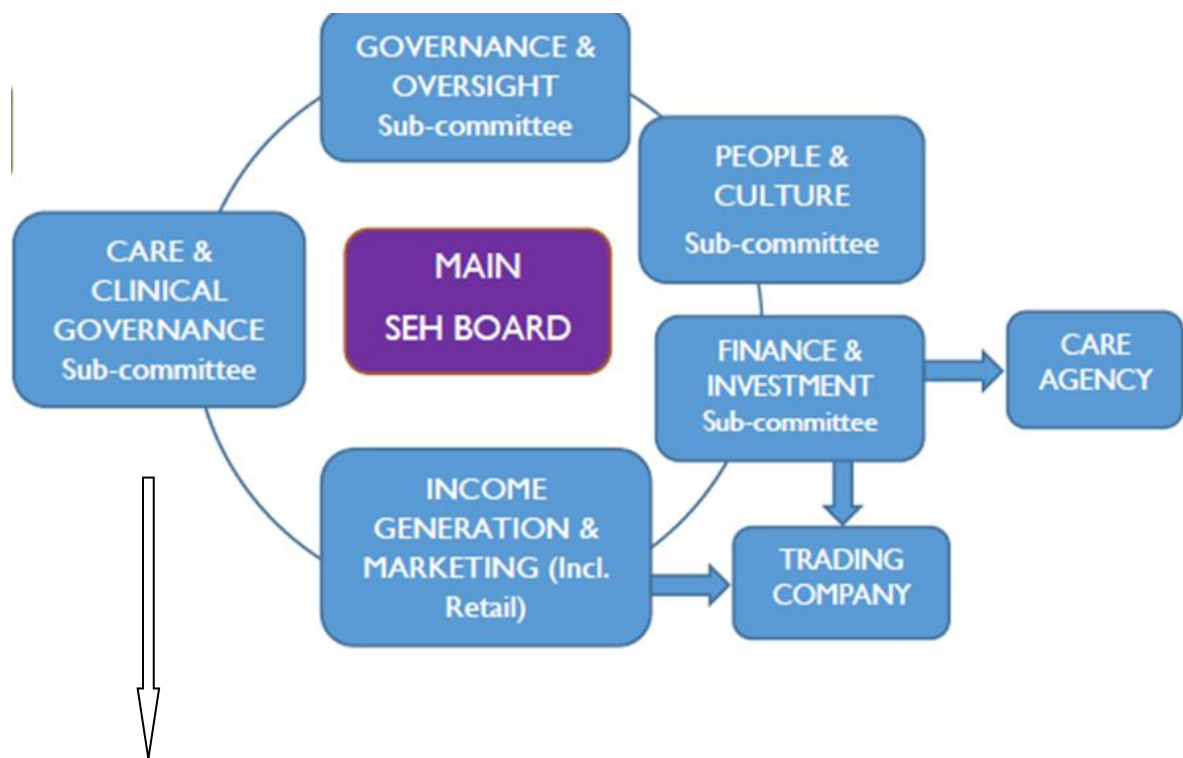
... without exception, every member of the team who either came to see her at home or who we dealt with on the telephone were so kind, caring, helpful, polite and considerate. The staff who attended daily were such a comfort. If we needed to contact someone over any matter, day or night, there was always someone at the end of the line. What a reassurance it all was and what a fantastic team you are.

3.2 St Elizabeth hospice governance

The organisation aims to ensure the overall direction, effectiveness, supervision and accountability of the organisation by putting in place a system and processes to:

- To **lead** the hospice, to establish, review and maintain its Mission, Vision and Values and make sure these are delivered within an overall framework of systems, processes, policies and standards;
- To **develop overall strategy** to achieve the hospice's mission and to make sure there is a clear system to delegate implementation of the strategies to the Chief Executive Officer and the employed staff team;
- To **monitor the performance** of the hospice against key performance indicators which track delivery of the overall strategy so that the hospice's Mission is achieved on a sustainable basis;
- To ensure **compliance with the law** and to ensure accountability to the organisation's stakeholders, in particular regulators, funders, staff, volunteers and the wider community served by the hospice, through the adoption and monitoring of appropriate policies; and
- To ensure **the Board itself performs effectively** and contains people with the skills and experience it needs, and provides for the recruitment, induction and development of new trustees.

St Elizabeth hospice governance structure



Health & Safety & IT feeds into Governance & Oversight Committee.

The Controlled Drug Accountable Officer (CDAO) is also the registered manager with the CQC and a member of the locality intelligence network group. The CDAO (or deputy) monitors controlled drug incidents, makes three monthly incident reports and assesses the arrangements for the safe storage, destruction and use of controlled drugs.

Each directorate has a risk register which is updated regularly. Risk assessments and non clinical incidents are raised at the health and safety group.

The hospice has its own Responsible Officer, Dr Alison Blaken. All doctors are now expected to be appraised on a regular annual basis and then revalidated every five years. All systems and processes are in place to ensure that this happens.

