

St Peter and St James Charitable Trust







Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Good	
Are services safe?	Good	
Are services effective?	Good	
Are services caring?	Good	
Are services responsive?	Good	
Are services well-led?	Good	

Summary of findings

Letter from the Chief Inspector of Hospitals

Services we rate

Our rating of this hospice stayed the same. We rated it as **Good** overall.

We found the following areas of good practice:

- The service had effective infection control procedures. Staff had access to and used protective personal equipment such as disposable gloves and aprons. This meant staff and people they supported were protected from potential infection during the delivery of personal care.
- Medicines were managed safely, and people received their medicines when they should.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff were dedicated to making sure patients received the best individualised patient-centred care possible, at the end of their life.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs. People's emotional and social needs were highly valued by staff and are embedded in their care and treatment.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service if possible included patients in the investigation of their complaint.

We found an area of outstanding practice:

- The hospice had three audio biographers who captured the patients' life stories and helped preserve valuable memories for their loved ones to listen to after their passing.

However, we found an area of practice the requires improvement:

- Although safeguarding children training was provided, it was not provided with equal weighting to that of adult safeguarding in line with national guidance.

Dr Nigel Acheson

Summary of findings

Deputy Chief Inspector of Hospitals (London and South)

Overall summary

St Peter and St James Charitable Trust is operated by St Peter and St James Charitable Trust in Lewes, East Sussex. The hospice primarily serves the communities of Haywards Heath, Lewes, Burgess Hill and Uckfield the surrounding rural villages.

Summary of findings

Our judgements about each of the main services

Service

Hospice services for adults

Rating

Good



Summary of each main service

We rated this service as good because it provided a safe, effective, caring responsive and well led service.

Summary of findings

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Good 

St Peter and St James Charitable Trust

Services we looked at

Hospice services for adults

Summary of this inspection

Background to St Peter and St James Charitable Trust

St Peter and St James Charitable Trust is operated by St Peter and St James Charitable Trust. It is a private hospice in Lewes, East Sussex. The hospice primarily serves the communities of Haywards Heath, Lewes, Burgess Hill and the surrounding rural villages.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and a specialist advisor with expertise in hospice services. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

Information about St Peter and St James Charitable Trust

The hospice is registered to provide the following regulated activities:

- Accommodation for persons who require nursing or personal care
- Diagnostic and screening procedures
- Treatment of disease, disorder or injury

During the inspection, we visited the inpatient unit, the Beacon View Wellbeing Centre, the mortuary room and the sanctuary. The hospice also provides care at home as part of the community services. We spoke with 26 staff including registered nurses, reception staff, housekeepers, fundraisers, medical staff and trustees. During our inspection, we reviewed three sets of patient records.

There were no special reviews or investigations of the hospice ongoing by the CQC at any time during the 12 months before this inspection. The hospice has been inspected once, and the last inspection took place in December 2014.

Activity (October 2018 to October 2019)

- There were 366 people using the hospice's services at the time of the inspection.

Track record on safety

- Three hundred and sixty six deaths.
- One serious injury
- No never events
- No incidences of healthcare acquired Meticillin-resistant Staphylococcus aureus (MRSA), Meticillin-sensitive staphylococcus aureus (MSSA), Clostridium difficile (C.diff) or E-Coli
- 166 compliments
- Six complaints

Services accredited by a national body:

- Hospice UK – organisation wide
- National Council for Voluntary Organisations- Organisation-wide

Services provided at the hospice under service level agreement:

- Clinical and or non-clinical waste removal
- Consultant Nurse in Infection Prevention
- Interpreting services
- Maintenance of medical equipment
- Medical on call provision

Summary of this inspection

- Medical staff revalidation
- Pathology and histology
- Pharmacy service

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Are services safe?

Good



Our rating of safe stayed the same. We rated it as **Good** because:

- Staff recognised incidents and reported them when needed to. Managers investigated incidents and shared lessons learned with the team and the wider service.
- The service-controlled infection risks within the department. Staff kept equipment and premises visibly clean. The service used appropriate control measures to prevent the spread of infections
- The service employed staff with the right qualifications and skills to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
- Patient records were clear and up to date, that included all key information, staff kept up to date records of patients' care and treatment.
- The service prescribed and stored medicines in line with local and national guidelines. Documentation around medications was consistent, documents and temperatures for the storage of medicines was recorded appropriately.
- The service had systems in place to recognise and respond to deteriorating patients' needs and clinical risks.

Are services effective?

Are services effective?

Good



Our rating of effective stayed the same. We rated it as **Good** because:

- Staff met patients' nutrition and hydration needs.
- Staff had the skills, knowledge, and experience to deliver safe care and treatment. Staff were appraised annually.
- Staff assessed and managed pain on an individual basis and regularly monitored this throughout patient care.
- The multidisciplinary team worked well together to support patients holistically; doctors, nurses and other healthcare professionals supported one another to provide good care.

Are services caring?

Are services caring?

Good



Our rating of caring stayed the same. We rated it as **Good** because:

Summary of this inspection

- Staff cared for patients with compassion and respect. Patients' feedback and those close to them throughout our inspection was positive.
- Patients' emotional and social needs were considered as important as their physical wellbeing.
- Patients who used the service and those close to them were active in their care and treatment.

Are services responsive?

Are services responsive?

Our rating of responsive stayed the same. We rated it as **Good** because:

- Patients' needs, and their preferences were considered and acted upon to ensure services were delivered and accessible in timely manner. The service planned and delivered services to meet the needs of people using the service.
- Patients concerns, and complaints were investigated, lessons were learned from complaints and shared with all staff, all complaints were dealt with in a timely manner.

Good



Are services well-led?

Are services well-led?

Our rating of well-led improved. We rated it as **Good** because:

- Leaders had the skills and abilities to run the hospice. They understood and managed the priorities and issues the service faced. Leaders were visible and approached to patients and staff.
- Staff engaged well with patients, staff, and the public and local organisations to plan and manage appropriate services and collaborated with other similar services effectively.
- There was a well-established governance structure and staff of all levels were clear about their responsibilities.
- Staff were committed to learning and improving the service. They had a good understanding of quality improvement.
- The hospice actively engaged with patients, staff, the community and local organisations to plan and manage services. They collaborated with partner organisations to help improve the service.

Good








Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Hospice services for adults

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

Are hospice services for adults safe?

Good 

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

Mandatory training

The service provided mandatory training in key skills to all staff and monitored the compliance with training.

- All staff had undertaken a wide-ranging mandatory training programme to equip them with the skills required to perform their role. Mandatory training modules included manual handling, infection control, data protection, fire and health and safety.
- Modules were identified separately for clinical and non-clinical staff. Information we received from the hospice showed mixed compliance with training. The hospice's compliance target was 80% and we noted clinical staff were achieving this in 12 out of the 17 modules available. Non clinical staff had achieved 80% or higher in seven out of 10 applicable modules.
- Most training was completed online except for safeguarding which was completed through face-to-face training. All staff and volunteers were expected to comply with the mandatory training schedule. Line managers monitored compliance regularly and reported quarterly to the quality and safety committee and board.

