St. John's Hospice North Lancashire and South Lakes

St John's Hospice

Inspection report

Slyne Road
Lancaster
LA2 6ST
Tel: 01524382538
www.sjhospice.org.uk

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

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

Summary of findings

Overall summary

Our rating of this service went down. We rated it as good because:

- The service had enough staff to care for patients and kept them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. Infection control was well managed. Staff assessed risks to patients, acted on them and kept good care records. Medicines were safely managed by staff and lessons were learnt from any incidents that occurred.
- Staff planned and provided good care and treatment, patients received enough to eat and drink, and pain relief when needed. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good care and treatment plans. Key services were available seven days a week for people to access.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families, and carers.
- The provider made it easy for people to give feedback and people could access the service when they needed it.
- Managers ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The provider engaged well with patients and the community to plan and manage services and all staff were committed to improving services.

However:

- We found personal protective equipment that expired and had not been removed.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	Good 	See main summary

Summary of findings

Contents

Summary of this inspection

Background to St John's Hospice

St John's Hospice is a charitable organisation located in Lancaster. The hospice provides palliative and end of life care for adults with life limiting illnesses. The staff team support people and their families, providing medical, nursing, personal, emotional support, therapy, and spiritual

care. They offer a 'hospice at home' service in the local community to assist individuals living at home and a variety of day and support services.

The hospice is purpose built and provides accommodation on the inpatient ward for up to 13 patients. The hospice is close to public transport routes and not too far from the town centre. It is set in large well-maintained gardens with adequate parking and clearly defined parking areas for disabled visitors. Situated in the grounds of the hospice is the 'Forget Me Not Centre', which provides counselling and bereavement services for patients and relatives. Situated in the centre of the hospice is the 'Courtyard Café' which serves as the hub for the local community.

Services are free to people, with St John's Hospice raising funds which is achieved through fundraising and charitable donations, with the remaining funds paid by NHS.

St John's Hospice has been registered with the Care Quality Commission since 21 January 2011.

The Director of Nursing and Quality was the registered manager and had been in place since 30 April 2014.

The service is registered to provide the regulated activity, treatment of disease, disorder, or injury.

We previously inspected and rated St John's Hospice as outstanding when we visited in July 2016, the report was published November 2016.

How we carried out this inspection

We inspected the service using our comprehensive inspection methodology. The inspection was unannounced (the hospice did not know we were coming). We carried out the on-site inspection on 20 December 2023.

During the site visit, the inspection team:

- Inspected the patient quiet rooms, communal garden areas, the mortuary, inpatient ward and supporting areas.
- Spoke with 20 staff, including the service user forum officer, head of ward services, director of nursing and quality, HR lead, health and safety officer, director of finance and resources, director of communications and engagement, reception staff, the chief executive officer and the chair of the board.
- Looked at training and recruitment files for 3 trustees (directors), 5 employed staff and 3 volunteers.
- We received feedback from people using the service including friends and family.
- Looked at 3 patient records.
- Looked at a range of policies, procedures and other documents relating to the running of the service.
- In the last 12 months there had been 161 patients admitted to the inpatient ward. There were 137 deaths and 35 patients discharged.

Summary of this inspection

- There had been 512 patients admitted to the community services, both Hospice at Home and Clinical nurse specialists. The team carried out 2620 face to face visits.
- There had been 509 night sits given to 185 patients.
- There had been 372 day respite visits given to 171 patients.
- There were 123 patients referred to day services.
- There were 128 referrals to the family support team (spiritual, talking therapies, and counselling- both adult, children and young people). the team gave 2854 1-1 sessions.
- Preferred place of death (PPD)- ward was 97% and community was 91%.

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Outstanding practice

We found the following outstanding practice:

- St John's hospice had produced a short film called 'Last days Matter' to support people without clinical qualifications to prepare for and help look after their loved ones. The film was being adopted by some teaching hospitals and other hospices locally and nationally.

- The hospice organised and contributed to an advice line, with senior palliative medicine physicians available out of hours to provide specialist palliative care advice to GP's and senior hospital doctors within the locality.

- The hospice had integrated patient records with GP and community services and could access the local acute NHS trust records to ensure continuity of care and real-time information. Clinical nurse specialists (CNS) worked jointly with the most socially deprived GP Practices in the area.

- St John's hospice hosted 2 students through a close partnership with a local university and had implemented their ideas regarding income generation activities such as, a music festival and a new charity shop at the university. The university had also worked with the hospice to develop a blueprint for an innovative App, 'The Memory Maker', which could host images of previous memories and enable new memories to be added.

- The hospice had developed and delivered an award winning 8 week schools programme for children who had suffered loss.

- The hospice had arranged for a persons horses to graze in the field outside their window during their last week of life when an inpatient. In addition, they had supported a young person, with the support of the police and prison service, to receive hospice end of life care.

Summary of this inspection

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

We did not identify any Action the service MUST take to improve:

Action the service SHOULD take to improve:

- The provider should ensure that effective checks are made of equipment and other expirable items and remove them when they have exceeded their expiry date. (Regulation 12)

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Hospice services for adults

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

Is the service safe?

Good

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

Mandatory training

The hospice provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up to date with their mandatory training, which was comprehensive and met the needs of patients. The hospice had a training schedule which detailed the requirements for mandatory training for clinical and non-clinical staff.

Training for staff was delivered through face-to-face and e-learning modules at least every 3 years, depending on the training topic. External organisations supported training requirements to ensure any updates were captured and delivered appropriately.

Nursing staff had a compliance rate above 93% for all mandatory modules.

Medical staff had compliance rates above 83% for all mandatory training modules.