The Caldicott Guardian is Dr Alison Blaken.

3.3. Safeguarding

St Elizabeth Hospice has a Designated Safeguarding Lead (DSL). The Hospice also has dedicated clinical staff who receive additional safeguarding training in order to be safeguarding deputies. All relevant staff have completed online safeguarding and Prevent training modules; Prevent is part of the Government's 'Contest' counter terrorism strategy, which has the aim of and detecting radicalisation. Relevant staff have also been included in face-to-face safeguarding training delivered by the DSL and safeguarding training and updates are formally and informally provided to staff throughout the calendar year. In addition, depending on role, staff are expected to complete additional safeguarding updates and training and provide evidence of continued development and learning in this subject.

Our Safeguarding (Adults) Policy incorporates the Suffolk Safeguarding Adults framework guidelines. Our DSL can support staff to accurately complete Mental Capacity Assessment, Best Interests Decisions, and Deprivation of Liberty Safeguards (DoLs) to ensure safe and timely assessments are completed to ensure safeguarding policies and procedures are adhered to.

We update information across the hospice via emails, noticeboards and other forms of communication to provide up to date information to staff, patients, volunteers, visitors guidance and information on the subject of safeguarding. Our DSL regularly attends handovers and multi-disciplinary meetings across all hospice services to provide support and a safeguarding presence. In addition safeguarding supervision is provided via a member of the Integrated Care Board safeguarding team to the hospice DSL. The DSL has attended training on supervision and is available to provide supervision as and when identified. The DSL attends safeguarding forums within local, regional and nationally as identified to ensure they are up to date with legislation and best practice which is then disseminated within the organisation.

The DSL and Clinical Compliance Lead meet monthly to discuss risks, concerns and policy changes as well as review system one safeguarding documentation and complete any appropriate identified safeguarding audits.

3.4 Compassionate communities

Compassionate Communities care for one another, particularly at times of health crisis and personal loss. They recognise that care in the community is everyone's responsibility.

Compassionate Communities was a new project for St Elizabeth Hospice in 2021 which aims to help our local communities to develop greater confidence to build networks of peer support and to expand upon talking about death more openly.

We are collaborating with other local hospices and community groups to develop a public health approach to death and dying which places communities at the heart of learning and how best to support one another through end-of-life experiences and grief. While also providing resources on the hospice website that offer guidance on how the public can support one another and facilitate the creation of a Compassionate Community.

This means that in the future, communities will be better placed to support one another. Due to the ageing population, we know that the demand for end-of-life services will increase in years to come and the hospice will not be able to support everyone. So building resilience within families and communities will help take some of the load, so that we can focus on helping those needing more complex support.

The project involves working alongside community networks, existing social networks, schools, workplaces and local service providers across East Suffolk, Gt Yarmouth and Waveney. In order to support and champion co-produced solutions that publicly encourage, facilitate, enable and celebrate care for one another during life's most testing moments and experiences.

3.5 Inclusion agenda

St Elizabeth Hospice is a hospice for all.

We believe everyone who accesses St Elizabeth Hospice services should receive outstanding care regardless of their age, race, socio-economic situation, gender, nationality, sexuality, disability or beliefs.

We are actively committed to ensuring we are inclusive and understanding to everyone from all backgrounds.

By building positive strong relationships within our local community, we are helping to improve our services and reduce inequalities for healthcare provision in East Suffolk, Great Yarmouth and Waveney.

We also aim to be a diverse workforce that reflects our local community.

We know we have a long way to go, and we may not always get it right, but we pledge to always make St Elizabeth Hospice a hospice for all.

3.6 Duty of candour

The Duty of Candour was established under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and requires providers to be open and transparent with people who use our services. It also sets out some specific requirements we must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, truthful information, and an apology. St Elizabeth introduced a Duty of Candour procedure in February 2019, and this approach is incorporated into our incident and complaints policies and training. Duty of Candour is also a mandatory section of our incident reporting form, ensuring that all staff reporting an incident must address the issue and report what they have told the patient or carer.

3.7 Freedom to speak up

At St Elizabeth Hospice, we are committed to ensuring that we create an environment where all staff feel empowered to speak up about a range of issues, whether this relates to patient care or anything else that has an impact on their working life.

We want speaking up to become a natural part of our day-to-day culture but recognise that some people may find it harder than others to speak up. To support our speak up culture, we are undertaking a number of initiatives, including strengthening our Freedom to Speak Up Guardian network, raising awareness through regular reminders and communications, and exploring a confidential platform for raising concerns.

We currently have four Freedom to Speak Up Guardians across the hospice, as well as a Trustee lead and Senior Lead who have responsibility for Freedom to Speak Up.

3.8 Mental health first aiders

We are dedicated to fostering an environment where the mental health and wellbeing of all staff are prioritised and openly discussed. We believe that a supportive culture around mental health is crucial for a thriving workplace.

