St Christophers Hospice

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Inspection report

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Ratings

Overall rating for this service	Outstanding ☆

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

Summary of findings

Overall summary

This inspection took place on 13, 14 and 15 September 2016 and was announced. The service was last inspected on 16 December 2013 and at that time was meeting all the regulations we looked at.

St Christopher's Hospice has charitable status and provides palliative and end of life care to a population of approximately 1.5 million people living in the five South East London Boroughs of Bromley, Croydon, Lewisham, Southwark and Lambeth. The hospice accepts referrals from anyone in the community who knows a child or an adult with a life threatening or life limiting condition. Care, treatment and support is provided to people with a life threatening/life limiting illness, their families, carers and friends by a range of multi-disciplinary health and social care professionals including doctors, nurses, health care assistants, physiotherapists, occupational therapists, dieticians, social workers, complementary therapists and volunteers. The hospice plays a key role at a local, national and international level by offering information, advice, education/training and research opportunities to individuals, groups and institutions wanting to know more about end of life and palliative care matters.

Although the hospice has two different sites located at Sydenham and Orpington in Bromley, St Christopher's considers itself a single provider with people in the local community, their families/carers, staff and volunteers visiting or working at both sites. This report relates specifically to the Sydenham site which has 48 beds divided into four wards named Nuffield, City, Alex and Rugby wards. Each ward includes a mix of single occupancy bedrooms and four bedded bays, a kitchen area and small sitting room or conservatory. The Sydenham site also includes the Anniversary day centre and cafe that is open to the public, the Pilgrim multi-faith room, the Pavilion Gardens meeting room and art lodge, a fully equipped gymnasium, a mortuary, various complementary therapies clinics, a conference room and the education and training centre. The hospice is surrounded by well-maintained gardens.

The specialist community palliative care team operates in collaboration with local primary health care teams to provide people, their families and/or carers with end of life care and support. Its primary task is to manage symptoms associated with people's illnesses and to support them and their families through the illness and into bereavement. The team also offers an advice and visiting service for patients throughout the 24hr period. New patients can be admitted in to the community or inpatient service at anytime.

St Christopher's provides pastoral and counselling/bereavement services for children, adults and families. The hospice has three distinct bereavement services for adults following the death of someone under the care of the hospice, for anyone who is bereaved and lives in Bromley and the Candle project for children and their families.

People in the local community can also access a range of group and social activities at the hospice's day care unit and Anniversary Centre where individuals, families and carers can relax, socialise, support each other and make use of a range of creative and complementary therapies, which includes a rehabilitation gym. St Christopher's creative arts and complementary therapy team also work with staff, in care homes and

with related projects in the local community.

At the time of our inspection there were 38 patients staying on the wards at the Sydenham site. The community palliative care team supports around 500 people in the community at any one time and offers advice and a 24 hour consultancy hotline for over 100 care homes in South East London. Nearly a thousand people used the facilities at the Anniversary centre in 2015/16. Approximately 120 people access physio sessions in the gym weekly and 20 young adults with life limiting conditions regularly attend social groups run by St Christopher's.

The service had a registered manager in post who is also the director of nursing. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

People and their families told us staff and volunteers looked after them in a very kind, respectful and compassionate way. Feedback we received from people, their families and community professionals supported this. We saw staff and volunteers built good working and caring relationships with people and their families and always treated people as individuals' and with the utmost respect and dignity.

People received care and support from a multi-disciplinary team of highly qualified health and social care professionals who were well trained and supported by their co-workers, senior staff and managers. There was a very proactive approach to the personal development of staff and the acquiring of new skills and qualifications. A system of competency based assessments ensured staff had the required knowledge and skills to meet people's needs and wishes and effectively. Systems were in place to support staff and volunteers to enable them to reflect on their own practice and that of their co-workers. This provided staff and volunteers with the knowledge, skills and confidence they required to meet people's needs and wishes in an outstanding and personalised manner.

The provider demonstrated a strong commitment to providing people with good outcomes and high quality care, and to continually improve, extend and develop the service to reach as many people as possible. The hospice had developed a number of innovative approaches to reaching more 'harder to reach' groups in the local community. This included young people with a life limiting condition and individuals who did not previously receive any specialist palliative care services because they did not have a primary diagnosis of cancer. The hospice had responded to these challenges by setting up the Bromley Care Coordination (BCC) team and a therapeutic/social day every other Saturday for young people with life limiting conditions. This is held at the Anniversary Centre on the Sydenham site.

The service worked collaboratively with other professionals and agencies. Staff worked in partnership with a wide range of external health and social care professionals and other organisations to improve the services St Christopher's offered to patients, people in the community and their families. Staff were encouraged and supported to undertake research and act as education facilitators to share best practice and ensure high quality outcomes for people with life-limiting conditions and those closest to them.

People received a personalised service. People were supported to make informed choices about their end of life care and to have as much control as possible about what happened to them before and after their death. Person centred care plans reflected people's specific needs and preferences in respect of how they wanted to be cared for, treated and supported. Staff ensured people received all the necessary information in a way and at a pace they could understand. This enabled people and their families to make more informed decisions about the end of life care, treatment and support they wanted. Consent to care was

sought by staff prior to any support being provided.

Robust systems were in place to enable people to receive support and advice whenever they needed it. This included a 24 hour advice line and visiting service aimed at helping people to manage their symptoms. People and their families/carers were able to access a wide range of group and individual social activities and educational classes at the Anniversary centre. People also told us staff understood their emotional needs and focused on their wellbeing as well as the wellbeing of their family member. There was a family support team which provided pre and post bereavement counselling for children, adults, their families and friends. There were no restrictions on visiting times at St Christopher's and families could stay overnight.

People's cultural and spiritual needs were respected and care and support was provided in line with an individual's faith and customs. Staff had received training and were aware of different religious and cultural practices at the time of and after a person's death. There was also a chaplaincy service to support people and their families with their spiritual needs.

There was strong emphasis on the importance of eating and drinking well and a commitment to providing people with what they wanted to eat and drink in a flexible manner. There was an excellent choice of meals, snacks and drinks, and staff went out of their way to buy people specific food if it was not available at the hospice. People were supported to receive good health care from the hospice's and other external community health and social care professionals. People received their medicines as prescribed and staff knew how to manage medicines safely.

The management team demonstrated a strong commitment to delivering people with high quality care in a well-managed environment. The management structure showed clear lines of responsibility and leadership. The provider regularly reviewed their performance and where further improvements were identified appropriate actions were taken. Managers used learning from near misses, incidents and inspections to identify improvements that would positively enhance the lives of people receiving a service from St Christopher's.

People said they felt safe on the wards or receiving care and support in their own home from the palliative community teams. Staff knew what action to take to ensure people were protected if they suspected they were at risk of abuse or harm. Risks to people's health, safety and wellbeing had been assessed and strategies to prevent and manage identified risks were robust. The provider managed accidents and incidents appropriately and suitable arrangements were in place to deal with emergencies. The recruitment processes ensured staff and volunteers were suitable to work with people who received a service from the hospice.

There were sufficient staff to meet people's needs, and staffing levels were regularly reviewed and adjusted accordingly to keep people safe. One-to-one staffing was provided to further support people and maintain their safety when required.

The provider ensured regular maintenance and safety checks were carried out at the hospice to ensure the building and equipment remained safe. The hospice was clean and there were processes in place to protect people from the risk of infection.

Staff were aware of who had the capacity to make decisions about their care and supported people in line with the Mental Capacity Act 2005. Where appropriate, staff liaised with people's relatives and involved them in discussions about people's care needs. Managers and staff understood when a Deprivation of Liberty Safeguards (DoLS) authorisation application should be made and how to submit one. This helped to ensure

people were safeguarded as required by the legislation. DoLS provides a process to make sure that people are only deprived of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them.

The service had an open and transparent culture. The service had systems in place to obtain feedback from people, their families/carers, staff and other health and social care professionals about the hospice. Specifically about what they thought the hospice did well and what they could do better.

People felt comfortable raising any issues they might have about the hospice with managers and staff. Complaints or concerns raised about the hospice were investigated and, where necessary, appropriate action taken to resolve the issue. The provider had a positive approach to using them to improve the quality of the service. People who used the service, their families and carers, staff, volunteers and external organisations were all involved in developing the future of St Christopher's.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Patients and people in the community received a safe service from St Christopher's whether it was on the hospice wards, at the centre and/or in their own home. Staff were aware of what to do if they witnessed or suspected abuse was taking place.