Volunteers were included in mandatory training where relevant. All staff, volunteers and members of the board met the compliance rate of above 90% for mandatory training. At the time of the inspection compliance was 94% overall.

Staff had training in fire safety with compliance rates of 100% for medical staff and 95% for nursing staff. The hospice held unannounced fire drills with the latest drills held in October and November 2023. One of these drills was conducted overnight to ensure procedures were robust 24 hours a day. All staff evacuated in less than three minutes. No issues were identified with their evacuation processes.

Managers monitored mandatory training and alerted staff when they needed to update this.

Safeguarding

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

The hospice had a safeguarding policy, which provided guidance for staff on how to identify and report any safeguarding concerns. The policy included instructions for staff for making referrals to external agencies, such as the local authority safeguarding team.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

The registered manager was the safeguarding lead and had completed children and adults safeguarding training levels 3 and 4. The safeguarding lead was responsible for the review, investigation and external referral for any safeguarding concerns that had been raised by staff. Staff had completed training specific for their role on how to recognise and report abuse.

Safeguarding training for adults and children was delivered face to face to the clinical team at levels 2 and 3.

Staff completed prevent (counter-terrorism strategy) training as part of their mandatory training. Records showed 100% of eligible medical and nursing staff and 97% of care staff had completed level 3 adult and children safeguarding training.

We reviewed 3 of the most recent safeguarding notifications from the hospice. These were not directly attributable to the care and treatment provided by the hospice, and we found staff had taken appropriate actions to protect patients, including referral to the local authority and other health and social care professionals involved in the patient's care.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff we spoke with were able to define safeguarding protocols and understood who to contact with safeguarding alerts when they had concerns.

We saw evidence the service had an organised system in place for storing disclosure and barring service (DBS) information. A DBS check is a way for employers check your criminal record, to help decide whether you are a suitable person to work for them. This includes deciding whether it is suitable for you to work with children or vulnerable adults. The staff files we reviewed had completed enhanced DBS checks and all results were appropriate for the roles being undertaken.

Cleanliness, infection control and hygiene

Staff used infection control measures when visiting patients on inpatient ward and transporting patients after death.

The hospice had infection prevention and control policies which provided guidance for staff and staff completed mandatory infection prevention and control training.

The inpatient ward, sluice room, treatment room, day therapies area, patient and relatives' communal rooms and dining areas were visibly clean and had suitable furnishings which were clean and well-maintained.

The in-patient unit had 3 multi-patient bays with 1 observation bay located near the nurses' station and 5 side rooms. There was a separate admissions suite to allow patients to be admitted privately to maintain privacy and dignity. The admission suite was a large room which allowed carers, family and friends (as appropriate) to support patients during their admission.

Cleaning schedules and daily checklists were in place and up to date, and there were clearly defined roles and responsibilities for domestic, housekeeping and ward staff when cleaning the environment and cleaning and decontaminating equipment. Cleaning records were up-to-date and demonstrated all areas were cleaned regularly.

There was a seven-day laundry and housekeeping team on site. Patients' clothes and belongings were laundered and returned in a package with the name of the person who had been 'Proud to care for you' on it. Housekeeping team members' names and photographs appear on the 'Who is caring for you today' board on the ward, they were considered an integral part of patient care.

Personal protective equipment, such as masks, gloves, and aprons, were readily available across all the areas we inspected. There were enough hand washing sinks and hand gels available. Staff we saw were compliant with hand hygiene and 'bare below the elbow' guidance.

We saw evidence water outlets were flushed regularly to minimise the risk of Legionella and the service had a Legionella risk assessment in place.

Staff carried out an infection control audit monthly to check compliance against national infection prevention and control guidelines and to monitor the cleanliness of the general environment and equipment.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

The inpatient unit and community completed quarterly hand hygiene audits. There was 100% compliance in the year prior to inspection. For the same period, commode audits had compliance of 97% sluice and mattress audits were 100% compliance. Any actions needed were monitored via the two monthly audit and a national institute of clinical excellence group (NICE) which was chaired by the medical director. This group fed into the quarterly clinical operations meeting.

The hospice took part in an annual national audit programme. Out of 10 areas audited, there was 100% for 9 areas and 93% compliance for 1 area.

The hospice participated in the annual NHS Place audit and had scored 98.77% for cleanliness.

Environment and equipment

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

The design and layout of the hospice promoted accessibility in all areas. All the areas we inspected were well maintained, free from clutter and suitable for providing safe care and treatment for patients. There was secure access to clinical areas.

Patients could reach call bells and staff responded quickly when called. All the equipment we saw (such as hoists and syringe pumps) were clean, well maintained and were within the service and calibration due dates.

There was a planned maintenance schedule in place that listed when equipment was due for servicing. Equipment servicing, calibration and portable appliance testing were carried out by external contractors in accordance with Health and Safety Executive guidance.

The hospice had suitable equipment to help them safely care for patients. We reviewed the resuscitation trolley and saw regular checks of the equipment were in place. Syringe pumps were serviced and tested, and staff knew how to report any concerns with specialist equipment.

Single-use, sterile instruments and consumable items were stored appropriately, and we saw these were within their expiry dates. Staff handled, stored, and disposed of clinical waste including sharps safely. The hospice had two emergency defibrillators; these were checked regularly by staff.

During the inspection we found 4 boxes of FFP3 (Filtering Facepiece) masks that had expired in September 2023, the ward manager was informed and removed the masks immediately.

The hospice participated in the annual NHS Place audit and had scored 100% for condition, appearance maintenance.

Staff had restricted access to the mortuary, and we saw evidence of regular temperature checks, the hospice had arrangements in place with a range of local funeral directors to allow patient and family choice and to ensure cultural requirements were met. For example, a member of the board was on the burial committee at the local mosque and was able to provide advice and guidance for Islamic burials as required.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.