To support this, we have established a network of trained Mental Health First Aiders. These individuals are available to provide a confidential listening ear, offer initial support, and guide colleagues towards appropriate professional help if needed.

We currently have 13 Mental Health First Aiders across the hospice, who have undergone recognised training to equip them with the skills to recognise signs of mental distress and provide early intervention.

3.9 Volunteering at St Elizabeth hospice

Volunteers are vital to the success of the hospice and without them we would not be able to support as many patients or generate as much income. Each month more than 1,600 volunteers fulfil 2,100 shifts; each week they donate approximately 8,400 hours, undertaking a variety of roles across the hospice.

Roles include receptionist, administration, community roles, gardener, retail, fundraising, assisting on IPU. Also work with corporate businesses for volunteering days and offer placements for Work Experience and Duke of Edinburgh schemes to young people.

The volunteers donate 436,800 hours collectively per year.

3.10 Education

Hospice Education is a jointly branded venture between St Helena, St Elizabeth and St Nicholas Hospice Care. It is a shared education department serving the internal needs of all three organisations and providing a range of education opportunities externally. The service comprises a Head of Department, a Team Leader, three Practice Educators, three Clinical Trainers, three Administrators, and two volunteers.

During the year, we have continued to support care homes with the accreditation. We are working closely with 20 care homes across SNEE and will be launching the Care Home Accreditation scheme in West Suffolk in May 2025, hoping to recruit 8 care homes to working with us to improve palliative and end of life skills in West Suffolk care homes.

External commissioned training

We continue to support professional development with bespoke sessions being requested on a variety of subjects including Dementia, mouthcare and pressure ulcers.

We delivered 8 Verification of Expected Death sessions, with 44 staff from external organisations attending the sessions and 43 passing their ViVA competency. Breakdown of delegates were 37 staff from care homes, 8 from the community teams and 1 from primary care.

External free training

We have supported assisted dying – bimonthly learning sessions, 30 on Thursday and some masterclasses.

Core education delivered by St Elizabeth

We deliver several core courses to our own staff and external delegates for a cost. These include:

- Advance Care Planning
- Compassion Satisfaction
- Dementia and palliative care
- End of Life Care for Registered professionals
- Foundations in End of Life Care
- Nutrition, hydration and mouthcare at end of life
- Palliative Care Emergencies
- Personal Care after death
- Syringe Pump
- Sensitive Conversations
- Verification of Expected Death

Apprenticeships

We currently have 7 clinical apprenticeships active, 3 staff from the care agency, 2 from Great Yarmouth and Waveney and 2 from Ipswich.

Study days for clinical staff in 2025

We have secured 41 external training days for clinical staff, which include topics such as

- Palliative and End of Life Care Module Level 7 & Degree Module
- Safeguarding for managers
- Outcome measures for palliative rehabilitation
- Guildford pain & symptom management
- Oxford Advance Pain
- European Certificate in essential palliative care
- Caldicott principles & information sharing in end of life
- Doctors new to clinical supervision
- General medicine for palliative care physicians
- Embark on your consultant career
- Managing lymphoedema
- Preventing falls in older people
- ILM L5

A schedule of topics, speakers and dates has been implemented for registered nurses, clinical support workers and healthcare assistants across all three hospices for 2025. Topics include brain tumours, conflict resolution, dementia care, delirium, EDI, motor neurone disease and PICC and portacath care.

3.11 Quality of the environment

Key projects for the Estates & Facilities team this year have included:

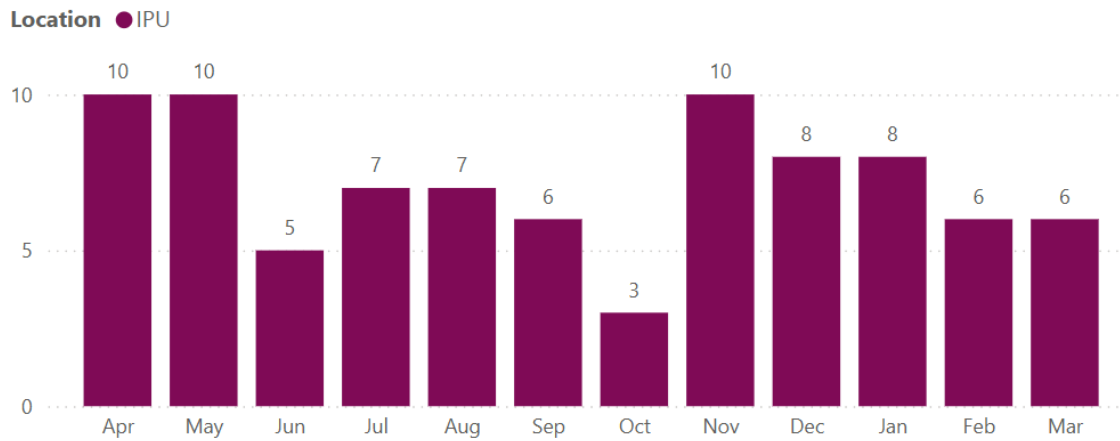
- The Maintenance Team have welcomed several corporate volunteering groups to the hospice, who have contributed valuable time and effort to various projects. Activities included garden improvements, repainting outdoor furniture, maintaining relaxing spaces within the grounds.
- With fantastic support from volunteers, we have redecorated corridors and clinical areas to create a brighter, more welcoming environment. We’ve also refurbished staff changing rooms and toilet facilities, improving comfort and functionality for our teams.
- We have installed new electric vehicle charging points to support patients, visitors, and staff in making more sustainable transport choices.
- Investment has been made in upgrading our laundry facilities, including the installation of equipment to support infection control and to make the hospice processes more resilient.
- Throughout the year, our Estates team has continued with regular water testing, ensuring full compliance with safety standards and maintaining a safe environment for all building users.