Assessments were undertaken to identify any risks to people who received an inpatient service from the hospice and these were regularly reviewed. The hospice's environment was safe and maintenance took place when needed.

Staffing levels were flexible and regularly reviewed to ensure there were the right number of staff on duty at anyone time to meet people's needs. Staff and volunteers were appropriately checked to ensure they were suitable to provide care and support to people using the hospice.

Medicines were stored safely and systems were in place to ensure that people received their prescribed medicines when they needed them. Processes were in place to protect people against the risk of development and spread of infections and infectious diseases.

Is the service effective?

Outstanding

The service was effective. St Christopher's carried out research and acted as education facilitators at a local, national and international level to share best practice and ensure high quality outcomes for people with life-limiting conditions and those closest to them.

People and their families/carers received support from very skilled and committed staff and volunteers. This was because staff and volunteers received comprehensive training to ensure their knowledge was kept up to date.

Managers, staff and volunteers knew their responsibilities in relation to the Mental Capacity Act 2005 and DoLS. People were involved in making decisions about their treatment and care needs. When complex decisions had to be made staff were aware how to make decisions in people's best interests.

People were supported to receive the health care they needed both from staff who worked for the hospice and other external community health and social care professionals. There was a strong emphasis on the importance of eating and drinking well and a commitment to providing people with what they wanted to eat and drink in a flexible manner.

Is the service caring?

Good

The service was caring. People and their families spoke consistently about the caring and compassionate attitude of staff and volunteers. People were involved in decisions about their care and felt staff listened to them. End of life care and treatment was provided in line with people's wishes and preferences. People's privacy and dignity were always respected.

The service ensured people were enabled to experience a comfortable, dignified and pain-free death, according to their wishes and preferences. Staff understood people's emotional needs and focused on their wellbeing as well as that of their families. Bereavement services were available for children, adults and their families.

Is the service responsive?

Good

The service was responsive. The hospice had developed a number of innovative approaches to reach more 'harder to reach' groups in the local community which had resulted in a young person's social group and the Bromley Care Coordination (BCC) team being set up to support people who had previously felt excluded from the hospice.

Advice for people, their families, carers, GPs and healthcare professionals was available 24 hours a day via a dedicated helpline. People told us that this lessened their anxiety and helped them to receive better care when they needed it.

People received person-centred care. Systems were in place to ensure that people's physical, social and psychological needs and wishes were comprehensibly assessed. Detailed and current information about people's needs and wishes and what was important to them was recorded and communicated to staff. This ensured staff understood people's needs and preferences.

Care plans were kept under constant review and the service was flexible and responded quickly to people's changing needs and wishes.

The provider had a positive approach to using complaints,

concerns and feedback to improve the quality of the service.

Is the service well-led?

Outstanding ☆

The service was well-led. The executive and senior management team demonstrated a strong commitment to providing people with high quality care.

Managers and staff worked to continually improve and develop the service. Systems were in place to routinely review the service's performance and to look for innovative ways to improve.

The service had an open and honest culture. People's views were sought and valued and encouraged to get involved in developing the hospice. Staff also felt able to express their opinions and that they would be listened to.

The service worked collaboratively with external health and social care professionals and agencies to deliver and share best end of life practice and care for people with a life limiting illness.

St Christopher's Hospice

Detailed findings

Background to this inspection

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

This inspection took place on 13, 14 and 15 September 2016 and was announced. We gave the provider 48 hours' notice of the inspection because we needed to be sure senior managers and staff would be available to speak with us on each day of our inspection. The inspection team consisted of three inspectors, a CQC pharmacy inspector, and a specialist advisor with experience of working with older people living with dementia and two experts by experience. Our experts by experience were people who had experience of caring for or being related to someone who had received end of life care.

Prior to the inspection we reviewed the information we held about St Christopher's, including the statutory notifications we had received. Statutory notifications are what the provider has to send to the CQC about significant events concerning the hospice. We also reviewed the information included in the provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the hospices most recent annual quality accounts report which services commissioned by the NHS are required to complete which gives information about the quality of the service they provide.

During our inspection we spoke with seven inpatients, five people attending the Anniversary day centre and seven family members/carers and/or friends. We also met 20 managers/heads of departments, 25 members of staff and six volunteers. Clinical managers and staff we talked with included the services registered manager and director of nursing, two consultants, the lead nurse (Matron), two nurse managers, eight registered nurses working on the wards, five health care assistants (HCA), five community nurse specialists (CNS), the hospices' pharmacist, the allied health care professionals lead, two physiotherapists and an occupational therapist.

Non-clinical managers and staff we spoke with included both St Christopher's Joint Chief Executives (JCEs), the new head of quality assurance and governance, the Anniversary (Sydenham) and Caritas (Orpington)

centres manager, the head of patient and family support, four social workers, a bereavement councillor, the volunteers coordinator, an arts therapist, the head of catering, a chef, two facilities and estates managers, two orderly's, two administrative staff, and the hospice's leads for spiritual care, complementary therapies, arts and music therapy, and the welfare and benefits advisor.

We undertook general observations during our time spent on all four wards, in the Anniversary centre and the surrounding gardens. We also attended the Schwartz round, which is a reflection group for staff that was held in the conference room and a community patient group chaired by a social worker in the Pavilion gardens lodge. We looked at six people's care plans and eight people's medicines records. We also saw the personnel files for fourteen members of staff and five volunteers. We were supplied with additional information relating to the overall management and governance of the hospice on request. This included accident and incident reports, complaints, compliments, health and safety checks and quality monitoring audits.

Over the course of this three day inspection we made telephone contact with a further 40 people living in South East London who had received an inpatient, community and/or day centre service from St Christopher's and 25 family members or informal carers. We had additional feedback from a representative of the five Clinical Commissioning Groups (CCGs) in South East London (Bromley, Lewisham, Lambeth, Croydon and Southwark CCGs) who formed a consortium to agree a range of end of life services, under one overarching contract. We also received comments from four social care professionals who managed nursing and care homes in Bromley and Croydon for adults with learning disabilities and for older people living with dementia. In addition, we looked at the outcome of various service user and staff satisfaction surveys conducted by the provider and audits undertaken by external bodies including Lewisham hospitals infection prevention team and Bromley Healthwatch. Healthwatch is the national consumer champion for health and care in England.

Good

Is the service safe?

Our findings

Patients, people in the community and their families consistently told us they felt safe receiving hospice services from staff and volunteers who worked at St Christopher's. One person said," I feel very safe with staff from St Christopher's. My nurses always wear their identity badges. I would and do trust St Christopher's with my life." A relative told us, "We feel safe with St Christopher's staff. We know the nurse really well because it's always the same one who comes to see my husband every week", while another relative said, "It's so important my [family member] feels safe when the nurses visit us at home, which is exactly how they make us feel."

People were protected from avoidable harm and potential abuse and neglect because the hospice had taken reasonable steps to minimise the risk of this happening. Staff and volunteers were aware of their responsibility to safeguard people from harm. All staff and volunteers received safeguarding adults and child protection training which was refreshed annually. Staff also received training on equality, diversity and human rights to help them understand how to protect people from discriminatory practices and behaviours. Staff and volunteers were knowledgeable about the different types of abuse and neglect and what action they were required to take if they suspected anyone was at risk of harm. It was clear from discussions we had with staff and volunteers they would liaise with their manager if they had concerns about a person's safety.

We saw staff had been provided with staff handbooks which contained safeguarding adults and children at risk guidelines and the hospice's staff whistleblowing policies and procedures. The hospice had also produced a prompt card for staff that contained a step by step guide telling them what they were required to do if they suspected people were at risk of harm. Several members of staff also showed us this card which they said they kept on them while they were at work for reference.

The hospice had a suitably trained and experienced designated safeguarding lead who had close links with all the local authorities in South East London, which helped them remain up to date with best safeguarding practice. A social worker gave us a good example of how they had worked closely with a local authority's social services department and community mental health team to keep a person safe and ensure continuity of their care following the death of their primary carer.

The provider identified and managed risks appropriately. We saw a number of risk assessments were in place for people on the wards, aimed at identifying and reducing potential risks people might face. This included risks associated with mobility and falling, using a hoist and sling, developing pressure ulcers and becoming malnourished and/or dehydrated. Where people were identified as being at risk, management plans were put in place for staff to follow. For example, if people were at risk of falls, preventative measures were put in place that included lowering the person's bed and/or providing them with additional one-to-one staff support as and when required.