Staff completed risk assessments for each patient on admission to the ward and community services and reviewed this regularly, including after any incident. These included Waterlow pressure risk assessment, falls, bedrails, nutrition, moving and handling and infection control. Additional individual risk assessments were carried out when required, for example, bariatric patients or those requiring enhanced 1 to 1 care for a cognitive impairment.

Staff we spoke with understood how to identify patients with suspected sepsis, including neutropenic sepsis.

Risk assessments where in place for patients who were deteriorating and in the last days or hours of their life and staff knew how to support these patients appropriately. Patients had person-centred care plans in place, so they received the right level of care. Staff carried out frequent patient observations so changes to the patient's medical condition could be promptly identified. We looked at 3 patient records and these showed patients were reviewed regularly and escalated appropriately for medical input when required.

Staff handover of patients included all necessary key information to keep patients safe.

If a relative or patient became unwell and required hospital admission for an acute event that required investigation or treatment the hospice was unable to provide, they would be transferred to an NHS acute hospital by emergency ambulance.

Records showed 100% of medical staff and 95% of nursing staff had completed basic life support training.

The hospice had fire safety risk assessments in place. Evacuation and assembly points were clearly signposted. We saw evidence fire alarm systems and fire extinguishers were routinely checked.

The inpatient unit (IPU) weekly 'Vital Observations and Information' audit from April 2023 to December 2023 showed overall compliance of between 90-100%.

Nurse staffing

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

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

The ward manager ensured staffing levels remained safe at all times. They accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The registered manager could adjust staffing levels daily according to the needs of patients.

At the time of the inspection, the inpatient ward had 7 patients. The staffing establishment on each shift was for at least 6 nurses on the morning shift, 6 nurses on the afternoon shift and at least 4 nurses on the night shift.

At the time of the inspection, turnover in the nursing team from the 1 April 2023 was 5.52% (4 people in total, including 2 people who retired) and sickness absence rates were 5.97%.

The hospice had volunteers that supported the clinical and non-clinical areas. Volunteers involved in any patient care underwent recruitment checks and had appropriate induction and training.

The inpatient ward, day therapies, hospice at home and specialist palliative community teams were fully established with no clinical staff vacancies at the time of the inspection. The hospice had recently recruited 3 newly qualified nurses to cover staff maternity leave. The hospice was in the process of advertising for 2 nursing posts to replace staff leaving in January 2024.

Cover for leave and unplanned absences was provided by the existing staff working additional hours and through the use of bank staff. Where bank staff were used, managers made sure the staff had a full induction and understood the service.

Medical staffing

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

The hospice had enough medical staff to keep patients safe. The areas we inspected had sufficient numbers of suitably qualified medial staff to provide timely and safe care and treatment.

The team was led by the medical director, who was the responsible clinician for the organisation and also worked clinically within the hospice.

There were at least 2 members of the medical team on site between 9am and 5pm on weekdays and 1 member of the team at weekends and bank holidays. There was an on-call process for medical cover out of hours which included cover for the inpatient unit and for the Morecambe Bay wide senior advice line.

The hospice organised and contributed to the Morecambe Bay wide senior advice line, with senior palliative medicine physicians available out of hours to provide specialist palliative care advice to GP's and senior hospital doctors within the locality. Two of the hospice doctors were rostered with local NHS trust palliative medicine consultants and associate specialist.

The management and co-ordination of the rota and the transferring of the phone lines to the relevant doctor were managed by the hospice. This allowed specialist palliative medicine advice to be available to any patient regardless of whether they were known to palliative care services, therefore, improving symptom control and increasing the likelihood of meeting patient's preferred place of death.

This was an innovative arrangement, making use of technology to ensure patients across a wide, rural geographical area were not disadvantaged out of hours.

At the time of the inspection, turnover in the medical team, since the 1 April 2023, was 7.69% (1 employee who retired) and sickness absence rates were 0.89%.

Records

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

Patient notes were comprehensive, and all staff could access them easily. Records were stored securely.

Staff used electronic patient records for recording risk assessments, consent, discharges, care plans, patient assessments, observations and for daily medical and nursing notes. When patients transferred to a new team, there were no delays in staff accessing their records.

We looked at the records for 3 patients. These were structured, complete and up to date. Patient records showed nursing and clinical assessments were carried out on admission. Patient's risk assessments were reviewed and updated regularly. Multidisciplinary staff interventions were recorded in patient's records, and these were up to date.

Patient's care plans were person-centred and were completed to a good standard. Person-centred care plans were in place, such as for falls, pain and medicines management, wound care, nutrition and hydration and personal care.

Staff carried out routine audits of patient records to check for accuracy and completeness including an inpatient unit (IPU) care plan and risk assessment audit which looked at 15 records over a 6-month period. Overall compliance was 91%. The 2 actions that were raised related to communication with external organisations and the updating of an electronic care plan. The monthly audit group were monitoring outstanding actions and the learning was shared across the organisation.

The hospice had integrated patient records with GP and community services and could access the local acute NHS Trust records to ensure continuity of care and real-time information.

Good

Hospice services for adults

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Medicines that required storage at temperatures between 2ºC and 8ºC were appropriately stored in medicine fridges, we saw evidence the temperature was checked twice a day.

Staff completed medicines records accurately and these were kept up to date. Staff carried out daily checks on controlled drugs and routine medicine stocks to ensure medicines were reconciled correctly. We looked at stock levels and found them to be correct. The hospice had an arrangement with a local trust and pharmacy for drugs ordering for individual patients and to replenish medicines when needed.

Staff stored and managed all medicines and prescribing documents safely. Staff followed national practice to check patients had the correct medicines when they were admitted.