3.12 Quality Markers

Falls

Patients are assessed on admission for risk of falls. Suitable low rise beds and chairs are available to reduce risk. There has been 86 falls on IPU this year. All falls are reported via incident forms within 24 hours and were all deemed unavoidable.

Total Falls - East Suffolk



Resulted in:

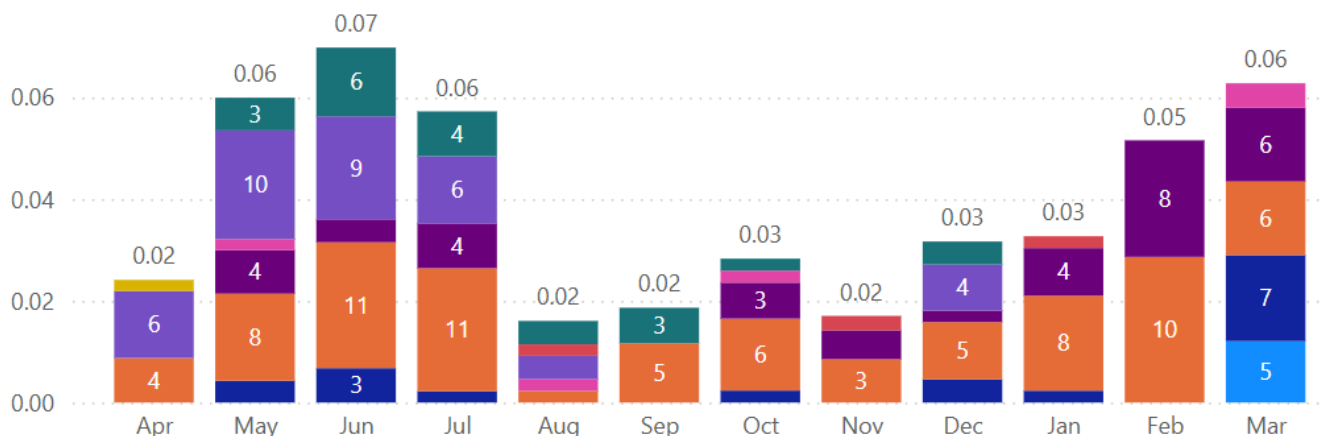
- No falls were reported to CQC.
- None were classified as Severe Harm/Death to Hospice UK Benchmarking
- During 2024 the call bell system on IPU was upgraded and is now compatible with falls equipment ie falls mats which are now in use.
- A new Falls Lead role with dedicated time set aside.
- Fall incidents are now discussed and signed off at the Incident, Risk & Complaints Group meeting

Pressure ulcers

Patients are assessed on admission for pressure ulcers. An incident form will be raised when staff discover an ulcer, whether on admission or developed during their stay. A care plan will then be produced.

IPU Pressure Ulcers per OBD - East Suffolk

Category (Blank) 1 2 3 4 DTI Medical Device Pressure R... Moisture Associate... Unstageable



Pressure Ulcer incidents are discussed and signed off at the Incident, Risk & Complaints Group meeting.

Resulted in:

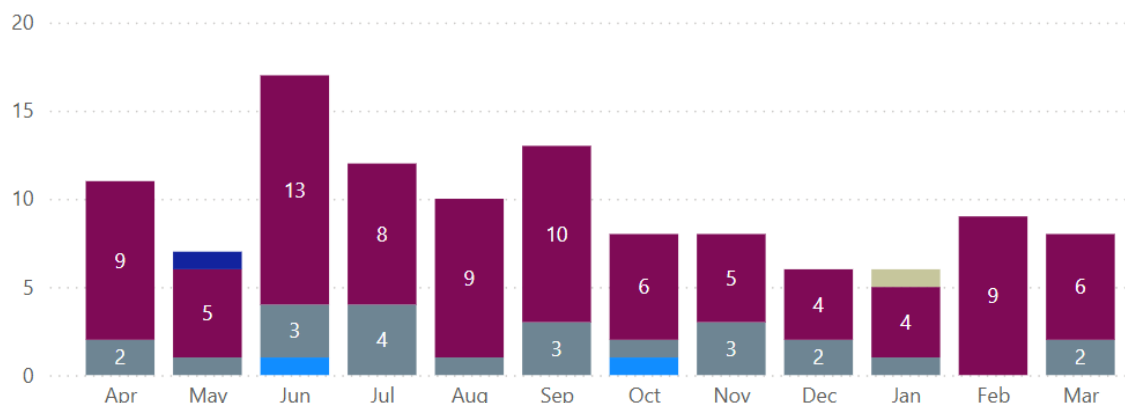
- 29 Pressure Ulcers were reported to CQC.
- None were reported for Severe Harm/Death to Hospice UK Benchmarking