If new risks had been identified patient's care records and the information board hung in the staff office on each of the wards were immediately updated to ensure staff had access to all the information they needed

to keep people safe. For example, the patient information board in the staff office we visited on one ward clearly identified who was at risk of falling and needed additional one to one staff support. A community nurse showed us electronic versions of environmental health and safety risk assessments they carried out on the homes of people they visited in the community. The risk assessments and management plans described above were all regularly reviewed and updated accordingly by clinical staff to help ensure people's safety.

Staff were knowledgeable about the specific risks people might face and the action they needed to take to protect them. For example, we saw equipment such as a pressure relieving mattress had been provided to support a person identified as being at risk of developing pressure ulcers. One member of staff told us, "It's always very clear from the information contained in a person's risk management plans what type of equipment we need to use to keep them safe and make their stay here as comfortable as possible."

The provider managed accidents and incidents appropriately. We saw care plans were immediately updated in response to any accidents and incidents that happened. This ensured care plans and associated risk assessments remained current and relevant to people's needs. We saw records contained detailed information about the occurrence of any incidents involving people using the service, action taken to support people and prevent similar incidents reoccurring. The managers reviewed all incidents that occurred to identify any trends or patterns.

The provider had suitable arrangements in place to deal with emergencies. There was a major incident procedure and a business continuity plan to help staff deal with such eventualities. Staff told us they regularly participated in 'major incidents tests' which in recent years had included various mock emergency scenarios involving a fire, a power cut and flooding at the hospice. The matron told us a major incident test would be happening the week after our inspection, but would not know until the day any details about the type of major incident scenario they would be practising.

We saw four fire risk assessments were in place for all the main buildings and personal emergency evacuation plans (PEEP) had been developed for people staying on the wards. This provided staff with clear guidance if people needed to be evacuated from the premises in an emergency. Staff demonstrated a good understanding of their roles and responsibilities in the event of a fire as they had received fire safety and emergency training, which was refreshed annually.

The premises and equipment were appropriately maintained. Equipment was serviced and checked in line with the manufacturer's instructions. For example, maintenance checks and servicing were regularly carried out at the hospice by suitably qualified professionals in relation to mobile hoists, pressure relieving mattresses, fire extinguishers, fire alarms, emergency lighting, portable electrical equipment and water, gas and heating systems.

We observed the environment was kept free of obstacles and hazards which enabled people to move safely and freely around the wards and communal areas, which included the gardens'. We saw chemicals and substances hazardous to health were stored safely in locked cupboards when they were not in use. Staff had received health and safety training and there was a lead who took overall responsibility for health and safety management at the hospice.

We checked the provider's recruitment processes to make sure they were thorough and that only suitable staff were employed. The staff and volunteers files we looked at all contained an application form, notes from interview, proof of identity, the right to work in the UK, a full employment history, relevant qualifications and experience and references from previous employers. There were also Disclosure and

Barring Service (DBS) checks. We noted DBS checks were renewed every three years for all clinical staff and every five years for non-clinical staff. There were also regular checks carried out on nurses, therapists, social workers and councillors with their respective professional organisations to ensure they remained registered and were suitable to practice. Staff were also asked to advise the human resources department if there were any changes in between these checks.

In addition, there was a robust recruitment process for volunteers, this included identity, criminal records and character checks to ensure they were suitable to work at St Christopher's. Volunteers who worked directly with people receiving a hospice service from St Christopher's were known as patient-facing volunteers. They had an additional interview about the demands of the work to establish if they were suitable for this role.

We saw staffing levels were sufficient to meet the needs of inpatients and people in the community, as well as keep them safe. People consistently told us staff spent quality time sitting and talking with them and their families. Several people also mentioned the high clinical staff to inpatient ratios on the wards. A person's relative told us, "You only had to press the buzzer once and they [staff] turned up right away to make sure my husband was ok." Throughout our inspection we observed staff and volunteers regularly spending time sitting and talking with inpatients, people visiting the centre and their family and other visitors.

Staffing numbers were determined according to people's needs. From observations we saw there were enough staff to meet the needs of inpatients on the wards and attending the Anniversary centre and the associated clinics and gym. The skills mix of the team at St Christopher's included clinical staff, therapists, social workers, councillors and volunteers. We saw the staff rota was planned in advance and took account of the level of care and support inpatients, people in the community and the centre needed.

It was also clear from discussions with staff that they felt the ward was adequately staffed. One member of staff said, "Things can get pretty hectic on the ward sometimes, but you can usual find time to just sit and chat to patients and their families. It's an essential part of what we do here." The matron told us the advanced practice team had carried out an audit of safe staffing levels in October 2015 to check they were meeting NICE Guidance for safe staffing. The review found there was a good balance with nurses spending slightly longer time in direct patient care when compared to other hospices. We were told if there were shortfalls in the staff rota, they used their own bank staff to cover shifts and never used agency staff. This ensured patients received continuity of care and support from staff who were familiar with their needs and wishes.

Managers gave us a good example of how out of hours nursing cover in the community had been improved in the past 12 months. This had been achieved by increasing the number of staff who worked on the wards at night to include an additional floating nurse and a health care assistant. These staff were available to cover night time requests for support from people living at home in the community. This was in response to concerns raised by a number of people and staff about not always having enough community nurses available at night to respond to out of hour's community calls.

The hospice was kept clean. People commented on the cleanliness of the wards. One patient said, "The whole place is absolutely clean. The orderly's do a fantastic job", while another patient's relative told us, "The wards are always spotless whenever I've visited". A recent audit carried out by Lewisham hospital's infection prevention team noted, 'The general environment on all four wards at the hospice was visibly clean and free from dust and dirt'.

Orderly's demonstrated a good understanding of their responsibilities and the importance of maintaining

high levels of cleanliness. We observed all staff washing their hands and using hand gel before entering and upon leaving patients rooms. To reduce the risk of infection all visitors were asked to use the alcohol foam dispensers before entering and leaving the wards. Staff wore personal protective equipment (PPE) as required. Staff followed appropriate guidelines in relation to the safe management of clinical waste and soiled linen. Appropriate systems were in place to minimise risks to people's health during food preparation, for example through the use of colour coded chopping boards and the daily checking of fridge and freezer temperatures. Managers and senior staff undertook regular checks on the cleanliness of the service and addressed any concerns with the orderly's so they could be rectified. Managers confirmed no MRSA infection or vomiting and diarrhoea outbreaks had taken place at the hospice in the last 12 months.

Medicines were managed safely. We received positive feedback from people about the way the hospice handled their prescribed medicines both on the wards and in the community. Comments included, "They [nurses] check that my [family member] is on the correct medicines and they are free of pain," and "They [community nurses] check with my [family member] to see he's not in any pain and they change his medicines if he needs it to be changed."

The provider had suitable arrangements in place for obtaining medicines and pharmaceutical supplies in an emergency. Staff could obtain medicines seven days a week. A senior clinical pharmacist was based at the hospice on weekdays from 9am until 2pm and outside of those times; staff could contact the local hospital pharmacy department or an on call pharmacist. For people looked after in the community by the hospice, staff (where possible) gave prescribing recommendations to the person's GP. The GP arranged medicines supplies by writing a prescription. If a medicine was needed urgently, hospice staff could provide a prescription for dispensing at a local pharmacy. If the medicine was needed in an emergency, the hospice had a small supply of pre-packed medicines that they could give to people.

We saw people had personalised medicines administration (MAR) sheets that were clearly written and included detail information about an individual such as their photograph, a list of their known allergies and information about how they preferred to take their medicines. Nurses signed the MAR sheets to provide assurance that medicines were given as prescribed. Our checks of stocks and balances of people's prescribed medicines confirmed these had been given as indicated on their MAR sheets. Medicines were administered by nurses that had received training in the safe management of medicines and whose competency was refreshed annually.

We saw medicines were securely stored in clinical rooms and medicines cupboards located on each ward. There was a robust procedure in place for the disposal of unwanted medicines, including patient's own drugs if they chose to dispose these at the hospice and sharps.

There were robust systems in place for the management of Controlled Drugs (CDs), which was strictly adhered to by the hospice's pharmacist and nursing staff. We saw there were appropriate records about the management of CDs and arrangements for the receipts and disposal of any unused or expired CDs.