Staff learned from safety alerts and incidents to improve practice. The staff we spoke with were aware of how to access emergency medicines and oxygen. Oxygen cylinders were appropriately and securely stored.

The annual audit by the controlled drugs accountable officer showed a 100% compliance.

The hospice had regular audits carried out by the local pharmacy, these showed an increase in prescribing errors since January 2023. The pharmacy benchmarked St John's to other hospices for prescription chart errors, when compared to other services the hospice was below average, the pharmacy indicated services with electronic prescribing had significantly lower errors. Managers told us they constantly reviewed every individual incident for themes and learning and there were plans in place for the service to move from paper prescriptions to electronic prescribing in 2024.

Between April 2023 and time of inspection, the hospice had reported more medicines incidents when compared to similar sized hospices and compared with all adult hospices via the Hospice UK Benchmarking Tool. However, these incidents were graded as zero to 2 with only 1 level 2 incident out of 5631 items prescribed.

There was an increase in prescription errors noted by the externally contracted pharmacist following a change in the criteria for the audits that the hospice were unaware of. Following this, prescribing errors have now reduced to low levels. There were plans in place for the service to move to electronic prescribing during 2024.

From 1 April 2023 to the date of the inspection, there had been 12 internal medicine prescribing incidents which was 0.2% of the 5631 items prescribed.

The hospice employed the services of an external pharmacy organisation who were on site one day per week. They carried out audits on medicine storage and documentation and supported the medical team with prescribing. They were available 24 hours a day via an advice line.

Good

Hospice services for adults

Incidents

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

Staff raised concerns and reported incidents and near misses in line with the hospice's incident reporting policies. Staff knew what incidents to report and how to report them.

Incidents were managed well. Staff were encouraged to report incidents and near misses via the electronic system and there were processes in place to learn from them. Champions for key areas were in post, for example, infection prevention, falls and food and nutrition. These Champions were actively involved in improving care and practice.

The hospice used an electronic reporting system for incidents. They have implemented the patient safety incident response framework (PSIRF) in collaboration with stakeholders and hospices.

Each week, all incident reports were reviewed by the senior management team and reviewed by the clinical leads monthly. Board oversight and scrutiny was provided in the quarterly board care, quality and services sub-committee. A programme of 'lessons learned' and 'Hot Topics' was in place to ensure learning was cascaded. For example, we saw the board request a 'deep dive' review into pressure ulcers at a recent meeting when there had been a small increase in reports in this area. The 'deep dive' provided assurance that all incidents where no harm/low level provided an opportunity to review processes.

Out of a total of 189 internal incidents reported since April 2023, (to the end of September 2023) all incidents were graded as low or no harm. The hospice used a root cause analysis 'missed moments' tool to support the team's learning.

Staff told us they received regular feedback from investigation of incidents, both internal and external to the service. The senior managers told us any reported incidents would be reviewed and discussed at daily huddles and relevant team meetings. We saw evidence of this in the meeting minutes we looked at.

The staff we spoke with were aware of their responsibilities regarding duty of candour legislation. The duty of candour is a regulatory duty that relates to openness and transparency and requires hospices of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Senior managers were aware of their responsibility to report notifiable incidents to the Care Quality Commission (CQC) and other external organisations.

Is the service effective?

Good

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

Good

Hospice services for adults

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies and procedures were based on national guidance, such as from The National Institute for Health and Care Excellence (NICE), Royal Colleges and other bodies. Staff told us policies were easily accessible and they were informed at meetings and via email of any updates to policies.

Staff protected the rights of patients subject to the Mental Capacity Act and followed the Code of Practice. Patients and their relatives were supported by the counselling team for emotional support.

At staff handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives, and carers. The hospice held weekly multidisciplinary safety huddles attended by bereavement counsellors and social workers to discuss patients' spiritual, psychological, and emotional needs.

Key Information Subject (KIS) reviews were undertaken by departmental managers weekly across all services between April and November 2023, to ensure the management of clinical data and care was compliant with current law, regulations and in accordance with best practice.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural, and other needs.

Patients and relatives told us there was choice of food and drink and spoke positively about the quality of the food offered. The hospice had menus with options available for patients with specific requirements.

The hospice had its own on-site kitchen garden and beehives. Much of the fruit and vegetables grown on site was used for patient meals which were cooked on site. Hospitality assistants would support patients to eat and drink as appropriate.

Staff made sure patients had enough to eat and drink, particularly those with specialist nutrition and hydration needs. Staff told us patients could be referred for specialist support such as dietitians and speech and language therapists.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. We looked at 4 patient records which showed staff carried out an assessment of patients' nutritional requirements on admission and this was updated at least weekly. Where patients were identified at risk, staff fully and accurately completed patients' fluid and nutrition charts to monitor food and fluid intake.

In 2023, the hospice took part in the National Audit of Care at the End of Life (NACEL). This showed that 100% of patients had their nutritional and hydration status assessed daily at the end of life, all patients for whom it was appropriate were supported to eat and drink in the dying phase if they were able to. All patients in the dying phase who were able were involved in a discussion of their nutrition and hydration options and 87.5% of nominated carers had a documented discussion of the patients' nutrition and hydration options.

The hospice participated in the annual NHS Place audit and had scored 100% for food tasting.

Good

Hospice services for adults

Pain relief

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

Staff assessed patients' pain and gave pain relief in line with individual needs and best practice. Staff used pain assessment tools to monitor pain symptoms at regular intervals.

Patients we spoke with told us they received good support from staff and their pain symptoms were appropriately managed during their care.