Medicines Management Group (MMG)

The MMG meets monthly to assure there is a comprehensive framework in place to ensure the safe management of medicines at St Elizabeth Hospice. All medicine errors have an incident form raised and are investigated.

Total Drug Incidents - East Suffolk

Total Drug Incidents - East Suffolk by Care Unit Community IPU Outpatients Virtual Ward



Resulted in:

- None reported to CQC.
- None classified at Level 4 (severe) or Level 5 (fatal) to Hospice UK Benchmarking

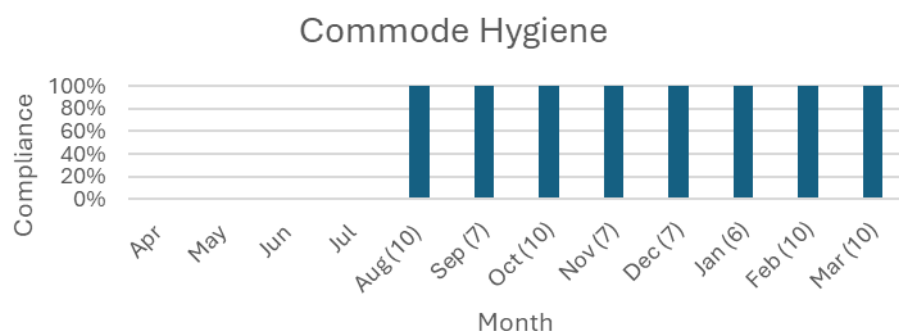
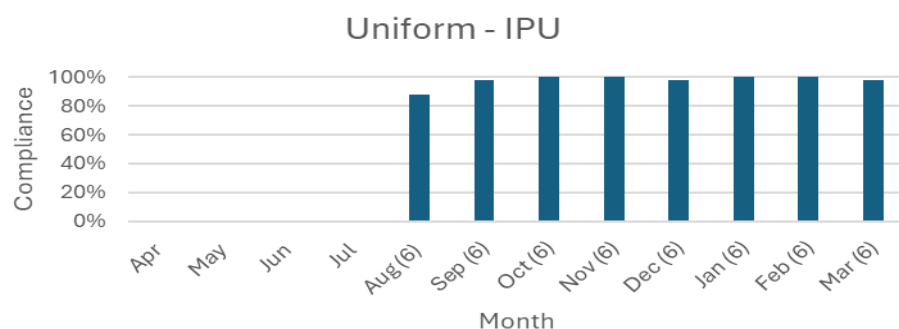
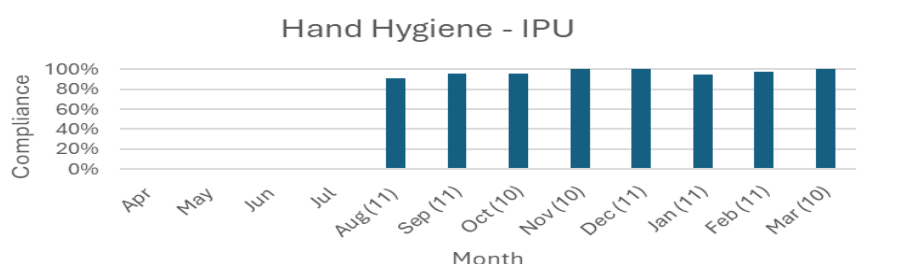
Our Controlled Drugs Accountable Officer (CDAO) reports our controlled drug errors quarterly to our Local Intelligence Network.

Infection Prevention & Control

During 2024 the hospice introduced a revised programme of infection prevention and control audits. Monthly audits are reported to the IPC Group and include:

- Hand Hygiene
- Uniform audit
- Commode cleaning
- High Impact Interventions (Catheters, Cannulas, Central Venous Access Devices)
- Cleaning Audit
- Laundry Dip slides
- Mattress Checks

These results are shared at the monthly IPCG meeting. Examples below:

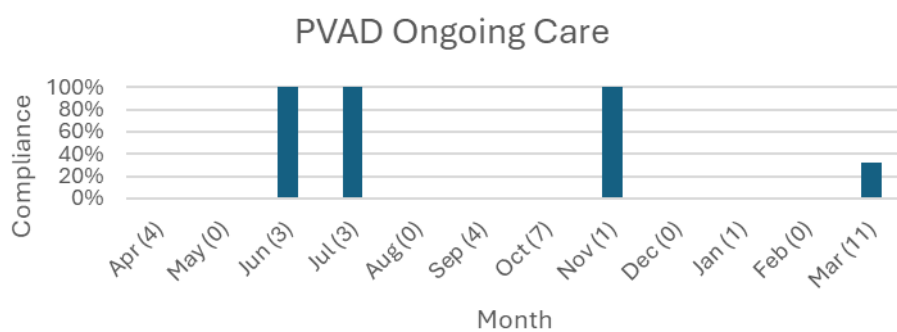
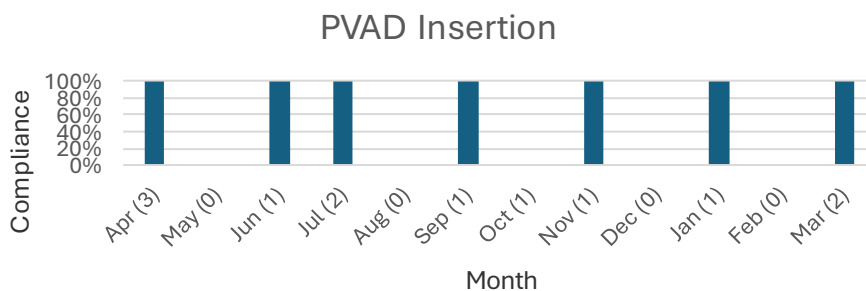
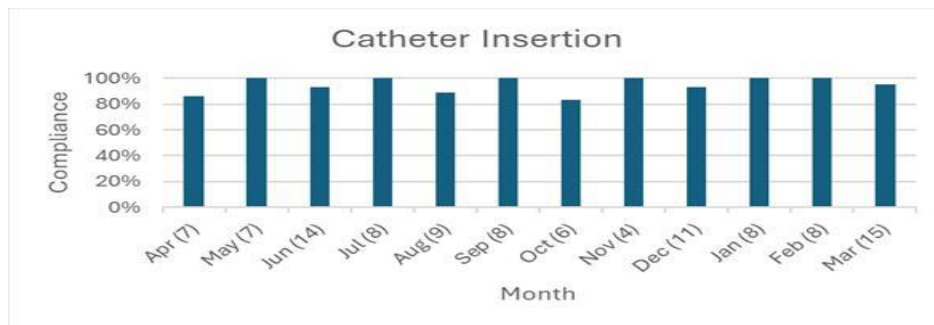


Infection Surveillance

Infection surveillance is a key component of infection prevention. The IPC Group monitors Meticillin Resistant Staphylococcus Aureus (MRSA) Bacteraemia, Meticillin Sensitive Staphylococcus Aureus (MSSA) Bacteraemia, Clostridioides Difficile (previously Clostridium Difficile), Extended Spectrum Beta-Lactamase Producing Organisms (ESBL), Vancomycin-Resistant Enterococcus (VRE), Carbapenem –Resistant Enterobacteriaceae etc

There were no reported healthcare-associated infections this year.

High Impact Interventions – Prevention of Urinary Catheter Care Infections

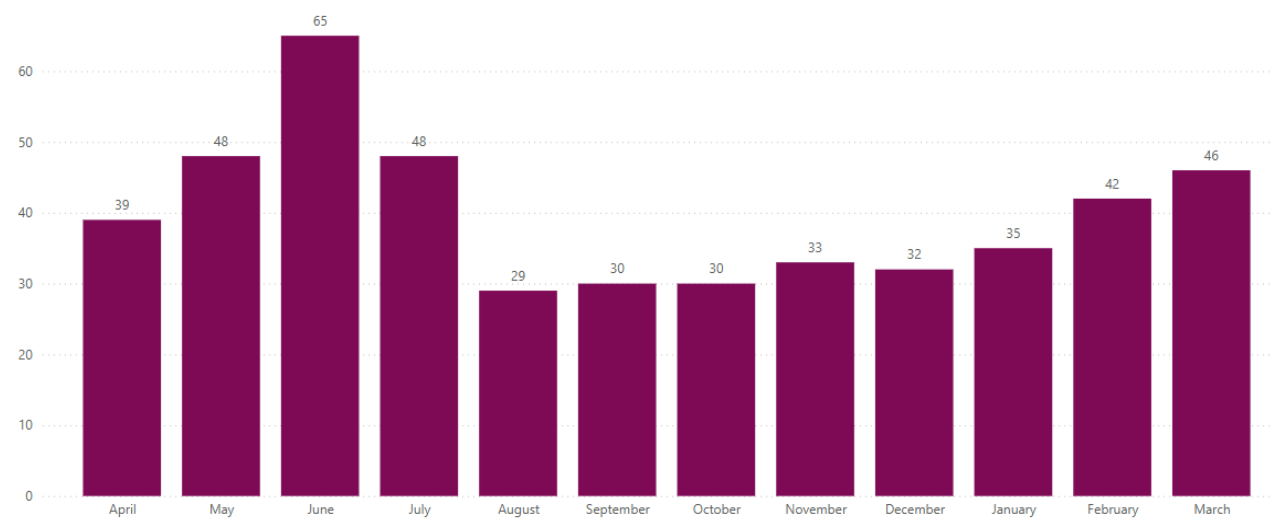


Resulted in:

- Highlighting the need for our electronic SystemOne processes for Peripheral Vascular Access Devices (PVAD) and Central Venous Access Devices (CVAD) to be reviewed. Currently, SystmOne is not set up to capture the information needed, so, to review our SystmOne processes, we aim to improve the results of these audits.