Medicines were reviewed on a daily basis by the pharmacist, doctors and nurses. For example, medicines reconciliation (the process of ensuring that the list of medicines a person is taking is correct) was conducted by a nurse during the admission process. Two registered nurses carried out daily checks on controlled drugs kept on the wards and weekly checks for those used in the community. We also saw evidence that all the blood glucose testing kits were calibrated daily. This provided assurance that blood sugar readings obtained for people were accurate. The pharmacist told us they conducted a bi-annual audit of all the hospices medicines handling practices and checked medicines expiry dates every two months.

The medicines optimisation committee, which was chaired by the hospice's pharmacist, regularly met to review medicines policies and errors. Staff reported medicines incidents on an electronic system. We saw evidence that medicines incidents were dealt with appropriately and practice amended where applicable to prevent recurrence. We also saw that learning was shared across teams. The pharmacist produced a 'Pharmacy Related News' (PRN) bulletin which was used to share information with staff. There was also a patient safety bulletin jointly produced by the pharmacist and senior nurse which had relevant information on medicines issues. Managers gave us a good example of how the hospice had responded to a number of medicines incidents by introducing a new tracking form used for medicines for patients on discharge from the inpatient units and the more frequent destruction of controlled drugs.

Outstanding ☆

Is the service effective?

Our findings

People told us staff were competent and that they had the right knowledge, skills and experience to understand and meet their needs and wishes. Feedback from people and their families included, "The nurses are so kind and definitely know what they are doing", "The nurses and volunteers are always so nice and always professional" and "All of them [staff] have an impeccable bedside manner". Bromley Healthwatch said, "St Christopher's had a strong focus on training of staff across the organisation", while a nursing home provider told us, "Two members of my staff team have received end of life care training from St Christopher's which they both have subsequently told me was excellent".

Staff who worked at St Christopher's benefitted from a high standard of training. Its education centre has pioneered developments in palliative and end of life care education and training for its own staff and other practitioners locally, nationally and internationally. The hospice worked in close partnership with other organisations to ensure they were following current best practice and providing high quality care through consultation, research, education and reflective practice. Comments we received from external health care bodies was extremely positive about St Christopher's education and training programmes. One community health care professional told us, "St Christopher's remains a pioneer in palliative and end of life care education and training for health and social care professionals working in the UK and globally", while Bromley Healthwatch stated, "There is excellent evidence of St Christopher's contribution to higher education programmes, public works and national and international publications".

St Christopher's had developed a ground breaking programme of vocational accredited end of life care training for staff in hospitals, care homes and domiciliary care agencies. For example, an innovative way the hospice supported staff working in local care homes to improve their palliative care practice included their Care Home Project Team (CHPT). This team provided regional training in the Gold Standards Framework (GSF) and ran the 'Steps to Success Programme' for managers and staff working in an adult social care setting. A manager of a care home for adults with learning disabilities told us the 'Step's to success programme' had provided them with, "A greater awareness of how to deliver good quality care to people they supported who were nearing the end of their life. The staff who delivered the programme were so knowledgeable; I would recommend this programme to anyone."

St Christopher's contributes and shares learning with other professionals and organisations such as schools, colleges and Universities. Courses provided at the education centre included a week long academy course for all professionals, Namaste training and principles in palliative care for people living with dementia, spiritual care, rehabilitation and exercise. The hospice also runs higher education programmes in palliative care for the faculties of nursing and medicine at Kings College London and in bereavement with Middlesex University. Working in partnership the hospice has set up a summer school with a local college for pupils interested in studying end of life care.

In addition to applying new practices for people using the service to benefit from, the hospice regularly shares learning internationally. Managers confirmed St Christopher's had given six international presentations in various countries in Europe, North America and the Caribbean in the past two years.

Managers told us over 300 hundred delegates from over 40 countries had received training from Christopher's in 2015/16. A manager gave us a good example of a five day event the hospice arranged in India in 2015 to promote palliative care nursing in that country

Staff and volunteers all received training appropriate to their roles and responsibilities. All staff received a handbook when they first start working at the hospice as a reference guide. This contained information for staff about the mission, strategy and aims of the hospice as well as health and safety reminders and employee wellbeing issues. All staff received a corporate induction to orientate them into work at St Christopher's and a role specific induction. The induction included sessions on the patient journey and the aims and philosophy of the hospice. All new clinical staff were assigned a mentor who they shadowed in the first month of their induction. In addition, it was mandatory for new clinical staff to complete training on safeguarding adults and children, the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS), moving and handling, infection control, food handling, oxygen management, incident reporting, confidentiality and fire safety as part of their induction. Health care assistants completed the St Christopher's Care Certificate programme which followed the nationally recognised programme for staff new to health and social care as part of their induction.

The provider had recently completed a review of the training they considered compulsory for each role so that staff had the necessary skills to support people effectively. This included specific end of life care and dementia awareness training for all clinical staff. Nurses also received training in pain/symptoms management, medicines, syringe drivers, pressure ulcer prevention and documentation, resuscitation, bereavement and having 'difficult conservations' about end of life care matters. One member of staff told us, "The end of life care training I've received at St Christopher's has been fantastic", while another member of staff said, "The on-going training I've received since working at St Christopher's has been second to none".

There were annual updates for clinical staff alongside the corporate refresher training which included manual handling, life support, mental capacity and dealing with people in distress. Specifically for nurses, there was medicines management and wound care updates. Attendance at training was monitored and any non-attendance addressed. Training courses were also evaluated by attendees to help make improvements. The hospice ensured managers and staff who hold professional qualifications, such as registered nurses and social workers for example, had opportunities for continuous professional development. Several nurses told us that in addition to the training described they had regular opportunities to improve their existing knowledge and skills by attending in-house medical forums and tutorials given by the medical director.

The hospice has 300 patient-facing volunteers. All these volunteers receive a structured training dependent on their role. Patient -facing volunteers must attend eight half day sessions which included the hospices vision and philosophy of palliative care, support of patients and the impact of illness, safeguarding, food hygiene, manual handling, communication skills, responding to difficult questions and fire safety. Volunteers spend time shadowing other experienced volunteers to familiarise themselves with the role. All volunteers were required to attend annual refresher training to ensure their knowledge and skills remained up to date. Most patient-facing volunteers had also received dementia awareness training. A volunteer told us, "I received a very thorough eight week induction from the hospice which I think prepared me well for my role here".

Staff were supported to undertake their roles and to consider their professional development. Throughout our inspection we observed a supportive culture amongst the staff group. Clinical staff regularly received formal one to one and group supervision sessions with their line managers and co-workers. This was confirmed by discussions we had with several nurses and health care assistants. In addition, there were regular team meetings and full organisational learning days for staff. One member of staff told us, "As a

nurse I've worked in many care settings, but I can safely say I've never felt so supported by managers and my fellow co-workers as I do at St Christopher's."

Patient-facing volunteers were also required to attend between three and six group support sessions with their colleagues and line manager throughout the year. Individuals support sessions with managers could also be arranged. Volunteers said they felt supported by their co-workers and managers. One volunteer told us, "If I have a problem or am worried about my work I can arrange to speak to the volunteer's coordinator, who I've always found to be very supportive."

Other means of support available to staff included the Schwartz round. The Schwartz round, which had recently been introduced at the hospice, is a forum for all staff from different backgrounds and levels of the organisation to come together once a month to explore the impact that their job had on them. The aim was to offer staff a safe environment in which to share their stories and offer support to one another. During our inspection we attended a Schwartz round where four members of staff from various departments within the hospice shared their experiences of working at the hospice. Several staff said they regularly attended the Schwartz Round because they found it such an uplifting and supportive experience. One member of staff said, "I always try to come to the Schwartz meetings if I'm not too busy. It's great to hear what my colleagues in other departments have been doing and more importantly how they feel about the work their doing. You certainly know we're all in it together after you've attended a Schwartz round."

There was an external counselling service available for both staff and volunteers. The hospice also organised reflective practice sessions where staff could discuss emotionally difficult situations they had experienced at the hospice. Two members of staff gave us good examples of how they had found a particular reflective practice session useful after they had been involved in a difficult end of life care situation.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes, hospitals and hospices are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw appropriate arrangements were in place to enable people to give informed consent to their care and support before this was provided. Care plans showed people's capacity to make decisions about specific aspects of their care was assessed. We saw staff explained the care they planned to give to people before providing it and respected the decisions people made. Staff had received MCA and the DoLS training and were aware of the implications of this in their practice. When people had been assessed as being unable to make specific decisions, best interests decisions processes were followed with the involvement of their relatives and other healthcare professionals. In cases where patients might have been deprived of their liberty, applications for the authorisation to restrict their freedom in their best interests had been made to the supervisory body under DoLS.