Safeguarding

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

- The hospice had separate safeguarding policies for adults and children, which outlined staff responsibilities regarding raising and reporting concerns to the appropriate persons and authorities. The hospice had a safeguarding lead supported by an organisation-wide team of level 3 trained designated officers and a nominated trustee with safeguarding responsibilities.
- All clinical staff including volunteers received level 2 safeguarding training. New staff undertook an interactive adults and children safeguarding course as part of their induction. Staff we spoke with told us they had received safeguarding training. They were knowledgeable about different types of abuse and told us they would escalate concerns to the senior member of staff on duty or a safeguarding officer. This was in line with the hospice's policy.
- Data showed that 90% of clinical staff and 80% of non-clinical staff had completed training in level 2 adult and children safeguarding. Training combined both vulnerable adults and children however, the registered manager told us the children's aspect of the training was not given in great depth, which was not in line with national guidance. The intercollegiate document 'Safeguarding Children and Young People; Roles and Competencies for Healthcare Staff (fourth edition: January 2019) states that organisations that integrate child and adult safeguarding training must

Hospice services for adults

give equal weighting to both adults and children safeguarding and demonstrate they have provided education, training and learning covering all elements of both adult and child safeguarding.

- The guidance stated that all staff including non-clinical staff who have contact with children, young people and/ or parents/ carers should be trained to level two safeguarding children and young people. The hospice did not carry out the regulated activity of caring for children and young people however, they provided counselling services to this group of people (with support from level 3 trained staff) and allowed them to visit relatives who were inpatients at the hospice.
- The hospice displayed safeguarding leaflets on noticeboards. The leaflets had a flowchart of actions to take and included contact information for the safeguarding lead and the designated officers.
- There was a safeguarding review group chaired by the chief executive officer (CEO) which met every two months. The group aimed to promote safeguarding discussions, shared concerns and learn from any safeguarding issues.
- The hospice required all staff to comply with Disclosure and Barring Service (DBS) checks as part of the recruitment process before working for the organisation to reduce risks to patients. We reviewed three staff files, and all had a DBS check based on a risk assessment of their role.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection.

They kept equipment and the premises visibly clean.

- Infection prevention and control was supported by policy, procedure, and audit. These reflected best practice guidelines. Staff had access to the infection prevention and control policy online. The policy outlined effective handwashing, clinical waste, protective clothing, spillages and sharps management. The registered manager was the infection control lead for the hospice.
- Staff received the infection prevention and control training as part of their mandatory training. Records showed a compliance rate of 93% and 88% for clinical and non-clinical staff respectively meeting the hospice's target of 80%.
- The hospice had a service level agreement with an infection prevention nurse consultant who attended the infection prevention working group. They worked closely with the hospice to introduce new standard operating procedures that reflected current guidance for Meticillin-resistant Staphylococcus aureus (MRSA), Clostridium difficile (C.diff), management of deceased person with known infection.
- The hospice had effective arrangements to prevent the spread of infection when caring for patients who had died. Systems ensured deceased patients left the inpatient ward in a timely and dignified way and any risks of cross infection were appropriately managed.
- Staff adhered to best hand hygiene practices. We observed staff throughout our inspection washing their hands and using hand sanitiser at before and after patient contact and when moving from one area of the hospice to another.
- The hospice carried out annual infection prevention audits. The last audit was undertaken in November 2019. The audit assessed the hospice in 14 sections including but not limited to environment, equipment, waste and hand hygiene. All sections were rated red, amber and green with red showing poor compliance and green being compliant. The service was not compliant in nine of the 14 sections including general environment safety and cleanliness, hand hygiene. An action plan had been drafted to respond to the concerns raised. We noted during our inspection the hospice had taken action to address areas of poor compliance.
- In the Patient-Led Assessment of environment (PLACE) 2019 for cleanliness, St Peter & St James achieved a score of 96%, this was similar to the national average of 99%.
- During our inspection we saw posters displayed with generic information on corona-virus. The registered manager had sent all staff an email with the Department of Health update. The current situation

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was discussed at a staff huddle we attended, and staff were given a list of critical staff to contact in case it was required. Advice had been sought from the infection prevention nurse consultant.

- The hospice reported no incidence of healthcare acquired infection in the 12 months before our inspection.

Environment and equipment

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

- The hospice had 14 beds, a medicines room, a mortuary, paddocks and a woodland walk with a pond.
- The hospice appeared clean and free of clutter and the grounds were well maintained.
- Clinical areas were located on the ground floor of the premises and all hospice rooms had patio doors which opened onto a paved area with views of the South Downs. The rooms in the in-patient unit were single occupancy and had en-suite facilities.
- The hospice had access to a team responsible for maintaining the building and the grounds. A maintenance and repairs log was displayed near the reception area and was accessible to all staff. We reviewed the log sheet and noted most jobs were completed within two days of being reported. Staff told us the maintenance team were very responsive and fixed equipment promptly.
- Maintenance arrangements for electrical equipment were identified electronically. The hospice had an asset register and maintenance log. We saw that medical equipment was checked and serviced in line with manufacturers' guidance. Syringe drivers were serviced annually. Portable electrical equipment had been serviced and tested within the last year.
- Emergency equipment checks were generally completed weekly in accordance with the hospice's policy. We saw records showing that staff had completed checks however, the checklist was not itemised therefore it was unclear what had been checked.

- There were suitable arrangements to promote security of equipment, medicines, patients and staff. The building was secure, and access was restricted with the use of keypad locks and the codes were changed monthly. All visitors and volunteering staff signed in at the main reception. Storage rooms were accessible to staff by a secure key pad entry. For example, the rooms which held medicines and cleaning equipment were secured to prevent unauthorised access.
- The hospice had clinical waste disposal arrangements throughout the hospice. People had access to bins that were clearly labelled, clinical waste or domestic waste. Bins were lidded and operated with a foot-pedal in clinical areas and toilets to prevent hand contamination.
- We looked at sharps bins and saw that staff observed good practice while disposing of sharps. They ensured the date of opening the bin was recorded and sharps bins were disposed of before they became too full.
- Fire safety training formed part of the mandatory training programme. Records showed a compliance rate of 89% and 93% for clinical and non-clinical staff respectively meeting the hospice's target of 80%.
- The location had appropriate fire equipment, including fire doors and fire extinguishers. Fire exits were clearly signposted throughout the building to the muster point. We checked six fire extinguishers during the inspection and found all had been serviced in the last 12 months.
- Staff were aware of the evacuation procedure which involved evacuating patients at highest risk first. A fire drill had been carried out recently to ensure all staff understood the process.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

- Staff completed care plans when admitting patients and these included falls, nutrition and hydration and waterlow (an estimated risk for development of pressure sores) score. Care plans were reviewed routinely and as required when a patient's condition changed.