Staff prescribed, administered, and recorded pain relief accurately. Patient records we reviewed showed patients received the required pain relief, and they were treated in a way that met their needs and reduced discomfort.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The hospice participated in relevant national clinical audits. Outcomes for patients were positive, consistent, and met expectations, such as national standards. Between December 2022 and November 2023, the hospice achieved the preferred place of death for 91% of community patients and 97% of inpatients. This showed the hospice was able to meet the wishes of most patients who had specified a preferred place of death.

Staff said the preferred place of death was discussed with new referrals to the hospice with the patient and relatives where appropriate. Staff told us the preferred place of death was reviewed at each visit in the community setting, and as often as needed.

Managers and staff reviewed the effectiveness of care and treatment and implemented local changes to improve care and monitored the improvement over time. The hospice held weekly multi-disciplinary meetings, attended by the ward team, community team, and local NHS trust's palliative care consultants. During the meeting deaths of patients receiving care by the hospice were discussed. Where preferred place of death had not been met, the patient's records were examined for any lessons to be learned.

The hospice used the Karnofsky Performance scale which is a gold-standard tool within end of life care and enables patients to be classified according to their functional impairment. The phase of illness measure from the outcomes assessment and complexity collaborative (OACC) suite was also used to monitor patients' care needs. In community services, the hospice employed a hospice at home co-ordinator whose role it was to continually review the case notes of all dying and unstable patients to ensure they were offered the appropriate care delivery and intervention.

The hospice took part in the National Audit of Care at the End of Life (NACEL) in 2023.

There were 75% of patients who had a 'do not attempt cardio pulmonary resuscitation' (DNACPR) decision in place, at the hospice, compared to 30% nationally. All patients had an individualised plan of care for their end of life needs compared to 89% nationally, and 75% of patients had documented evidence of involvement in discussions about their individualised plan of care compared to 46% nationally. The remaining 25% were documented to lack capacity to engage in these discussions. All patients had documented evidence of assessment of needs across both physical and psychological/spiritual domains.

The family support team used a range of outcome measures including the outcome scale (ORS) for adults and young people or the child outcome rating score (CORS) for children aged six plus.

Competent staff

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

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. We reviewed 5 clinical staff files, all had the relevant qualifications, references, and registrations with bodies such as General Medical Council and Nursing and Midwifery Council.

Managers gave all new staff and volunteers a full induction tailored to their role before they started work.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Records showed appraisal completion for all staff, including clinical, volunteers and board members was approximately 94% for the current year, which demonstrated most staff had completed their annual appraisal. The compliance rate target was 90%.

The medical team received clinical supervision bimonthly by an external supervisor and received quarterly 1:1 supervision by the medical director.

Clinical leads attended supervision every two month. All patient-facing staff were paid time to attend regular supervision sessions.

Managers made sure staff received any specialist training for their role. The clinical educators supported the learning and development needs of staff. The hospice had introduced a development programme for newly qualified nurses and was in the process of rolling out a similar training programme for health care assistants.

In the 12 months prior to inspection, the hospice supported two clinical leads and two members of the senior team to complete master's qualifications.

All senior registered nurses had the opportunity to complete a palliative care diploma. Junior registered nurses complete the European certificate in palliative care. In the 12 months prior to inspection, all registered nurses attended a 5 day nurse development programme.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Multidisciplinary working

Doctors, nurses, and other healthcare professionals worked together as a team to benefit patients.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. There was effective daily communication between multidisciplinary teams across the hospice. Staff handover meetings took place during shift changes and 'safety huddles' were carried out on a daily basis to ensure all staff had up-to-date information. The meetings were an opportunity to discuss any issues relating to the patient risks, admission, discharge information and death of patients.

Good

Hospice services for adults

A weekly multidisciplinary team (MDT) safety huddle included medical and nursing representatives from the hospice, including the inpatient ward, day therapy unit and community services teams as well as bereavement, counselling, spiritual and pastoral staff. The weekly MDT was attended by representatives of the local community, such as social workers and NHS palliative care consultants.

Clinical nurse specialists (CNS) worked jointly with the most socially deprived GP Practices in the area. They supported people facing issues of financial deprivation and they were often called upon to support the traveller communities.

Due to the rurality of the area, the hospice community team collaborated with external health care partners by sharing the same patient record systems and using information technology communication tools to discuss patient care.

Volunteers were seen as part of the multidisciplinary team with their input increasing capacity and effectiveness. For example, the family support and bereavement team had trained an additional 12 'bereavement listeners'" who supported the Grief Café and provide talking therapies for bereaved people. These volunteers were supported in this role by regular supervision with the paid staff team.

Seven-day services

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

The inpatient ward operated 24 hours a day, seven days a week. The ward accommodated overnight patients 7 days a week and staffing levels were suitably maintained during out-of-hours and weekends. There was also a 24/7 telephone helpline for patients and families.

The community specialist teams and hospice at home operated 7 days per week, with a night sitter service available for patients requiring overnight support.

The day therapies unit provided sessions Monday to Friday during routine working hours. The bereavement and counselling teams operated during normal working hours on weekdays. In addition, bereavement support was available 7 days a week via the bereavement listening volunteer team.

Health promotion

Staff gave patients practical support to help them live well until they died.

The hospice had relevant information promoting healthy lifestyles and support throughout the hospice. The day services multidisciplinary team provided a range of initiatives. One targeted group helped respiratory patients to cope with fatigue, anxiety and breathlessness. A range of other sessions were delivered by the team and a Friday 'drop in' session which was said to be popular for patients known to the hospice to call in for practical support and advice if required.

Staff assessed each patient's health when admitted to the ward or community services and provided support for individual needs. For example, patients and relatives were signposted to bereavement support services and podcasts. The hospice held a monthly grief café drop in session for anyone needing support.