There was a strong emphasis within the hospice on the importance of good nutrition and hydration. People told us the food they were offered at the hospice was "good" and that they were always given a choice at mealtimes. Typical comments we received included, "The food is fantastic. It's always so well presented here", "You can choose whatever food you'd like to eat whenever you want it by using the electronic device

in the ward kitchenette which sends your order down to the cooks in the main kitchen. It's like being in a posh hotel with 24 hour room service" and "We ate in the little restaurant in the Anniversary centre and really enjoyed our meal". In addition, a bereaved family member who had participated in a recent satisfaction survey conducted by the hospice wrote, "My mother stopped eating in her last couple of days but the nurses tried to tempt her with food she might like, exactly as if she were at home."

When people first came into the ward one of the chefs would meet them and get additional details about what they liked and wanted to eat. We saw patients were given a comprehensive seasonal menu which included starters, mains, desserts, light meals, snacks and hot and cold drinks. Catering staff told us they prepared and delivered all these meals to order and fresh from the main kitchen.

There was flexibility in the meals offered and people were able to request specific meals whenever they wished. A relative of a patient gave us an example of how they had used the electronic call ordering service located in the kitchen on each ward to order some 'nibbles' for their family member to snack on because they had declined to eat any food during the day. Staff confirmed patients were asked what they would like to eat at set mealtimes throughout the day, but people could decide to eat whenever they wished. Catering staff also told us they regularly went out shopping to buy items of food that people had specifically requested to eat that were not available in the hospice. For example, a member of the catering staff told us, "In the past I've gone out shopping for lobster, which I cooked for one patient who said they had never eaten lobster before and would love to try some before they died."

People's nutritional needs were assessed by staff as part of the initial planning of their care and support. Care plans indicated people's food and drink preferences and dislikes, dietary requirements and the level of support they required for eating and drinking. Catering staff told us they were in daily contact with medical and nursing colleagues to ensure they were updated about the dietary requirements of patients. For example, staff knew patients' preferences for meals including those related to their cultural preferences, allergies and medical conditions. We saw the hospice used a system of red trays, plates and cups system to help staff identify which people needed additional support when eating or drinking or had special dietary needs, such as a pureed diet.

Where people were assessed as being at risk of malnutrition or weight loss, appropriate action had been taken by staff to refer them to specialist health care professionals, such as a nutritionist or dietitian. Staff closely monitored and recorded the dietary intake of people identified at risk of malnutrition on a daily basis, which ensured they had all the information they needed to determine whether they were eating and drinking sufficient amounts. We saw care plans for people who were in the last stages of life, contained additional information for staff about how to keep people hydrated and comfortable.

A number of people received feeding through percutaneous endoscopic gastrostomy (PEG), which is a tube directly into the stomach of a person to give them specialised feed. Staff were well able to manage PEG feeding, although consideration was given to people being given opportunities to taste food in their mouths, where it was considered safe to do so, in order for them to have the sensation of food.

Patients and people in the community received holistic care from a multi-disciplinary staff team which meant they had access to specialist palliative care doctors and nurses, physiotherapists, occupational therapists and counsellors There was also a range of complementary therapies available such as aromatherapy, acupuncture, massage, hypnotherapy, relaxation, stress management and reflexology. One person told us, "Ultimately it's about improving the quality of life and regularly having my feet and tummy massaged by the complementary therapist really helps with the stiffness I experience." Several people told us about how complementary therapies are used for pain relief. One person said, "They really do focus on

pain relief here." A complementary therapist gave us a good example of how they had improved the physical health and emotional wellbeing of a patient through the use of acupuncture and massage. The member of staff told us these complementary therapy techniques had helped relax the person, which ultimately reduced their anxiety levels and the physical symptoms associated with that stress.

The physio and occupational therapists from the allied health care team ran a range of rehabilitative sessions including regular gym sessions to promote people's independence and physical health for as long as possible. Over a hundred people who receive a community service and inpatients care accessed physio sessions in the gym each week at the hospice. A physiotherapist gave us a good example of how they had set up the treadmill in the gym to make it safe for a visually impaired person to use after an individual had told them they had really enjoyed running before they lost their sight. The physiotherapist said this individual had told them they had "really enjoyed the experience of running again, which they said had made them feel like their old self." St Christopher's also ran specialist clinics that users of the service can benefit. For example there was a specialist lymphoedema (a condition where fluids collects in tissues causing swelling because of blockages in draining fluids from the body) service to support people across Bromley and patients with palliative care needs.

Most people had an up to date Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms completed and their advanced care preferences and decisions were clearly stated in their care plan. This meant staff were aware of the person's wishes and were able to make appropriate decisions about medical treatment in line with the person wishes.
Relatives told us the hospice was good at communicating with them and kept them informed of any changes in their family member's health. One patient told us, "Staff handover at the end of each shift must be good because everyone knows all about any changes in my condition immediately, which makes me, feel very safe." Staff told us multi-disciplinary team meetings were regularly held at the hospice to ensure people's health care needs were routinely reviewed. If specific needs could not be met by the hospice, there were discussions with people about referring them onto other specialist teams.

People told us they were happy with the hospice's environment. A patient told us, "It's pleasant enough in the shared bay on the ward", while another patient said, "I've got everything I need in my room, which is relatively comfortable space. No complaints about it". Feedback we received about the Anniversary centre and the hospices gardens were equally complimentary. One person's relative said, "The gardens are beautiful. I find them very comforting," while a visitor told us, "I often come to the centre for a cup of tea and a bite to eat with my friend. It's a fantastic little restaurant and the atmosphere is always so relaxed and pleasant".

The inpatient units had been decorated to a good standard mainly in white which gave these spaces a light and airy feel. Managers told us about a one day workshop in April 2016 which staff had attended to learn about 'enhancing the healing environment'. Several staff told us the workshop had really helped them understand how light, colour and art could be used to create a more healing and dementia friendly environment within the hospice. As a result of the workshop a plan and a task force had been set to improve the environment over the next 12 months.

The hospice's internal and external spaces were accessible to wheelchairs and those with mobility impairment. We saw there were passenger lifts that lead to all the inpatient units and ramps leading to public areas, which included the Anniversary centre and cafe, the Pilgrim multi-faith room, gymnasium, complementary therapy clinics and gardens. A relative told us, "My father loved live music, so I was so pleased the nurses took the trouble to wheel his bed downstairs to the Anniversary centre one evening when a concert was on." Several people visiting the centre and staff confirmed it's not uncommon to see patients

who are unable to move, in the garden enjoying it from the comfort of their bed.

The hospice stocked a wide range of equipment such as hoists, walking frames and commodes. This meant, the hospice could respond quickly to ensure people staying in the hospice and those in the community had access to equipment when they needed it. When a patient mentioned their bed was not particularly comfortable because it felt lumpy the nurse in charge of the ward changed the mattress immediately. We saw beds were adjustable which meant they could be lowered if someone was at risk of falling out of bed. Staff told us the hospice had good links with other organisations providing a range of equipment, such as pressure relieving mattresses and hoists so these can be obtained promptly if needed.

Good

Is the service caring?

Our findings

People and their families told us St Christopher provided excellent care and typically described the hospice as "amazing". Comments we received included, "The standard of care my [family member] received was outstanding. A top notch service", "Ten out of ten. The hospice is marvellous. I cannot speak more highly of them and would recommend them to anyone" and "The hospice is first class. I could not ask for better. I'm extremely pleased with them". In addition, most people receiving a community service who had participated in a recent satisfaction questionnaire carried out by St Christopher's rated the care they had received by the home care teams as 'exceptional'. A person who had completed this questionnaire also wrote, "My [family member] could not have received better treatment in their last few days than they did at St Christopher's."

Feedback we received from people about the staff and volunteers who worked for the hospice was equally complimentary. People typically described staff as outstanding", "compassionate" and "kind". People felt they had developed close working relationships with staff. Comments made included, "We have nothing but admiration for all the staff who work for St Christopher's. They're like angels"; "The St Christopher's staff are a credit to their profession. Best carers I have ever had the pleasure of meeting. They're all absolutely charming" and "From the first day I met the staff it's been a beautiful experience. The nurses are always smiling and polite".