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- Patients who deteriorated while on the inpatient unit and were identified as being appropriate for escalation to hospital transfer, or patients who had been previously discussed by the medical and nursing team regarding 'ceilings of treatment' were transferred to the local NHS trust by emergency ambulance.
- There were arrangements to transfer patients supported by the community clinical nurse specialist (CNS) team to the hospice if they became acutely or suddenly unwell during a visit. The CNS discussed hospice admission with the patient and/or next of kin and with the medical and senior nursing team at the hospice to make the required arrangements for transfer. If necessary, an urgent GP visit was also requested.
- People who became acutely unwell while attending the Wellbeing Centre were reviewed by an on-site doctor, depending on the nature of the situation, if required, staff told us they would immediately call 999.
- The hospice had responded quickly to the corona virus outbreak. After our inspection the hospice followed government advice relating to physical distancing and avoiding non-essential travel and had stopped all visitors attending, except in exceptional circumstances with agreement from ward manager to prevent exposing patients to potential risks.

Staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix .

- The hospice had 40 nursing and allied health professionals, 20 healthcare assistants and 95 supporting staff on a combination of full time, part time and bank contracts.
- The inpatient unit nursing and care leadership team comprised of one nurse manager and two team leaders. They were supported by a team of registered nurses and healthcare assistants (HCAs).
- In the inpatient Unit (IPU), the hospice had adapted a nationally recognised safer staffing tool to sense check their approach to safe staffing levels. This enabled them to calculate time out required for annual leave, study leave, sickness rates, and to take into consideration the layout of the inpatient unit (all the rooms were single occupancy with no bays), and the time required to care for people after death. The hospice had recently purchased an establishment tool endorsed by NICE, to further develop work on their staffing levels and shift times.
- The registered manager said this work had been helpful to determine the safe minimum staffing levels required overnight or during winter months/adverse weather conditions, when anticipating staff having difficulty getting to work. The IPU nurse manager was not counted in staffing numbers routinely but worked clinical shifts both planned and at short notice if required to cover absence.
- The community team consisted of 5.2 full time equivalent clinical nurse specialists led by the head of community services. The team provided expert support and advice to people, and those important to them, at home or in residential accommodation.
- The service was provided seven days per week with one clinical nurse specialist (CNS) on duty at weekends and bank holidays except for Christmas Day. The four full time CNSs worked nine days over a fortnight, two part time CNSs worked eight days over three weeks and one staff nurse for the team worked seven days over a fortnight. This ensured there were suitable service provisions and that team members had sufficient time away from their work.
- The Beacon View Wellbeing Centre would normally be staffed by one registered nurse and one healthcare assistant, both of whom would be on part time contracts. Both posts were currently vacant, and the hospice were actively recruiting to both posts. In the meantime, in order to keep the centre open and to be able to continue to support people therapeutically, a bank registered nurse was employed on a six-month contract and they were using bank healthcare assistant as well as some agency staff when necessary.

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- Patient numbers and complexities were closely monitored informally at the caseload review meetings and through staff one-one meetings to ensure there were enough staff available to provide the community service.
- The hospice had a lone working policy due for review in September 2021. Communication was shared amongst staff relating to potential risks and risks assessments were completed to ensure staff and patients were kept safe.
- St Peter & St James had a contract with a local agency and used staff from this agency when required. From November 2018 to October 2019, 187 hours of nursing cover and 1,932 of healthcare assistant cover had been provided by agency staff. The hospice used the same agency staff for consistency for people to continue to feel safe and supported.
- Between April 2019 and October 2019, the hospice reported a sickness rate of two percent for nursing staff, healthcare assistants and other staff.
- The hospice had 442 volunteers who were also involved in providing complementary therapies, counselling, befriending, welfare and support with Wellbeing Centre therapeutic activities under supervision of substantive staff.

Medical staffing

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

- The hospice employed two accredited specialist doctors in palliative medicine: a medical director who worked full time, providing seven sessions for the hospice and a part time consultant in palliative medicine working five sessions at the hospice.
- There were three part-time specialty doctors providing 15 sessions between them.
- The medical team attended the daily admissions meeting, a community team meeting to review new referrals and any complex issues and a ward handover meeting followed by a daily ward round with the

inpatient unit staff. They also attended a morning safety huddle as well as a clinical update at the end of the day to ensure clear communication within the clinical team.

- The medical team provided a two-tier on-call rota for out of hours, weekends and bank holidays, supporting the inpatient unit and the community service. First on-call response was provided by the three contracted specialty doctors plus an additional three doctors who were employed on a bank basis. This covered all out of hours, overnight and weekend work.
- The on-call doctor attended the hospice on a Saturday morning to undertake a ward round and check in with the clinical nurse specialist on duty regarding any issues requiring medical input. They provided telephone advice as well as attended the hospice for medical reviews or admissions. The first on-call doctor was supported by a consultant second on-call service.

Records

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

- The hospice had a records management policy. This outlined the responsibilities of staff in relation to record keeping, storage, handling and security of records and referenced The Records Management: NHS Code of Practice and Royal College of Physicians - Generic medical record keeping standards.
- We reviewed three sets of patient notes and found they contained comprehensive and person-centred care plans which clearly identified patients' emotional, social and spiritual needs alongside their physical health needs. Staff completed care plans appropriately and we saw they recorded when care was carried out in line with the care plan. Staff reviewed care plans weekly or when a patient's circumstances changed.
- Staff could access patient specific information from the care plan which included information on communication, psychological and mental health and end of life care. All care records contained a 'This is me' document that detailed the patient's needs and

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preferences and took account of any additional needs such as dementia and behavioural needs. This was completed in all care records we reviewed and demonstrated the involvement of the patient.

- The hospice used both electronic and paper-based systems to record patient care. The information needed to deliver safe care and treatment was available to staff in a timely and accessible way. For example, hard copies of care plans for moving and handling and continuous subcutaneous infusion charts were kept at the patient's bedside.
- We reviewed the records of one patient on an end of life care plan. The records were holistic and appropriate, focusing on comfort such as good mouth care, pain relief and family support. The end of life care plan included organ donation as well as contact details and a spiritual assessment.

Medicines

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

- Medicines management was part of the mandatory training programme. Records showed a compliance rate of 90% for clinical staff, meeting the hospice's target of 80%.
- The registered manager was the controlled drugs accountable officer for the hospice. Controlled drugs are medicines which require additional arrangements for storage and administration under the Misuse of Drugs Act 1971 (and subsequent amendments).
- There was a medicines management policy for controlled and non-controlled drugs. This had been reviewed in January 2020 and complied with national guidelines.
- The medicines room was clean and spacious with plenty of room for preparation of medicines.
- The service had a medicines fridge within the medicines room. Staff checked the fridge temperatures daily and we saw records from December 2019 to February 2020 confirmed this had happened. Staff knew what they would do should the temperature of the fridge go out of range; however, this had not happened before, as confirmed by the staff we spoke with.
- The drugs fridge was clean with a dated 'I am clean' sticker. It was kept locked to restrict access and fridge temperatures were recorded and monitored to ensure medicines were kept within normal limits.
- Medicines and medicines related equipment were managed well. There was a system for ordering, transporting, storing and safely and securely disposing of medical gases, emergency medicines and equipment.
- Medical gases stored correctly in locked cupboard with access to outside for delivery. Cylinders were in good supply and stored upright and secured to a wall with a chain. There were three cylinders of nitrous oxide stored for the use of alleviating complex pain in patients.
- Pharmacy services were provided through a service level agreement with an external company. A pharmacist attended the hospice weekly providing four hours of onsite support including discussion around prescriptions, challenging pharmacological management, audit activity and cost breakdown reporting.
- Medicines were prescribed on prescription and administration charts. Allergies were recorded in the patient care record and on patients' individual drug charts.
- We witnessed two nurses preparing and checking controlled drugs to be given to a patient. The controlled drugs register was taken to the patient's bedside whilst medication was administered, which was in line with the medicines management policy.
- There was a designated controlled drugs cupboard and register for controlled drugs awaiting destruction. We checked the controlled drugs cupboard. All medicines were in date and correct according to the controlled drugs register. Private prescription pads were also stored in the cupboard with private prescriber codes for 'to take out' medicines.
- The hospice had a medicines management group which met every other month. Meetings were chaired by the controlled drugs accountable officer (CDAO) and attended by a pharmacist. The CDAO shared

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quarterly trends and learning from medicine incidents with the hospice. The CDAO attended controlled drugs local intelligence network (CD LIN) meetings twice a year and submitted occurrence reports.