Good

Hospice services for adults

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available. We looked at 3 patient records which showed patient consent had been obtained and planned care was delivered with their agreement. Do not attempt cardiopulmonary resuscitation (DNACPR) orders and discussions were clearly recorded in patients' records.

The medical staff were trained to carry out mental capacity assessments, in order to determine if a patient had the capacity to make their own decisions. We saw evidence of capacity assessments undertaken in the patient records and the assessments were complete and up to date.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. For example, we saw a case study that had been presented to the Board regarding a patient who was admitted to the inpatient unit for symptom control. Their end of life care involved very complex best interest decisions around place of care and appropriate management of symptoms with full involvement of the family who were not communicating well with each other. This case study evidenced the team actively monitoring and reviewing consent and involving a number of family members with differing views in decision making and treatment.

Staff received and kept up to date with training and knew how to access policies in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and they knew who to contact for advice.

Is the service caring?

Good

Our rating of caring went down. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and met their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff were caring, compassionate and committed to providing the best patient care possible.

We observed staff across the inpatient ward and saw patients were treated with dignity, compassion, and empathy.

Patients and relatives said staff treated them well and with kindness.

Staff followed policy to keep patient care and treatment confidential. Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

We spoke with 6 relatives and 3 patients, and all were complimentary of the staff and the care they had received at the hospice.

Examples provided by the hospice demonstrated good care for patients and their relatives, such as hosting a hen party and a wedding blessing so that a patient, the mother of the bride, could see her daughter married before she died.

Pets were welcome on the inpatient unit with many patients having died with their pets by their side.

We looked at a selection of surveys and feedback comments relating to the service from the last 12 months. The survey results showed patients and their relatives were overwhelming positive about the care and treatment they received.

The hospice participated in the annual NHS Place audit and had scored 88% for privacy, dignity and well-being.

Emotional support

Staff provided emotional support to patients, families, and carers to minimise their distress. They understood patients' personal, cultural, and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. The patient and carer survey report demonstrated patients, and their relatives felt their privacy and dignity were respected.

Patients and families were encouraged to complete a ‘This is Me’ document so they could record likes and dislikes and make their wishes and beliefs known.

In the past 12 months, the hospice had made a significant investment in family support and bereavement services. After research was conducted with the local university, the hospice provided “whole family support” for families affected by bereavement, this was a unique service in the area. The award winning design of the “Forget Me Not Centre” was intended to feel different to the clinical environment in the hospice.

The hospice held a monthly grief café for anyone that required support.

A staff member gave an example of a time she helped support a patient that was end of life who wanted to write birthday cards for her three grandsons.

Staff understood the emotional and social impact a person’s care, treatment or condition had on their wellbeing and on those close to them. The hospice had a multifaith chapel and had good links with religious leaders in the area. Consultation had taken place with the main faith groups in the area to provide feedback on their requirements for the redevelopment of the chapel area which was due for refurbishment in Spring 2024.

Good

Hospice services for adults

Patients and families had access to hospice employed social workers, counsellors, complementary therapists, virtual reality experiences, and spiritual carers from all faith and belief systems as required.

Understanding and involvement of patients and those close to them

Staff saw people, who were approaching end of life. Staff were committed to working in partnership with patients, families, and carers to involve them in the care and treatment they received.

Staff spoke with patients, families, and carers in a way they could understand, using communication aids where necessary. Staff supported patients to make advanced decisions about their care.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The patient and carer survey report supported the views shared by patients and relatives we spoke with on site, with 100% of correspondents answering strongly agree to 'I understood how to ask questions and discuss any concerns about my care and treatment'.

Is the service responsive?

Outstanding ☆

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

Service delivery to meet the needs of local people.

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

Managers planned and organised services, so they met the needs of the local population and proactively sought ways to support those with more complex needs. Community teams had caseloads linked to GP catchment areas; they attended Gold Standards Framework meetings in the GP practices which allowed them to review all patients in the last year of life on the GP register whether known to hospice care or not. This ensured integrated, person-centred pathways of care were delivered, especially for those with multiple and complex needs.

Facilities and premises were appropriate for the services being delivered. The inpatient unit had 2 bays and 5 side rooms. All the bays and side rooms faced out to the gardens which surrounded the hospice.

The inpatient ward had a mixture of bays and single rooms, the ward layout enabled same sex accommodation with appropriate segregation. There had been no mixed sex accommodation breaches reported by the hospice in the past 12 months.

The hospice had 2 rooms for relatives to stay overnight and had a number of quiet rooms and areas with a calm and relaxing environment.

The hospice provided a range of services including the inpatient ward unit, day therapies, hospice at home and specialist palliative community services. The hospice's bereavement centre was situated on site.

The hospice did some outreach work with different faiths in the local community. They had recently been involved in the production of a film about advance care planning within different faiths.

There was a gift shop and coffee shop open to members of the public.

The hospice was planning a major refurbishment of its ward in the next 3 years, patients and staff had been involved in an engagement exercise so their views could inform the development and design of the new facility.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made exceptional adjustments on occasions to help patients access services. They provided coordinated care with other services and hospices.

The hospice gave examples of when they had met individual needs to an outstanding level, for example, care of a young prisoner whom the hospice agreed to support with the help of the police and prison team. Another example was a person who wanted to see their horses for the last time, the team arranged for them to come into the garden and graze outside their window in the last week of life.

The Forget Me Not centre team delivered an innovative schools programme called "Seasons for Growth" which was delivered over 8 weeks with children who have suffered a loss. At the end of 8 weeks, children who need more support were invited to attend sessions at the Forget Me Not Centre. Patients and relatives also said they were supported with their emotional needs and were able to voice any concerns. Patients or their relatives could be referred for counselling and bereavement support if required at the Forget Me Not Centre.