People's privacy was respected and their dignity maintained. People told us staff were respectful and always mindful of their privacy. It was clear from the outcome of a recent satisfaction survey conducted by the provider that most people felt staff always treated them or their family members with respect and dignity. We observed staff draw a privacy curtain around a patient who was staying in a shared 4 bedded bay before they were about to be provided with personal care. Managers gave us a good example of how they arranged for the Pilgrim multi-faith room to be used as a meeting room as well as overnight accommodation for the large extended family of a patient who was part of a travelling community. This helped to ensure the person could spend time with their family in private without disruptions to other patients and their visitors. We saw other separate rooms were available at the hospice to have conversations with family members if people did not wish for this to take place in their bedroom or a shared bay.

Staff treated people with respect and dignity. People looked at ease and comfortable in the presence of staff and we saw they supported people in a caring and dignified way. For example, we heard conversations between staff and inpatients were characterised by warmth and compassion. We also saw staff reassure a patient who looked frightened and taking their time to calmly explain what personal care they were about to provide this person.

People and their families were fully involved in the end of life care planning process that included finding out what was important to the individual, assessing their symptoms and pain so these could be managed appropriately and what outcomes they wanted to achieve. People told us they felt comfortable discussing their health and social care needs and preferences with staff who took time to explain what their care and treatment options were. One patient said, "I have a care plan and I was totally involved in saying what went into it." Staff had received training on how to have difficult conversations which enabled people to express

their end of life care preferences. This ensured people had the opportunity to let their family, friends and professionals know what was important and mattered to them in the event of them not being able to express their wishes. Several relatives whose family members had expressed a wish to die at home told us how supportive staff had been when it came to ensuring their family members dying wishes were met.

People were given information about the services and facilities offered by the hospice to enable them make decisions about their care. In addition to people being given a brochure there were a set of colour coded booklets available to people and visitors on a range of subjects regarding end of life care. For example, this included information about what it's like to be an inpatient, making wills, medicines used in pain management and understanding bereavement. We also found that some of the information was available in easy to read formats for those people who might benefit from these.

Staff were respectful once a person had died and ensured the person's body was treated with dignity and respect. Staff told us how they gave family members the space and time they required to stay with their loved ones after death. The hospice had a viewing room specifically designed for families who wish to see their family member's body. Family members were also given the opportunity to attend a bereavement meeting where they could obtain practical advice and support about arranging the funeral.

Staff and volunteers had a knowledge and understanding of the issues surrounding confidentiality and were able to tell us how it worked on a day to day basis. For example, the times they needed to share health information with other professionals.

People were supported to maintain relationships with their families and friends during the last moments of their lives. People's families were supported to visit the hospice at times that suited them and the person receiving care. There were no restrictions on visiting times. One relative commented, "I've been allowed to spend every night with my [wife] in her room and I've been given a reclining chair beside her bed to sleep in, which is surprisingly comfortable." Staff told us people could have visitors stay overnight in their room if they wanted to be closer. The Anniversary centre and café is open 13 hours a day, seven days a week and vending machines selling snacks and drinks are available when the café is closed.

Bereavement support in the form of counselling was available to children, adults and their families. The hospice ran a bereavement service for adults and their families following the death of someone under the care of St Christopher's and the Candle project for children who have lost an important member of their family. There is also a telephone advice line. People told us they had been offered counselling and support before and after their family member had passed away. One person told us, "I find it a great comfort to come to the centre to sit and talk with other people who have been recently bereaved like me", while another person said, "I've continued coming to the Anniversary centre long after my [family member] died because it's a great place to have a chat with the staff and volunteers, especially if I'm feeling a bit down." Most people who had participated in recent surveys by the hospice also said they had received enough help and support from St Christopher's since the death of their family member or friend.

During our inspection we were invited to attend a support group lead by a social worker for people receiving a community service from the hospice. People told us they found this group a useful forum to talk to others who may have similar experiences of dying and loss. Another visitor to the centre told us how useful they found it talking to the volunteers about their recent loss because their own family were reluctant to discuss it with them. Staff told us bereavement support and a death chat group regularly meet at the centre which gave people an opportunity to meet and talk about death and dying with staff, volunteers and others who may have similar experiences of loss. Staff also told us the day after a death the bereaved family would be offered the chance to meet with professionals involved in their family members care. Each ward had a

designated social worker who would listen to any concerns or worries people may have. The hospice also made contact with bereaved family members within six months of their loss to enquire how people are coping and whether or not they needed additional support. There were also remembrance services held throughout the year, which gave families, friends and staff the opportunity to remember people who had died.

Staff encouraged and supported people to be as independent as they wanted to be. One patient told us, "They [staff] let me be as independent as possible. For example, I always have staff to help me with my hoist, but I can do my own personal care, so staff leave me to get on with that." A member of staff gave us a good example of how one inpatients constantly changing health condition meant on occasion they were capable of eating their meals independently, so staff ensured this individual was always given the opportunity to choose whether or not they needed any staff assistance to eat and drink at every mealtime. We saw a risk-assessment the hospice used when a person expressed a wish to self-administer their medicines, which included information such as stocks of medicines and if the person was capable of managing their own medicines safely. There were also initiatives to help people stay in their own homes for as long as possible rather than be admitted to the hospice or to hospital. A community nurse gave us a good example of how they had enabled a person who wanted to stay in the community to continue receiving a hospice at home service by teaching a family member to use the syringe driver their family member needed.

The hospice was committed to meeting the diverse cultural and religious needs and customs of the population it served. Staff were knowledgeable and respectful of people's diverse cultural and spiritual needs including before, during and after death. Several staff told us they had access to information about different religious rites and practices which included Christian, Muslim, Sikh, Hindu and Jewish faiths. There was also regular contact between the hospice and various faith groups in the community to continuously consider how end of life care could be provided more appropriately. These measures ensured wishes for end of life care could be met. For example, staff knew for some religions it was important that a burial needed to happen soon after the death of a person, and they could work with funeral directors to ensure this happened. The hospice has access to an interpreting service so staff were able to communicate with people who were unable to speak English. This ensured people had the information they required to make decisions about their care, and communicate their wishes.

A chaplaincy service was available to support people and their families with any spiritual or religious needs they had. During a tour of the premises we visited the Pilgrim room which is a multi-faith space where people could practice their faith or just spend time in peaceful reflection or quiet meditation. We saw candles that people could light, a book to record thoughts and memories and Muslim pray mats were available in this room for people to use. The hospice's Reverend gave us some examples of religious services he had performed at St Christopher's at the bequest of patients, which had included a baptism and numerous marriages, including several gay weddings. Another member of the chaplaincy team told us the spiritual care service was able to support people and their families with funeral arrangements.

Good

Is the service responsive?

Our findings

People's individual needs, preferences and differences were respected. People told us the hospice provided them with a personalised service which was responsive to their care needs and wishes. One person's relative said, "The staff have treated my [family member] as both a human being and an individual."

Staff and volunteers were motivated and committed to providing the best quality end of life care they possibly could in accordance with people's wishes. They told us that they always found out what was important to the person and tried to do what the person wanted. The hospice had recently introduced 'one-page' profiles which patients and their families were encouraged to complete so staff understood more about who people were and how they wanted to be supported. One person told us, "They [staff] asked me lots of personal details about myself when I first arrived on the ward, which was fine by me because the nurses were just trying to get to know me."

Discussions with people about their physical, social and psychological support needs were undertaken by the community palliative care team as part of the initial assessment. We saw each person had a care plan that was tailored to meet their individual needs and preferences. These personalised plans provided clear information for staff about people's physical and emotional care needs, life history, individual preferences that included dietary and religious requirements and family and social relationships that mattered to them. We also saw that people had advance care plans which documented their wishes and preferences in regards to end of life care, including what life support they would want and in what circumstances. This enabled people to make informed choices as to when and if they wanted to be taken to hospital for further life support. The service was also accredited to the Gold Standards Framework (GSF). The GSF is a model that enables good practice to be available to people nearing the end of their lives, irrespective of diagnosis.

People told us the staff routinely reviewed their treatment, support and care needs. Care plans were reviewed daily or more frequently if required, to ensure the care and treatment people received was in line with their current needs and took into account the frequency with which people's needs and preferences might change. It was also clear from staff handover meetings and records that information regarding changes to people's care needs were communicated across the entire staff team so they were all aware and to make sure people's changing needs were being met.