3.13 Risk and incident

Total Patient Safety Incidents – April 2024 – March 2025
(excluding Health & Safety, Information Governance & Safeguarding)



All incidents in respect of patients, families and staff are logged onto Vantage, an electronic online system. From where investigations are carried out by a senior member of staff and actions are raised. The hospice uses the Patient Safety Incident Response Framework (PSIRF). The actions and any learning are reviewed by IRC Group.

3.13.1 Information governance

St Elizabeth Protection Officer (DPO) works across the organisation to ensure that we are fully compliant with the UK General Data Protection Regulation, the Data Protection Act 2018, and the Privacy and Electronic Communications. We will assess all new projects involving personal data using Data Protection Impact Assessments (DPIAs)

In addition to having a DPO, our Medical Director serves as our Caldicott Guardian, tasked solely with ensuring the protection and proper handling of patient information.

During this year we have logged 48 incidents. Investigations are carried out and actions are raised. The actions and any learning are reviewed by IRC Group.

3.13.2 Data security and protection toolkit

The NHS Digital Data Security and Protection Toolkit submission for 2023-24 status - Standards Met. The 2024/25 submission is due by 30th June.

3.14 Complaints and compliments

We received 20 complaints throughout the year Apr 24 – Mar 25 covering all patient services. In addition, there were 3 Income Generation & Marketing complaints and 14 retail complaints. No complaints went to the Ombudsman in 2024.

Of the 20 clinical complaints received, all were investigated and responded to as per our complaints policy.

Complaints were from across all of our sites including East Suffolk inpatient unit, East Suffolk Community, Great Yarmouth and Waveney (GYW) Community, administration and emotional wellbeing (EWB).

7 complaints were regarding East Suffolk inpatient services, 6 regarding East Suffolk community, 2 for GYW, 1 for EWB, 1 for admin, 2 which involved both St Elizabeth Hospice (SEH) and East Coast Community Healthcare (ECCH) and 1 which related to all clinical services.

The complaints which involved both SEH and ECCH were investigated jointly and 'after action' review meetings were arranged to get all staff from both areas together to discuss and review the issues of the complaints. Face to face meetings were offered and arranged according to the wishes of the complainants and followed up with written responses.

All complaints had the learning actions recorded and have been monitored and followed up by the Incident, Risk and Complaints Group (IRCG) as per St Elizabeth Hospice Governance structure.

The main themes for complaints were: communication, support / symptom management, expectations of service and out of hours support. In response to complaints, SEH are making changes to processes as appropriate, a task and finish group has been set up to look at standards for reactive one calls, standard operating procedures are being reviewed and the outcomes of all complaints are disseminated across teams for shared learning.

In the same period, we received 282 compliments, covering all patient services, retail, volunteers and support staff. A few extracts have been added to this Quality Account.

3.15 Who has been involved in the QA?

- Chief Executive Officer
- Senior Leadership Team
 - Director of Care
 - Medical Director
 - Chief Operating Officer
 - Director of Income Generation
- Senior Management Team Members
- Quality Assurance and Improvement Group
- Governance & Oversight sub-committee
- Care and Clinical Governance sub-committee
- Board of Trustees

3.16 What others say about St Elizabeth Hospice

Feedback received following care on our Virtual Ward

...I am writing this on behalf of myself my sister and mum for the care and compassion shown to my Father during his last week of life. My beloved dad was diagnosed with a brain tumour on 14th March and was given only a few months to live. Dad's wish was to come home and with the commitment of myself, sister and mum we made this possible.

It was a tough journey at times, but one I wouldn't change. Dad deteriorated very rapidly over a week ago and the hospice HCA's came in to support us. I can't thank them enough for all the care and support they gave my beloved Dad, mum, sister and I during dad's last week of life. They are all fantastic at what they do and provide an amazing service for families at their most difficult time.

Losing a loved one is devastating and having them come in to provide care in the home is lifesaving. Each and every one of these ladies that work within this service are truly wonderful. My mum has just said that each one of them are actually 'Angels.'

Could you please pass on my heartfelt thanks from us all.

Thank you received after care received on the virtual ward.