- The hospice's pharmacist had completed a self-assessment audit and controlled drugs audit and proposed improvements to processes recommended and instigated.

Incidents

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

- Staff knew what incidents to report and how to report them. Staff reported all incidents that they should report. We were not aware of any incidents which were not reported when they should have been.
- From October 2018 to November 2019 the service reported 162 incidents.
- In the reporting period the hospice reported zero never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The hospice reported one serious incident relating to a controlled drug given to the wrong patient. We reviewed the investigation of this incident and saw that no harm was caused however the patient did have an unplanned overnight hospital stay. The investigation highlighted that the issue was system wide and the hospice took action which included competency reassessments and medicine management retraining. Staff we spoke with spoke highly of the learning and changes that came from this incident. They told us they were more confident when prescribing and administering medicines and would challenge poor practice.

- Duty of candour formed part of the mandatory training programme. Records showed a compliance rate of 62% and 88% for clinical and non-clinical staff respectively. Although clinical staff did to meet the hospice's target of 80%, all clinical staff we spoke with understood their responsibilities to be open and honest and tell patients when something had gone wrong with their care or treatment.

Are hospice services for adults effective? (for example, treatment is effective)

Good 

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance.

- Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The hospice had begun attaching quizzes to the end of policies to ensure staff had read the and understood updated policies or guidelines.
- Decisions regarding symptom management and end of life care were based on existing national guidance such as NICE: Care of Dying Adults in the Last days of Life, NICE: Palliative Care for Adults: Strong opioids for Pain Relief, local Palliative Adult Network Guidelines, and specialty evidence-based resources such as the Palliative Care Formulary.
- The approach to planning care was taken at a multidisciplinary level. We observed a multidisciplinary team (MDT) discussion, where the lead professional encouraged all those present to input into the care planning for patients.
- The service had an audit schedule to measure and drive improvements to the service. Audits included, controlled medicines use and reviewing the effectiveness of specific care pathways such as care of deceased patients.

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- The service were members of Hospice UK and received weekly communication and updates, related to best practice.
- The hospice had an end of life care plan template for caring for patients in the last few hours and days of life. The end of life plan contained relevant information such as an initial assessment, hydration and nutrition, current issues and details for a repeat assessment. Additionally, anticipatory medicines for distress, agitation, seizures and pain were prescribed and given in line with NICE guidelines for care of the dying adult in the last days of life and palliative care for adults.
- Patients had personalised care plans, these were up to date and reflected any complex needs.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other needs.

- The hospice used the patient led assessment of nutritional care (PLANC) as an assessment tool for patients on the inpatient unit (IPU). Staff completed a PLANC assessment with the patient. The need for enhanced or adapted diet was identified on admission and throughout their stay. The dietary plans were shared with the hospice's kitchen staff.
- Patient's nutrition and hydration was assessed and monitored as part of patients personalised care. This included a mouthcare and oral hygiene plan. Discussions with patient's relatives about nutrition at the end of life were clearly documented in the plan.
- All food was freshly prepared on the premises. Patients were offered a choice of meals from a menu each day and provided with snacks and drinks throughout the day. Kitchen staff had received training in enhanced and adapted diets from a Macmillan consultant oncology dietician along with several members of the nursing and care staff.
- The hospice had a nutrition lead and a nutrition and hydration working group with membership from the inpatient unit team, facilities, kitchen staff, wellbeing centre staff and the registered manager.

- The hospice had recently secured the support of a primary care dietitian from the local clinical commissioning group. The dietitian had provided refresher training for nursing and care staff in nutritional care. Staff mentioned how beneficial this had been in improving the care they provided.
- St Peter & St James performed well in the Patient-Led Assessment of environment (PLACE) 2019 for organisational food. The hospice achieved a score of 91%, which was similar to the national average of 92%. However, inpatient unit food achieved a score of 88% which was below the national average of 93%.
- Food hygiene was part of the mandatory training programme. Records showed a compliance rate of 98% and 50% for clinical and non-clinical staff respectively. This had been highlighted to the head of facilities and estates to action.

Pain relief

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

- We reviewed care records and saw patients had appropriate pain assessments and pain care plans. Staff recorded when as required medicines were prescribed and given for pain relief. Anticipatory medicines were prescribed appropriately in people identified as approaching the end of life.
- Staff used an appropriate tool such as a body map to help assess and indicate the level or area of pain in patients who were unable to communicate verbally. Medical staff prescribed anticipatory medicines for the relief of pain in patients approaching the end of life. Anticipatory medicines are prescribed before a patient requires them to ensure they are available once a patient does require them.
- Staff had access to syringe drivers to administer pain relief. Staff did not raise any concerns about accessing equipment, such as syringe drivers, to support patients in pain.

Patient outcomes

Hospice services for adults

Staff monitored the effectiveness of care and treatment.

- The service had implemented the Outcome Assessment and Complexity Collaborative (OACC) initiative which aimed to implement outcome measures in routine palliative care.
- The hospice used the Karnofsky Performance Scale and Phase of Illness to classify patients as to their functional impairment. The score was used to compare effectiveness of different therapies and to assess the prognosis in individual patients. We saw outcome measures of Karnofsky performance status and OACC being used to assess patients in the services multidisciplinary team meeting.
- To ensure care was personalised and bespoke, the service planned to make better use of the integrated palliative care outcome scale (IPOS) cohort data to inform future service design and strategy. This work was to help ensure services were continuing to care in the most effective way for the whole population.
- The hospice had begun contributing data to the Hospice UK national benchmarking tool for the inpatient unit as of 2019.

Competent staff

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

- The organisation ensured staff were recruited through robust procedures. Qualifications and character checks were undertaken, with records held in individual personnel files. Applicants were required to complete a disclosure and barring service check to ensure they were suitable to work with vulnerable adults. HR checked professional registration to ensure registered nurses and medical staff were suitable for ongoing employment. We reviewed three sets of recruitment records for staff working at the hospice. These showed systems had been followed when recruiting the staff members and appropriate checks made to ensure the suitability of the person to work with vulnerable adults.