Staff were aware of the signs and symptoms to look for that indicated a person's health was deteriorating and knew how to appropriately manage people's changing health care needs. Staff were proactive in reviewing people's changing needs and preventing any other complications. For example, we saw pressure relieving mattresses were available and people were regularly turned to relieve pressure to particular areas of the body and reduce the risk of pressure sores developing.

The community palliative care team provided a hospice at home service for people who chose to spend the later stages of their illness in their own home. A relative we spoke with about the community team told us, "They [community nurses] come to visit my husband at home now every week. They do all the checks and make sure all is well. I can call them at any time if I am worried about my husband." Another person's

relative said, "The community nurses make appointments with my [family member] and they always turn up on time. They are really helpful and they make sure everything is ok."

The community palliative care team is managed by a clinical nurse manager and consists of clinical nurse specialists and staff nurses. They provide symptom control, advice and practical and emotional support to patients and their families. People's individual needs were regularly re-assessed and reviewed. The community palliative care team worked flexibly and in collaboration with other healthcare professionals within the community in order to respond effectively to people's changing needs and/or preferences.

The hospice clinical nurse specialists work a shift system up until 10pm. Overnight, the advice and visiting service is managed by senior nurses on duty in the inpatient unit. Staffing levels for this reflect the need for community support. Medical advice, support and patient assessment is also available from the medical team 24 hours a day/seven days a week. The hospice also has a hospice at home service providing practical nursing care to support patients and families at home in the last days of life.

The hospice had a 24 hour helpline run my medical and specialist nursing staff, which meant people and their families/carers living in the community, could seek professional advice and support whenever they needed it. A relative told us, "I know I can call the helpline any time if I am worried about how to manage my husband's pain", while another person's relative said, "Communication is very good with the hospice. I did call them once late at night when I was having a bit of a crisis and needed some additional support."

The hospice supported people to engage socially with others to help prevent social isolation. One person's relative told us, "They [community team] assessed my mother's needs at home and then got a physiotherapist involved who encouraged my mother to do some light exercises at St Christopher's gym as well as join in some of the social activities they provided at the Anniversary centre. The hospice has been very good at getting my mother motivated again." A community nurse told us how a nurse, a physiotherapist and a volunteer all worked in partnership to help a person in the community use their walking frame again to go for short walks with a volunteer. This helped improve the individual's mobility and reduced the risk of them becoming socially isolated in the community.

Furthermore, the hospice has a team of eight art and music therapists who offer inpatients, people in the community and their families a wide range of complementary art and music therapies including, quilting, painting, ceramics, creative writing, life story work, art therapy, digital art, music therapy, music lessons, dance and drama groups. An art therapist told us how they had helped a person who liked music to write a rap song and then asked the Brit-school (A performing arts school in Croydon) to put the lyrics to music. The member of staff told us, "[the young person] had been delighted their dream of having a rap song they had written put to music had become a reality." We saw a large collection of paintings and patchwork quilts that had been created by patients, people in the community and their families were displayed throughout St Christopher's. This helped people maintain their social interests and contact with others.

The Anniversary centre staff said they kept people staying on the wards informed about the social activities taking place at the centre and would offer one-to one-activity sessions to people, if they chose not to take part in the group activities. Computers and free Wi-Fi were available at the centre for public use and to help people maintain contact with others. There was also a hairdresser on site for patients. A person told us, "If you look good you feel better." A team of volunteers had also arranged to give those people who wanted to a make-over to make people feel better about themselves and to improve their self-esteem.

People's care records included information for staff about how they could actively support people living with dementia to get involved in helping them plan the end of life care they received. A member of staff told

us about a weekly café group they had set up in the Pavilion Garden lodge specifically for people in the community living with dementia and their relatives/carers. This was in response to concerns raised by staff about the risks of people living with dementia becoming disorientated and distressed in the main Anniversary centre which was often quite busy and noisy. Several clinical members of staff confirmed they had received dementia awareness training. Staff told us the hospice had three designated dementia champions whose key role was to promote dementia awareness and provide colleagues with information and support about dementia care.

The hospice responded to feedback from young people they supported who were living with a life limiting condition by setting up a group for young adults aged 17-25 who wanted the chance to meet other young people with similar conditions. A member of the young adult group said, "Going out and meeting people is really good as it makes us feel 'normal'." The project offered weekly drop-in sessions at the Anniversary centre for approximately 20 young people, their siblings and friends. The aim of the group was to offer young people the chance to socialise and have lunch without their parents and participate in a wide range of complementary therapies and social activities including music, painting and drama. Staff told us how they had attended a music festival with some young people using the service over the summer and had camped for several nights. One member of staff told us, "Although the trip had been logistically quite difficult to arrange, it had definitely been worth it because so many of the young adults group have said since how much they had enjoyed camping out at a 'proper' music festival like other people their age."

The hospice employs welfare and benefits advisors to support and signpost people and their families to information that may be beneficial to them in relation to their social, employment or legal needs. This may include any help they require in respect of social benefits, welfare advice, and legal matters such as appointing a power of attorney. A relative said, "A welfare officer from St Christopher's told us about how we might be able to get some financial assistance from the local authority to help my [family member] with her energy bills." A welfare and benefits advisor described the service they provided as, "Being a bit like a mini citizens advice bureau." They gave us several examples of the varied work they did which had included arranging for pets to be rehomed after their owner had passed away.

People we spoke with were aware of the provider's complaints policy and told us they felt comfortable talking to managers and staff about any concerns they might have about the hospice. One person told us, "If I had to make a complaint I would just call them and I know they would sort things out for me." The consortium of commissioning CCGs also told us, "We have found them [St Christopher's] quick to respond to any issues raised and are very pleased with the services we have commissioned from them." We saw St Christopher's had produced a complaints leaflet which was available throughout the service for people to access. We also saw that comments boxes were available for people to given written feedback to the hospice.

There was a system to manage complaints and we saw that complaints received had been investigated and dealt with effectively and resolved to the complainant's satisfaction. We saw that, where required, processes had been reviewed and changed to improve the service. For example, a person complained about a delay in their family member being admitted to a ward which resulted in them dying at home contrary to their wishes. The complaint was upheld following an internal investigation and staff were reminded that an urgent request for an inpatient admission should not wait for the morning ward meeting. This is a good example of how the hospice had learnt lessons to minimise the risk of something similar reoccurring. The hospice had apologised to the family.

The provider recorded compliments received and discussed any arising theme during their governance meetings. The hospice received over one thousand letters or thank-you cards from discharged patients and

bereaved families following the care they received from St Christopher's in the last 18 months. Recent compliments we read related to the warmth and kindness of staff and the time staff were able to dedicate to support people using the service. Compliments were discussed and used to share good practice amongst the team.

Outstanding ☆

Is the service well-led?

Our findings

People, their families and external community professionals were very positive about the way the hospice was managed and consistently described the service as exceptional. Comments we received included, "For such a big place I don't know how they run it so well" and "The people at the top are clearly very good at what they do".

There was a stable and clear management structure to ensure accountability and for the service to be provided in a seamless and exceptional way. Throughout the organisation staff understood their lines of responsibility and accountability for decision making about the management, operation and direction of the hospice and its services. Managers demonstrated strong leadership and a commitment to providing people with safe, high quality care.

Staff were very complimentary about the hospice's executive team and managers and said they were approachable, open and honest. One member of staff told us, "The hospice is extremely well-led. All the managers are also very approachable and can always be seen wandering about on the wards and in the day centre", while a volunteer said, "All the managers and staff make you feel like you're an essential part of the team. A lot of them [staff] have told us we couldn't run St Christopher's the way we do without our dedicated army of volunteers". Staff and volunteers also described St Christopher's as being the most "life affirming" place to work.

Executives, senior managers and staff spoke about their vision for St Christopher's including the importance of their core values. St Christopher's core values included providing compassionate care, empowering people, working together as a team, working with the local community and in partnership with external professional's bodies, and being the pioneers and experts in end of life care. It was very evident from comments we received from staff throughout our inspection that they embraced and demonstrated these values in all aspects of their work. One member of staff told us, "I'm so proud to work at such an amazing place", while another member of the catering team said, "You'd think it might be depressing working in a hospice all day, but it's probably the most life affirming job I've ever had. It's an absolute honour to make people a meal, which is sometimes their last".

Managers promoted an open and inclusive culture which welcomed and took into account the views and suggestions of people using the service. One person said, "The staff are always asking me to fill out questionnaires about how well they're doing, which is fine by me", while another person's relative told us, "All the staff listen to what my [family member] and I have to say about what they do really well at St Christopher's and what they could possibly do a bit better".