...I want to express my heartfelt thanks to your organisation, especially your amazing team of community healthcare assistants. Sadly, my dad suffered a severe stroke and it has always been his strong wish to pass peacefully at home with his family. The hospital were arranging discharge within a day but it was only your ability to react almost immediately and offer personal care at home that made it possible for his wishes to be respected. I think the hospital requested your help at lunchtime and you agreed and organised care from that evening. Your team were so caring, respectful and kind to dad as well as all of us. They offered support and practical advice and were truly outstanding. When the CHC funding came through 4 days later your team were brilliant in offering and organising to continue to care for dad through until the end which sadly was the next morning. Having been in touch with the private care provider the contrast with your team's professionalism, true understanding of end of life needs and genuine care was marked.

It was only because of your ability to react so quickly and appropriately, that dad was able to come home at a point when he could recognise and appreciate that he was home. He also received the most outstanding and considerate care from all your team. I cannot thank you enough.

Email from a CNS following a bereavement visit.

..C had been known to the hospice for many months. Over recent weeks there has been a clear global decline, she has since had a more rapid decline in the last week and significantly the last 24/35 hours. Julie kindly visited last evening to commence a CSCI and C died very peacefully this morning with J and sister in law at her side. J wanted me to pass on his huge gratitude to all that had supported both him and C over this difficult time. He stated that he will be forever grateful for all the kindness, comfort and support he has encountered over his numerous contacts with OneCall and face to face visits.

Feedback from care home

..Last offices carried out this evening for J. The family have asked us to pass on their appreciation for all the support we have shown to J and the family throughout. The daughter from New Zealand also wanted to thank the person/people she spoke to on Monday afternoon who even called her back whilst she was still in New Zealand and said this was above and beyond so thank you.

Care Quality Commission Inspection Report

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

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

- Services were delivered in a way to ensure flexibility, choice and continuity of care and were tailored to meet patients' individual needs and wishes. The service planned and provided care in a way that fully met the needs of local people and the communities served. It also worked proactively with others in the wider system and local organisations to plan care and improve services.
- Leaders ran services well, led innovations and supported staff to develop their skills. Staff understood the vision and values, and how to apply them in their work. Staff were motivated to provide the best care they could for their patients. There was a common focus on improving the quality and sustainability of care and people's experiences.

- Staff were proud to work at the service and felt respected, supported and valued. Leaders operated effective governance processes and staff at all levels were clear about their roles and accountabilities. The service engaged well with patients, staff and the local community.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

We found areas of good practice:

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

However:

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

3.4.1 Statements provided from Suffolk Health Scrutiny Committee, Healthwatch and NHS Suffolk & North East Essex ICB



Suffolk Health Scrutiny Committee

As has been the case in previous years, the Suffolk Health Scrutiny Committee does not intend to comment individually on NHS Quality Accounts for 2024-25. This should in no way be taken as a negative response. The Committee acknowledges the ongoing engagement and contributions made by the NHS to the work of the Committee and wishes to place on record our thanks for everything being done to maintain NHS services for the people of Suffolk.

A handwritten signature in cursive script, appearing to read "Jessica Fleming".

County Councillor Jessica Fleming
Chairman of the Suffolk Health Scrutiny Committee

Healthwatch Suffolk (email dated 3.6.25)

Thank you for getting in touch with us and for inviting Healthwatch Suffolk to contribute towards your Trust's Quality Account.

Sadly we have very little in the way of public feedback on what St Elizabeth Hospice has provided during 2024/25. We are therefore not in a position to offer a constructive and evidenced statement.

Andy Yacoub
CEO
Healthwatch Suffolk CIC



St Elizabeth Hospice Annual Quality Account

Date: 18 June 2025

The Suffolk and North East Essex (SNEE) Integrated Care Board (ICB) confirm that St Elizabeth Hospice have consulted and invited comment regarding the Annual Quality Account for 2024/2025. This has been submitted within the agreed timeframe and SNEE ICB are satisfied that the Quality Account provides appropriate assurance of the service.

SNEE ICB have reviewed the Quality Account and the information contained within the Quality Account is reflective of both the challenges and achievements within the organisation over the previous twelve month period.

SNEE ICB look forward to working with clinicians and managers from the service and with local service users to continue to improve services to ensure quality, safety, clinical effectiveness and a good service user experience is delivered across the organisation.

This Quality Account demonstrates the commitment of St Elizabeth Hospice to provide a high quality service.

A handwritten signature in black ink, appearing to read 'L Nobes'.

Lisa Nobes
Chief Nursing Officer
Suffolk & North East Essex Integrated Care Board

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A blue hexagonal shape with rounded corners containing the text for St. Elizabeth Hospice.

St. Elizabeth Hospice

565 Foxhall Road,
Ipswich, Suffolk,
IP3 8LX

A purple hexagonal shape with rounded corners containing contact information for feedback.

If you have any feedback on
this document, please email
our enquiries line on
enquiries@stelizabethhospice.org.uk
or visit our website
stelizabethhospice.org.uk
and complete our form for
comments, compliments or
complaints, which is found
in the contact us section.