- The medical team supported medical student education for those studying at a local medical school. Three times a year for two days students experienced the hospice environment and learnt how to work in a truly holistic model. The registered manager told us this was well evaluated, and they felt they were making a positive contribution to the future of the medical students.
- The hospice did not have regular training posts but had recently started providing placements one day a week for GP trainees.
- Some of the registered nurses had completed post-registration qualifications in End of Life Care or mentorship as well as having areas of special interest via link nurse roles. The healthcare assistants all completed the Care Certificate and some of them had completed NVQ Level 3 in Care.
- The hospice supported both pre-registration student nurses and post-registration return to practice students. In addition, they had begun to participate in the rotational placement of trainee nursing associates in conjunction with a local university.
- Support for medical appraisal and revalidation was provided with a prescribed connection to the hospice through a service level agreement with a local NHS Trust.
- The hospice had recently appointed a practice educator who was in the process of collating continuous professional development (CPD) resources for staff to access. Staff told us there were many opportunities for CPD and they discussed these with the educator or their line manager at appraisal.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care.

- There was an effective multidisciplinary team that worked well to assess, plan and deliver care and treatment.
- There were weekly multidisciplinary team meetings attended by nursing, medical and wellbeing staff.

Hospice services for adults

Discussions included current patients, safeguarding concerns, reviews of each death over the previous week. Changes to a person's plan of care were communicated to them and their family by the team.

- We observed an admissions meeting which was held daily. The meeting was attended by the medical director, other doctors, head of community services, clinical nurse specialist (CNS) team, inpatient unit staff, director of care, ward clerk and clinical information administrators. The admissions meeting aimed to identify priorities for admission to the inpatient unit or other interventions that may be provided in the person's usual place of residence (home or care home) and expected care needs/preferences for care.
- There was regular medical support for the community team. This included a daily team meeting to review new referrals and discuss complex cases as well as ad hoc advice throughout the day. Medical time was provided for clinic appointments or home visits where medical input was required. The medical director attended the community caseload review meetings.
- For the last two years the consultant team had been working with consultant colleagues at a neighbouring hospice, to provide a 1 in 5 on-call service for bank holidays and weekends. A service level agreement was drawn up to support this work and the two teams had worked closely to align on-call processes with weekly handovers and regular governance and continuous professional development meetings.
- 'SafeTea' huddles were held twice a day. The huddles were focused on the whole hospice as an organisation. They also featured a clinical review of community in order to be aware of potential patients, day patients and current inpatients.
- The community team regularly liaised with GPs, district nurses, continuing healthcare and other agencies such as the ambulance service. The hospice communicated with the ambulance service to see if there had been any paramedic attendances to people known to the hospice team.
- St Peter & St James engaged with local services to provide care to patients at the end of their lives. The hospice collaborated with a local charity that provided services for children and young adults with complex

physical disabilities and health needs. They supported the end of life care for a long-term resident who had been referred to the hospice following recurrent hospital admissions. Both services worked closely with the patient's family and carers known to the patient to support care, communication and to ensure normal care routines were maintained while in the care of the inpatient unit. Once the patient's condition stabilised, further collaborative meetings were held to arrange the patients transfer back to their previous residence to be in a familiar environment and support them with complex ongoing end of life care.

Seven-day services

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

- The hospice was open 24 hours a day, seven days a week. There was an open visiting policy up to 5pm, although the hospice was flexible to meet the needs of the patients and their loved one's family if they wished to stay longer.
- The hospice had a team of doctors who carried out a daily ward round and were on site from 8.30 am to 5.00pm.
- Patients had access to a physiotherapist 14 hours per week.
- A pharmacist was available for four hours per week on Thursday afternoons and contactable by phone out of these hours.

Consent and Mental Capacity Act

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions.

- The hospice had a mental capacity act policy which was in date and version controlled.
- Staff understood their requirements in relation to the Mental Capacity Act, 2005. Staff were able to describe how they would support someone who lacked capacity to consent to care and treatment. Staff were able to provide examples of how and when to assess whether a patient had capacity to make decisions about their care.

Hospice services for adults

- Clinical and non-clinical staff such as volunteers received Deprivation of Liberty safeguards (DoLs) and Mental Capacity Act (MCA) training. Records showed a compliance rate of 85% and 100% for clinical and non-clinical staff respectively meeting the hospice's target of 80%. The hospice shared with us a case where DoLs and MCA principles had been applied to protect the interests of a vulnerable patient and ensure they received the care they needed at the end of their life. It was evident that through effective multidisciplinary team working with other agencies and use of legislation, the patient was able to achieve a more favourable end of life in the care of hospice staff.
- The safeguarding lead has attended training in preparation for the implementation of Liberty Protection Safeguards which was due to replace the Deprivation of Liberty Safeguards regulation in October 2020.
- Staff understood how to obtain consent from patients. We saw that consent was recorded electronically on the patient's care records. Staff explained the procedure to patients and ensured they felt safe to withhold consent if they chose.
- When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions.
- All inpatient unit staff had undertaken face to face training delivered by a member of staff who was an advanced life support instructor with the Resus Council on 'do not attempt cardiopulmonary resuscitation' (DNACPR). We reviewed one patient record which had a DNACPR. We saw the record was completed in full and met national guidance.
- People who used services and those close to them were active partners in their care. Staff were fully committed to working in partnership with people. Care records, feedback from patients and our direct observations showed that staff empowered people to vocalise their needs. The inpatient unit used a 'What Matters to You Today' question each day.
- People's individual preferences and needs were reflected in how care was delivered. Patients were supported in accessing things of value that gave them comfort, even when they were inpatients at the hospice. There were lots of examples; children could visit and stay with patients on the ward and staff facilitating donkey therapy where patients could feed the hospice's donkeys from their rooms.
- Staff approached patients in a kindly manner and with a smile. Care was delivered in an unhurried manner. Staff told us they tried to make every day a meaningful day for people who used the service.
- Staff recognised that people needed to have access to, and links with, their support networks in the community and they supported people to do this. They ensured that people's communication needs were understood. Family members and carers could stay with their loved ones and were encouraged to do so. We saw chaplains involved with patients and their families providing them with religious and spiritual support when they requested it.
- Staff facilitated the matrimonial ceremony of a young couple supported by the Hospice. The staff were actively involved in the preparation's and planning stage of the wedding.
- People's privacy and dignity needs were understood and always respected, including during physical or intimate care and examinations. Patients had individual rooms for privacy. We saw all staff knock before entering and they checked if it was fine to enter each patients' private space.
- Staff took the time to interact with people who used the service and those close to them in a respectful and considerate way. We observed compassionate interactions between all staff and people who used the service. We saw evidence of appreciation from people in the form of cards, donations and fundraising.

Are hospice services for adults caring?

Good 

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

Compassionate care

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

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- Staff told us they provided person centred care and took an interest in the person; for examples upon hearing that one patient enjoyed building models (boats, airplane etc) staff from the Wellbeing Centre invited the patient to join a model building session, which the patient enjoyed, especially the opportunity to meet and converse with other attendees who shared the hobby.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

- Staff understood that patients' emotional needs were as important as their physical needs. Feedback from patients about how they were cared for was consistently positive. Staff showed a profound awareness of the emotional impact of conditions on patients and took account of this during assessments.
- Staff understood the impact that a person's care, treatment or condition had on their wellbeing and on those close to them. People were given timely support and information to cope emotionally with their care, treatment or condition.
- Patients told us they had opportunities to discuss any bad news with staff and they were given support when receiving bad news. Patients also told us that staff provided comfort when they were upset and often sat with them talking and holding their hand when they were distressed.
- Staff welcomed relatives and friends to visit, as this provided the patient with emotional support. The hospice had an open visiting policy, so relatives and loved ones could spend time with the patient. The patient lounge was converted in a family room to accommodate families wanting to be together.
- The hospice provided personal and practical support for relatives and the bereaved. Welfare services were available and remembrance services were held in the sanctuary throughout the year.