The provider had a range of satisfaction questionnaires to get feedback from inpatients, people in the community or those using the Anniversary centre, and bereaved family members. Other ways to receive feedback included a forum for carers held in the Anniversary centre, comments boxes situated throughout the hospice and consultant ward rounds where patients and their families were given the opportunity to discuss any health and social care issues they might have.

It was clear from the findings of the 2016 satisfaction survey that people were satisfied with the services they received from the hospice. People said staff 'always treated them with respect and dignity, and had time to listen and discuss things with them'. Furthermore, over 90% of patients who were discharged from the wards and bereaved relatives who also completed this survey said they were 'extremely likely' to recommend St Christopher's to their family and friends.

A good example of how the provider valued patients' and their families' views in improving the service was the patients safety – prevention and confidence group. The group which was set in April 2015 and met regularly to gather feedback from patients, people receiving a community service and their families about their experiences of trips, slips and falls. Managers told us information received from the group was currently being analysed to consider if any trends in the number and type of falls experienced at the hospice had emerged so strategies to prevent or minimise the likelihood of such incidents reoccurring could be developed. Additionally, the hospice had taken account of feedback from people wanting easier access to St Christopher's out of hour's service. Managers told us the hospice had responded by increasing the number of night staff to respond to out of hour's calls and by producing fridge magnets with out of hours contact details on them so people in the community had this information easily to hand.

The hospice used innovative approaches in an attempt to reach more people in the local community who would otherwise not access hospice services. For example, the Bromley Care Coordination (BCC) was a service specifically designed by St Christopher's to enable people, thought to be in the last year of life, to receive timely and coordinated care. The majority of these people would not have met the referral criteria for "specialist palliative care" services and therefore had previously been excluded from receiving hospice services. Community nurses told us nearly 200 people who had chosen to receive palliative care at home are in regular contact with members of the BCC team. Nurses told us the aim of the service was to address inequalities in access to services for dying people in Bromley, prevent unnecessary hospital admissions, provide support to their families and carers, and to help people die with dignity in the place of their choice.

The outstanding service provided by the hospice was supported by comments we received from external community health and social care professionals. The consortium of commissioning CCGs wrote to us to say, "St Christopher's offers high quality end of life services to their patients. They have a reputation both locally and nationally for offering a holistic approach to end of life care. They are considered pioneers in end of life care and were recognised for such innovation with an award by Hospice UK for their work commissioned by Bromley CCG." A care home manager also told us, "The end of life care and support we received from St Christopher's was excellent. They motivated my staff team and helped us ensure we provided the person who was dying with the best end of life care and support we could provide them."

Managers told us how the hospice had acted upon comments made by visiting senior managers from Macmillan cancer support who had suggested making feedback St Christopher's had received from people about their experiences of using the hospice be made more accessible. The provider took on board these comments and created large posters with patients' feedback clearly displayed on them, which we saw throughout the hospice.

The provider used a number of initiatives to support staff and to involve them in the provision of the service including a quarterly staff forum which was attended by the chief executive, to show that staff's views counted and were important. The minutes of the last staff forum showed that a range of issues such as the hospice's equality and diversity policy, staff recruitment and selection and parking, were discussed. Staff also participated in an annual satisfaction survey conducted by an independent auditor. The results for the 2015 showed that the majority of the feedback was positive. For example, over 90% said they would be happy for a friend/relative to be treated at St Christopher's Hospice.

The provider had effective and established governance systems to assess, monitor and improve the quality and safety of the service people received from the hospice. There was a rolling programme of audits to monitor the quality of the service. The frequency was determined according to the aspect of the service being monitored and the audits were carried out on a monthly, quarterly and annual basis. These included audits of mattresses, infection prevention and control, staffing levels, medicines, pressure ulcer management, records and information governance. Findings from these audits were presented to the various committees described above. Where an issue had been found, an action plan was put in place to rectify the concern and make improvements.
Managers, heads of departments and staff met through various groups and committees and shared their discussions and findings with the quality and governance committee so any areas for improvements could be implemented. These groups included patient safety, medicines optimisation, nutrition, infection control, skin and wound care, safeguarding, data management, equality and diversity, health and safety, patient feedback, and the staff forum. The quality and governance committee whose members included Trustees from the board, the executive team and senior managers met every two months to review all the hospices performance indicators including any reports and improvement plans that related specifically to the quality of care patients and their families received from St Christopher's.

The provider was keen to continue developing the hospice into one of the leading hospices in the country and the world. They had reviewed their governance systems working in partnership with the Cicely Saunders Institute at Kings College London by piloting their Outcomes Assessment and Complexity Collaborative (OACC) programme. This is a quality assurance approach that focusses on measuring outcomes of care for patients and their families, such as good pain and symptom control, family support, well-coordinated and integrated care and continuity of provision. During the last 12 months St Christopher's surveyed patients, people receiving a hospice at home service and people living in care homes about their dependency levels, the 'burden' of their symptoms, the stage of their illness and the 'burden' of caring experienced by their families. Outcomes for patients were regularly analysed and reviewed through presentations from the OACC team and on-going discussions with academics, the hospice's Board of Trustees, clinicians and managers to assess their approaches to care for people and to identify any learning.

St Christopher's had also set up of a new committee to review the extent to which the organisation reached people who would not normally access the hospice's services because of their diverse backgrounds such as some hard to reach communities within South East London. The consortium of commissioners gave us a good example of how St Christopher's took into accounts the needs of the wider community by introducing a single point of access system which made it easier for external health care professionals to refer people into their end of life pathway.

To demonstrate that St Christopher's was one of the leading hospices in the country it took part in piloting and implementing the Integrated Personalised Plan (IPP). This was a new end of life care plan targeted at people in nursing homes. The provider helped staff working in local nursing homes to implement this initiative. To date the hospice had provided training to over 600 nursing and care staff from 17 nursing homes within Bromley, Croydon and Lewisham. A recent appraisal of the project concluded the IPP had been successful because there was evidence that the IPP document had helped to deliver better outcomes for people living in these nursing homes who were nearing the end of their life.

The hospice played a leading role in promoting end of life care within the local community and worked in close partnership with external community professionals and bodies. Feedback we received from community health and social care professionals was very positive about the working relationship they had with St Christopher's. The consortium of commissioners told us, "We have forged a strong working relationship with St. Christopher's. As many of St Christopher's services form part of a strategic out of

hospital transformation programme, they have worked hard to integrate with other community providers, to ensure a smooth transition into their care". A care home manager also said, "We have a fantastic working relationship with the hospice. Staff are always so willing to offer you their expert advice and support." Managers confirmed St Christopher's was represented on many of the local end of life care development groups, which included the End of Life Care Steering Group in Bromley and the Lambeth and Southwark End of Life Care Strategy Group.

The hospice was actively involved in building links with the local population. For example, the hospice involves local schools and art galleries, including the Royal academy, to regularly participate in art exhibitions and projects at St Christopher's. A patient's relative told us, "I love it when the school children visit the hospice and sing for us." The hospice also has a comprehensive social programme that operates out of the Anniversary centre that is open to the public. This ensures local people can join in social events at the hospice with people from the local community, their families, staff and volunteers. This helps the local community have a better understanding of the work St Christopher's does end of life care matters. Weekly social events at the centre include a community choir and pizza night, a curry and arts night, a quilting project, a series of concerts, a drama group, and tours of the hospice and Sunday lunch. Several staff and volunteers told us they felt the social events described above helped dispel a lot of the myths and preconceptions people who have never visited a hospice might have about St Christopher's.

St Christopher's plays an outstanding role in leading research and developing evidence based practices in the field of end of life care and palliative care. It works in close partnership with the Government and other national and international organisations, including various academic and research institutions to develop the field of end of life care. The hospice's medical director is the honorary chair at the Cicely Saunders Institute, Kings College London and leads research on behalf of the organisation. They also work closely with the research team based at the Florence Nightingale Faculty of Nursing and Midwifery at Kings College and with a number of academics from across Europe interested in developing new approaches to end of life care. Examples of some of the research projects that are currently on-going at St Christopher's and which people using the service can benefit from include, music therapy and spirituality, delivering quality and cost effective care for people with advanced conditions, informal carer's experiences of providing bladder and bowel care to patients with palliative care needs, the changing face of memorialisation and bereavement and theatre in the community.