Staff mandatory training included dementia, autism and learning disability awareness. Staff told us there were appointed staff champions for infection prevention control, pressure sores and dementia.

Care plans were regularly reviewed and updated, and referrals were made to members of the multidisciplinary team according to patient's needs. The hospice held carers drop-in sessions, providing peer support for anyone in a carer role with family or friends cared for at St John's hospice.

Staff understood meeting the information and communication needs of patients with a disability or sensory loss was important. Staff supported patients living with dementia and learning disabilities by using 'This is Me' documentation.

Managers made sure staff, patients, family, friends, and carers could get help from interpreters or signers when needed. The hospice told us they could print information leaflets in different languages when required.

The hospice had 2 staff who were 'learning disability and autism champions' and were piloting a national scheme 'The Victoria and Stuart Project' in collaboration with an out of region university to evaluate end of life care planning resources for people with learning disabilities.

The hospice supported open visiting for relatives and carers 7 days a week. Patients told us visitors to the hospice were always offered refreshments. Patients were given a choice of food and drink to meet their cultural and religious preferences. The hospice had voluntary gardeners that worked to provide homegrown produce. In the most recent patient and carers survey, 100% of respondents answered strongly agree to 'I was offered choices of food and drink and enjoyed what I chose'. The hospice had two separate suites that could be used by relatives for overnight accommodation. They had also purchased two 'cuddle beds' to enable patients and families to share a bed on the ward overnight. Feedback provided by the hospice after the inspection from a relative said, "They were very privileged to be able to use a cuddle bed which meant they could be close together in those final precious moments after death which was very precious to them both."

There was a play area with toys and books for children attending the hospice.

The hospice participated in the annual NHS Place audit and had scored 100% for dementia and 93.4% for disability. Following the inspection, a visit by Healthwatch reported the main building was suitable for people with physical disabilities and those with dementia.

After the inspection the hospice shared information they had invested charitable funds to buy specialist equipment such as an ultrasound machine to care for patients with complex and multiple needs. The medical team were trained to undertake ultrasound scanning to diagnose certain conditions that were not available as a day patient at the local hospital. The hospice also had a bladder scanner and routinely admitted end of life patients for blood transfusions providing a more positive experience for patients than having to go to the hospital.

Access and flow

Patients could access the specialist palliative care service when they needed it. Waiting times from referral to achievement of preferred place of care and death were in line with good practice.

Managers monitored waiting times to ensure patients could access services when needed and receive treatment within agreed timeframes and national targets. The hospice reviewed all referrals in a weekly multidisciplinary meeting and could accept urgent referrals 7 days a week including out of hours. Community nurse specialists contacted patients by telephone to triage all new referrals assessments promptly.

On average within a 12-month period, the hospice inpatient unit treated 18 patients per month. Patients preferred place of death (PPD) on the inpatient unit was 97% followed by 91% for patients whose PPD was in a community setting such as their own home. Bed occupancy at the hospice was 97%

The hospice recognised the PPD was important to patients and made every effort to discuss this with patients and families. They recognised that any advance care planning could change frequently.

PPD was discussed with all new referrals to the hospice at the first opportunity with the patient and/or their family. This was reviewed at each visit in the community setting, and as often as required dependent on changing circumstances.

The hospice team, supported by the hospice-employed social workers, started planning patient discharges as soon as possible. Compared to the Hospice UK benchmark audit, the length of stay was longer than similar sized hospices. The hospice had done a review of this which showed the lack of care home places in the region was a significant limiting factor. This had been escalated to the local Integrated Commissioning board (ICB).

A weekly multi-disciplinary meeting was held, attended by ward and community staff, and acute trust palliative care consultants, where all deaths of patients were discussed. If the PPD had not been met, the patient's records were reviewed for any lessons to be learned.

All families received a bereavement call from the department caring for their loved one when they died. Any issues around PPD could be discussed if the family wished.

Learning from complaints and concerns

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

Good

Hospice services for adults

The hospice had a concerns and complaints policy with clear lines of responsibility. They maintained a register of complaints with actions and how lessons had been learned and shared. Patients, relatives, and carers knew how to complain or raise concerns and information was clearly displayed in patient areas about how to raise a concern. Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. There had only been 6 complaints over a 12-month period, with a full review by the Hospice in a timely manner. All 6 complainants had received feedback and where changes could be made, these were implemented.

Is the service well-led?

Good

Our rating of well-led went down. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

The hospice had a clear management structure with lines of responsibility and accountability. The hospice had a board of volunteer trustees with a broad mix of skills and experience.

A senior management team led by and including the CEO consisted of 6 members of staff.

The senior managers had the relevant skills and abilities to manage the hospice services effectively. They understood the risks to services and had clear oversight on patient safety, governance and performance issues through daily involvement and quality monitoring.

Staff said all managers, leaders and the CEO were very approachable and visible throughout the service.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The hospice undertook extensive engagement during 2023 to develop its new strategy. The hospice's new 2024 to 2029 vision and strategy will be launched in January 2024 and was developed from the views of patients, families, communities, organisations and health and social care colleagues. As a result of the new strategy, a small film was produced for people coping with death in the workplace.

The strategy acknowledged that hospice care was part of a wider system, to ensure it was aligned to the strategic aims of all partners. They reviewed national, local and health care strategies as well as research papers and studies on the future health needs of the UK population. Four themes, stability, agility, community, and sustainability were the foundation of the strategy.

The vision and strategy realistically took into account economic challenges and funding streams with 25% of funding coming from the NHS to achieve their ambitions.

The hospice ensured it was aligned to its vision and strategy by checking their core purpose with the support of volunteers going onto the ward and keeping in touch with bereaved family members and carers up to 6 months after their bereavement, to capture feedback.