Understanding and involvement of patients and those close to them

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

- Staff made sure that people who used services and those close to them were able to find further information, including community and advocacy services. They could ask questions about their care and treatment. They were supported to access further information through direct conversations with staff, leaflets and other agencies who worked on or off site.
- Staff routinely involved people who used services and those close to them (including carers and dependants) in planning and making shared decisions about their care and treatment. Records were available to show regular discussions were held with those close to patients.
- Staff assisted patients in maintaining their independence or normalcy as best as they could when they were admitted to the hospice. For example, the hospice had coordinated the transportation of a patient's independently-controlled electric wheelchair to the hospice from a out of area location to ensure the patient could independently explore the hospice grounds as an important part of processing and coming to terms with their diagnosis.
- The patient's preferences for arrangements before and after death including funeral arrangements were discussed and actioned where possible. People received personalised end of life care that respected their needs and wishes. Bespoke booklets were given to bereaved families to support the after-death process.
- The hospice had three audio biographers who were volunteers for the service. They had undertaken a two-day training course. Biographers captured the patients' life stories and helped preserve valuable memories for their loved ones to listen to once they had passed.
- The hospice had recently facilitated the repatriation of two deceased people to their original home in the European Union (EU) as per their request before death. They worked with a number of traditional and more creative funeral directors to assists with people's choices.

Are hospice services for adults responsive to people's needs?

Hospice services for adults

(for example, to feedback?)

Good 

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

Service delivery to meet the needs of local people

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

- Services were accessible to all, regardless of background, and there was a flexible referral criterion to support all with palliative care needs. Referrals were made by GPs, hospital palliative care teams, specialist teams, community services and self-referral.
- Services were fully accessible to those with physical disability, and the hospice could adapt the environment for sensory disability.
- People were admitted to the inpatient unit for end of life care or management of complex symptoms such as pain or nausea and vomiting. Complications arising from a person's underlying condition were also managed: breathlessness, confusion, deranged blood chemistry amongst others. Towards the dying phase the hospice managed underlying symptoms as well as terminal agitation.
- A family room or quiet space and kitchenette facility were always provided and accessible to visitors. Families were encouraged to use facilities the kitchenette to prepare beverages or food.
- The hospice had a multi-faith quiet space that held services and prayers as well as being available for
- The hospice had an integrated process for bereavement assessment, flexible befrienders service to support carers with range of visits and telephone support. There was a drop-in service at Wellbeing centre, with volunteer transport service to support access.
- The Beacon View Wellbeing Centre provided therapeutic activities three days a week ranging from

whole day attendances for 10 weeks or drop in attendance for selected activities. There was a weekly carer's support group which provided complementary therapies and a monthly bereavement group.

- The community team worked with people at a local HM Prison and members of travelling communities for example. The community and inpatient teams had good links with a local service for children's and young people with complex neuro-disabilities. The hospice supported young adults and their families at the end of life facilitating well-managed deaths.
- The hospice was located in a rural part of Sussex with limited public transport, therefore they ran a home pickup service. This ensured all patients who may otherwise not have any means to travel to the hospice were able to access the service.

Meeting people's individual needs

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

- Upon admission, hospice staff carried out a full holistic assessment of patient's individual needs. We reviewed three records and found this information had been documented where required in the patient care records.
- The hospice had a complementary therapy team who offered a range of therapies including aromatherapy, massage, reflexology and reiki. The team ran clinics three mornings week and if patients were too unwell, the team could arrange a home visit where necessary.
- The inpatient unit had made improvements to offer a better environment for people living with dementia or other cognitive impairments. The hospice had made changes to the room décor, signage that could be personalised, equipment and accessories including radios/clocks and non-verbal communication aids. The room also featured bedding which enabled easy patient positional movement with low friction.

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- Patients had access to interpreting services via a local interpreting service. Staff told us this had last been used last summer and gave an example of the use of a Bulgarian interpreter.
- The hospice offered counselling services in a safe confidential space to help people make sense of and adjust to life during a difficult time. Patients were invited to access the service individually or as a couple/family either in their own home or at the hospice.
- We asked staff what they would do to support of different faiths. Staff told us the hospice had links to an array of faith leaders to support people.
- All in patient rooms had an overhead tracking hoist and a pull-down bed for a relative or friend to stay overnight if necessary.
- Staff worked with people to understand their life history and what was important to them. The service had facilities for family members to stay overnight when requested.
- There was an open visiting policy up to 5pm, although the service was flexible to meet the needs of the patient and their loved one's family if they wished to stay longer.
- Where patients wished to go home to die and this was possible, all attempts were made to respect the patient's wish to die at home. Data provided by the hospice showed that of the 107 patients whose preferred place of death was known, this was achieved in 91 cases. Thirteen patients died in hospital with the preferred place of death noted as home, six in the hospice and two in a nursing home.
- The hospice had launched a listening project called candid conversations to help improve the care they provided and inform future engagements with service users. Patients and relatives who had used the services were invited to give feedback about their experience of the hospice and what mattered the most to them in a safe and supportive environment. A qualitative questionnaire was developed to gather responses across a wide spectrum of people. It focussed on individual experiences including the fear of the word 'hospice', anxiety experienced when arriving for the first time, challenges with accessing

external care, feelings of loss and feeling let down when loved ones entered hospital or died at home instead of in a hospice bed. Feedback was gathered over two months through focus groups and one to one interviews. Recommendations from study included but were not limited to, training staff and volunteers to conduct their own research conversations, incorporate the key inquiry themes into their framework and establish an annual candid conversations month.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were effective.

- At the time of our inspection, there were 366 people using the hospices services including the inpatient unit, community services and therapy services.
- A daily admissions meeting was held in the inpatient unit. People requiring admission were discussed and priorities identified if more than one person needed to be admitted. The team supported two admissions a day depending on bed availability, complexity of patients already in the unit and staffing.
- The hospice monitored referral and admission rates for its service as part of a clinical activity report. We reviewed dashboard for quarter one, two and three of 2019/20 and saw that the inpatient unit had received 172 requests for admission and had agreed to admit 102 (59%) of the requests. The hospice responded quickly to admitting patients to the inpatient unit. They reported that all admissions from home were achieved within a day of the agreement at the admissions meeting and 92% of patients were admitted within 48hours of the referral being made.
- The most common reason for admission to the inpatient unit were pain or symptom control (45%) and for end of life support (45%). Other reasons for admission were for emotional or psychological, social and financial and carer support.
- The average length of stay in the inpatient unit was 12 days which was similar to the previous year.
- Bed occupancy over the first three quarters of 2019/20 was 78%. This was lower than the previous year's

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occupancy of 83%. The hospice reported that in October 2019, they had to reduce their bed number from 14 to 10 due to a significant staffing and capacity issues.

- The community team managed a total caseload of approximately 170 people every three months.
- The clinical nurse specialist team used a phase of illness and level of intervention to indicate complexity of patients' needs on their caseload. These indicators were usually met by the team. These ranged from level 1 which may be a single contact or advice to a professional to level 4 where people had the most complex support needs and required visits or telephone contact several times a week.
- The community service received 453 referrals in the first three quarters of 2019/20 and had accepted 383 (70%). Of the 60 declined referrals, 35% was due to patients not meeting the referral criteria. Referrers were asked to indicate whether the need for admission was 'urgent' or 'routine'. Urgent referrals were responded to within two working days and with routine referrals within five working days. On average, 95% of patients received urgent contact from the team within two working days.
- In the 28 days before completing the pre information request, the hospice provided 491 hours of care and support in the community. None of the patients had purchased the service using an NHS personal health budget or a local authority direct payment.
- There was a system for triaging referrals to ensure the service were using their resources appropriately and offering individuals the right choices at the right time for them. Since November 2019, the community team had started operating with a triage role, assigning one clinical nurse specialist to review and triage incoming referrals, field telephone calls and respond to urgent review requests.

Learning from complaints and concerns

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

- St Peter & St James had a complaints policy. The policy was clear and outlined timeframes for dealing with complaints such as acknowledgement of a complaint within three days and resolution in seven days. If not resolved within seven days, a full written response was sent to the complainant.
- Patients and their relatives were encouraged to make complaints and supported during and after the investigation. The hospice had held one face-to-face meeting with a complainant in the last six months in conjunction with a local community trust which the hospice said was helpful for all involved. The family involved had agreed to speak with staff about their experience for learning purposes. Furthermore, the family engaged in a county wide conference collaborating on end of life care pathways.
- The chief executive officer was responsible for overseeing any investigations. There was a collaborative approach to exploring where things could or had gone better with other services such as, community nursing to learn and improve the service. The hospice had recently introduced reflective meetings open to all to review where things went wrong, to look at improvements.
- In the reporting period the hospice had received six complaints and had upheld one compliant in the reporting period. All six complaints were resolved in the target time. Complaints were monitored to identify similarities or trends.
- We reviewed one complaint in its entirety. The response was provided in a timely way, was clear, thorough and all parties that should have contributed to the investigation did so.

Are hospice services for adults well-led?

Good 

Our rating of well-led improved. We rated it as **good**.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the

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

- Since the last inspection in 2016, St Peter and St James Charitable Trust had a new but well-established and embedded leadership structure. The new structure was implemented in April 2019 and aimed to integrate services, strengthen leadership and introduce a clinical and wider strategy.
- The Chief Executive Officer (CEO) held day-to-day responsibility for running the hospice supported by an executive board, which included but was not limited to the director of care (who is the registered manager), medical director, the director of income generation and head of finance. They were supported by the board of trustees who included people from both clinical and business backgrounds.
- Clinical services were led by a director of care, a medical director, a head of community services, a head of wellbeing and outreach and an inpatient unit nurse manager, who subsequently lead their own teams.
- Leaders had the varied skills and experience to effectively run the hospice. The CEO had more than 10 years of experience working as a director in UK charities. The director of care had over 30 years of experience in cancer and palliative nursing.
- Leaders were visible and approachable to both operational staff, patients and visitors. Staff told us that outside of meetings, the CEO was often seen working in the conservatory of the hospice in order to interact with people. Staff felt they could raise concerns, issues and ideas with the CEO, their line manager or escalate to any member of the senior leadership without hesitation.
- The senior leadership team demonstrated effective leadership skills within their roles. Their knowledge, enthusiasm and commitment to the service, the people in their care and all staff members was exemplary.
- The registered manager was respected, trusted and empowered to make decisions and implement change to improve the service. The senior leadership team

recognised their roles and responsibilities and worked cohesively. The hospice was receptive to new ideas and sought the registered manager's views and those of the wider team.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. Leaders and staff understood and knew how to apply them and monitor progress.

- The service had an operational plan which included all the hospices services and aligned with their strategy. The service had sought the views of their patients and staff when creating the strategy and aimed to align the plan with hospice UK guidance, national strategy and local sustainability and transformation partnership for end of life. The aims of the strategy were extending their reach, developing their expertise, identify and meet need and support people to live well.
- The hospice's vision was to make a positive difference to the experience of everybody in their community who faced death or bereavement, by offering choice and support through their expert and compassionate care, knowledge and understanding. It was clear that all staff we spoke with understood their role in achieving the vision and were invested in doing so.
- The hospice had an established set of values which included nurturing, unified, transparent, professional and empowering.
- The services objectives and plans were achievable and flexible. Strategies and plans were fully aligned with plans in the wider health economy, and there was a demonstrated commitment to system-wide collaboration and engaging with the wider community to ensure equity of access to care. For example, the CEO was part of collaboration of six Sussex hospices which contributed to the oversight and development of end of life care services across the region.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in

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daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

- Staff told us the senior leadership team were always available and worked side by side with staff to support and encourage them. Throughout the inspection the CEO, registered manager and medical director were present and took time speaking with people and supporting staff. It was clear they knew everyone including the volunteers extremely well and promoted the inclusive culture that had developed in the hospice.
- Staff recognised people's diverse needs and equality characteristics. Staff worked hard to meet these needs. The hospice had an equality policy which promoted engagement of a variety of people and staff. Equality and diversity training was part of the mandatory training programme. Records showed a compliance rate of 92% for clinical staff, which met the hospice's target.
- All staff we spoke with were positive about working for the hospice. They described feeling valued and supported in their role. Staff who worked remotely said they felt connected to the rest of the team and the organisation.
- There was a recognition of the importance of ensuring patients received a good end of life care experience across all staff groups and services. Staff were engaged with the hospice and proud of the care and treatment they provided for patients.
- The culture of the hospice encouraged openness and honesty. Staff told us there had been a 'massive shift' in the culture since the last inspection and this was echoed by all staff, clinical and non-clinical and trustees we spoke with. Staff explained the culture of reporting incidents or near misses was looked upon positively as an opportunity to learn and improve the service for their patients for instance.
- Staff said there was always a willingness to try new things which was driven by the CEO's 'can do attitude'.

- There was a culture of reflection within the service. There were many examples where the hospice had reflected on both positive and negative occurrences or aspects of the service to ensure they could learn, embed and improve the hospice.
- The service valued the contribution of its volunteers and it was clear in the interactions we observed during our inspection. The hospice had organised a BBQ on the grounds of the hospice for all volunteers last summer to thank them for their hard work.

Governance

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

- The service had a strong governance structure that supported a feed of information from frontline staff to senior managers and trustees. The hospice held regular meetings which in turn fed into the board meeting or shared information with other agencies. The quality and safety committee met quarterly and reviewed clinical reporting framework and clinical activity report before sharing the report with the clinical commissioning groups.
- We reviewed three sets of minutes from the senior leadership team meetings, inpatient unit meetings, clinical nurse specialist meetings and board meetings from the last 12 months. There were standardised agenda items for regular discussion and monitoring of progress. We noted agreed actions were allocated to individuals who were responsible for following up on actions and reporting back at the next meeting ensuring accountability.
- There were a number of sub committees including quality and safety, senior leadership team, multi-disciplinary team, health and safety committee and finance and resources and fundraising.
- committees including the regular clinical governance and senior management team, multi-disciplinary team, health and safety committee and finance committee. Where issues were identified, they were escalated to the board as necessary.

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- We attended a board meeting which was well attended by both executive directors and trustees including the CEO, registered manager, medical director and director of finance. The board meeting was chaired by a trustee. Directors submitted reports to the board relating to performance, quality or finance for the executive team to interrogate where necessary. The meeting was well structured with a good level of challenge and discussion.
- Leaders understood current issues, challenges and priorities and we saw evidence including action plan and audits that demonstrated the hospice was determined to make improvements and real changes that would positively impact the hospice and their patients.

Managing risks, issues and performance

- The hospice had three risk registers for quality and safety; finance, resources and income generation and operations and governance. These were reviewed by hospice directors and departmental heads quarterly or more regularly if new risks were identified or existing risks were mitigated. Reports were submitted to the quarterly trust committee meetings and updated summary to the board of trustees.
- We discussed the risk register with the senior leadership team and trustees during the inspection. Both the senior leadership team and trustees had a good knowledge of the risks associated with the service, including clinical, non-clinical and financial risks. They articulated the risks well, knew the actions that had been taken to mitigate risks and the work still required and planned.
- The hospice had a risk management policy. The aim of the policy was to create robust structures, systems and processes that will minimise or eliminate, so far as is reasonably practicable, risks to patients, staff and the hospice by promoting consistency in practice in clinical and non-clinical areas. Responsibilities for risk management lay with board of trustees.
- The senior leadership team had a clear understanding of their financial position and action to take ensure they could continue to fund the service. The director of income generation told us they were looking at fundraising opportunities and planned to open more shops in the region to increase their retail income.

- The hospice carried out audits in various areas to identify areas of risk or poor performance. Following the infection prevention control audit, they highlighted areas of improvement such as monitoring and offering staff immunisation. The hospice now had a service level agreement with a local NHS trust providing blood borne virus testing and immunity to staff if required.
- The hospice had a business continuity plan that detailed how to be prepared for any events that could impact on extended service outage. The plan was credible, it identified members of the emergency response team, alternative locations to relocate patients if necessary.
- At the previous inspection concerns were identified regarding the overseeing and management of certain systems including the recording of medicine administrations. During this inspection we noted an improvement in the way medicines were recorded and administered. There was now one system used for consistency and ensured staff were administering medication correctly.

Managing information

- The hospice had clear and robust performance measures for monitoring performance. Quality and performance reports was reviewed by the quality committee included data on a range of indicators including staffing, complaints, incidents infection and pressure ulcers,
- The hospice had a documentation control centre to ensure there is no duplicity and communication was strengthened as well as following General Data Protection Regulation.
- The hospice used an electronic system and were able to share information electronically with patient consent. Staff had access to up-to-date and comprehensive information regarding patient's care and treatment. The system was also used by the majority of GP services in the local area and staff confirmed there were secure processes to share information.

Hospice services for adults

- Data protection formed part of the mandatory training programme. Records showed a compliance rate of 85% for both clinical and non-clinical staff, meeting the hospice's target of 80%.
- Information was also available on the hospice's website. This was up to date and had information about the services provided, contact information, upcoming charity events. There was also information relating to the recent viral outbreak.
- Computers were available to staff and all locked when not in use.

Engagement

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

- There was a strong ethos of encouraging communication at the service. This resulted in people being able to make choices. People were involved in meetings and encouraged to engage.
- There were many opportunities for the hospice to engage with the public and for the senior leadership team to engage with staff. A staff forum had been running for the past year. This had been received positively and staff we spoke with told us they felt empowered to make suggestions and were valued for their contribution to improve the hospice. A member of staff had commented that the hospice did not recycle waste. Leaders agreed that this was an area they could easily start making changes to and had started to recycle their domestic waste.
- Staff told us communication had greatly also improved. The CEO sent a weekly email to all staff and volunteers to ensure that all were aware of what is going on and to encourage dialogue. The email was also printed and displayed on staff boards for all to read.
- Staff we spoke with told us previously they had been unaware of things happening in the hospice and felt "left in the dark". However, with changes to the leadership this had dramatically changed. There were now many streams of information and they felt included and knew about what was going on in other areas of the hospice, not just their department.
- The hospice produce a seasonal magazine called the 'Caring Magazine'. This featured stories from people or relatives of people who had or were still using the service. There were also articles from staff telling of their experience with the service and upcoming social and charitable events for the community to get involved with.
- Staff said the hospice held social events such as a book club to bring staff together and break down the silo working.
- Staff were consulted on any changes planned to take place. For example, the hospice moved from paper-based payslips to electronic. The senior leadership team took time to explain to staff how to access this and answer questions they had.
- A staff HR consultation was carried out between July and October 2019 to address long standing issues staff had about shift patterns and mandatory training amongst other concerns. This had begun following individual staff meetings with the new inpatient unit manager. Seventy eight percent of staff participated in a series of questionnaires and opportunities to share possible resolutions. As a result, a trial period of new a rota and shift patterns had started in January 2020 and was in progress during our inspection. The trial was in progress during our inspection and initial feedback was positive. Staff told us the long shift patterns meant they could provide continuity for the patient but also meant staff could have a meaningful break away from work.
- The hospice was engaging with six other hospices in the region of Sussex as part of project Echo. They also undertook collaborative work for learning and sharing information around leadership, management development and HR resources.
- A staff and volunteer survey was last completed in 2018 and the hospice was due to repeat it this year to benchmark their progress and understand what mattered to their staff and volunteers.

Learning, continuous improvement and innovation

Hospice services for adults

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement.

- The hospice was in the process of updating its new electronic system. The inpatient unit manager told us this was a six-month project. The project was driven by a team of core group users from all clinical departments of the hospice. The team met weekly and updated the wider group monthly. The aim was to make the system user friendly and more bespoke to all needs of the hospice, meaning that data could be collated and shared more easily. The system was also used by local GPs in area therefore would improve the sharing of data.
- St Peter & St James had started to upload ResPECT document (advance care planning and ceilings of care). Staff were currently undertaking training online.
- A head of digital transformation and communications had been in post for seven months and was working on various digital transformation projects. The hospice was at the early stages of a digital transformation project to move to the 'Cloud' which would allow them to work more collaboratively and securely. The move would replace less secure paper processes, reducing the need to print information and removing the requirement for virtual private network (VPN) server access.

Outstanding practice and areas for improvement

Outstanding practice

- The hospice had three audio biographers who were volunteers for the service. They had undertaken a

two-day training course. Biographers captured the patients' life stories and helped preserve valuable memories for their loved ones to listen to once they had passed.

Areas for improvement

Action the provider **SHOULD** take to improve

- Children's safeguarding training should be provided separately or with equal weighting to that of adult safeguarding.