Culture

Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff were highly motivated, patient-focussed and spoke very positively about working at the hospice. They told us there was a friendly and open culture and departmental and site managers were visible, approachable, and provided them with good support. The nursing, medical and support staff said they received regular feedback to aid future learning and were supported with their training needs.

Staff reported the hospice as being a 'fantastic place to work' and they 'felt very proud' to work there. They said the culture was 'good' with everyone making a great team. Staff reported they had been 'on a journey' to get a great patient experience 'from the front door to the ward.'

Staff reported the hospice had a very caring culture and when staff needed extra support there was a 'feeling of the hospice wrapping it's arms around you.'

Staff reported feeling respected, supported, and valued. They were focused on the needs of patients. The hospice had a freedom to speak up and whistleblowing policy with posters in public areas including next to the staff cafeteria.

Staff said they felt confident to raise concerns if necessary and were aware of the freedom to speak up guardian who was a trustee.

Staff said they were given opportunities to develop their skills. For example, health care assistants were supported to train to undertake bloods from patients and medicines training as a second trained staff member to check medicines had been administered correctly.

The hospice offered a private healthcare and well-being package to all staff in addition to other benefits such as complementary therapies, subsidised food and free food was offered over the Christmas holiday and New Year period.

Governance

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

There were governance structures in place that provided assurance of oversight and performance against safety measures. The board of directors met quarterly for board sub-committees.

The hospice had three sub-committees to oversee the running of the service supported by appointed board members. The sub-committees held quarterly meetings and were responsible for monitoring the clinical governance and compliance with regulatory standards. The three sub-committees' team reported directly to the board of trustees.

An integrated governance committee (IGC), whose purpose was to oversee the development, implementation and monitoring of the hospices integrated governance arrangements reported directly to the relevant board sub-committees and then through to the board. IGC meetings were held quarterly.

The trustees received presentations at board meetings from clinical staff, so they had a good understanding what was happening in the service. Case studies were shared such as, best interest decisions and safeguarding incidents.

Leaders operated effective governance processes and systems were in place to ensure these were effective throughout the service. For example, when polices were approved they went to a review group for quality control and then through to the board for oversight and signoff.

Senior leaders said the board provided effective challenge, setting high standards.

Management of risk, issues, and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Senior leaders understood the risks they faced in the service including financial, and recruitment and retention of nursing staff.

Leaders held weekly team meetings to review risk and incidents with oversight being reported to the board and then information reported back to the ward.

The hospice had risk management policies and procedures in place that outlined the process for identifying, assessing, and mitigating risks. The key risks relating to services were incorporated into the organisational risk register and board assurance framework. The risk register showed control measures were put in place to mitigate risks. A risk scoring system was used to identify and escalate key risks and each risk had a review date that was regularly updated. Meeting minutes showed key risks had been reviewed and discussed at routine board meetings, risk management meetings and governance and audit committee meetings.

Senior leaders attended a clinical operations and performance committee to review and discuss clinical operations and performance including day-to-day issues and to share information on performance, patient safety, incidents, and audit results.

There were effective processes and systems of accountability to support the delivery of good quality and sustainable services. These were regularly reviewed, and improvements made as required. We reviewed audits and minutes of monthly and quarterly meetings where staff discussed these and other topics.

The St. John's was part of a hospice collaborative to share lessons and learning from the patient safety investigation reports framework.

The hospice had a business continuity plan in place with clear lines of responsibility and communication to deal with unavoidable circumstances.

The hospice had a recruitment policy and followed safe recruitment practices. We looked at a sample of recruitment files for employees including executives and found they had undergone appropriate checks.

Volunteers were recruited in line with a volunteer policy which required a disclosure and disbarring check dependant on the roles they undertook.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were submitted to external organisations as required.

Patient records were accessible to staff and stored securely. There were systems in place for the safe storage, circulation, retention, and destruction of electronic and paper-based records.

Staff completed general data protection regulation and confidentiality training as part of their mandatory training. Staff could access information such as policies and procedures in paper and electronic format. The policies we looked at were version-controlled, up to date and had periodic review dates.

Significant investment had been made in digital transformation following the pandemic with new laptops and smart phones for community staff allowing the updating of patient information whilst in community and increasing staff safety. A new digital transformation manager had been appointed and new software had been implemented to improve data and cyber security. The hospice said it was fully compliant with the requirements of the annual Data Security and Protection Toolkit which required an annual information governance audit. Improvements were being made to ensure all online policies and procedures were in place and easily accessible to all staff as required.

A new website had been developed in response to patient and public feedback which had accessible resources such as, the hospice podcast and support guides.

Engagement

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

The hospice engaged with patients, carers, family members and clients in a variety of ways including, informally, patient surveys, feedback forms and community events. The hospice had carried out extensive engagement with the local community, this included face to face and online engagement. Staff visited local workplaces such as supermarkets, outdoor markets, and a health festival.

The hospice played an active part in the Lancaster Communities Together Group. This was a group of local faith leaders and representatives. Joint projects included a film about faith at the end of life which formed part of the Last Days Matter programme, a ‘Faith at the End of Life’ booklet, supporting and attending the Festival of Culture. Also, engagement regarding the refurbishment of the hospice chapel making it accessible and welcoming to all faith groups. Engagement with this group resulted in an invitation to attend a Muslim Burial Awareness Event at Lancaster University, the first time a hospice had been invited.

The hospice had a close partnership with the local university, which had led to hosting 2 students and including their innovative ideas in the Annual Hospice Newsletter. The hospice had implemented student ideas regarding income generation activities, for example, the Highest Point Music Festival and a new charity shop at the University. The University had worked with the hospice staff to develop a blueprint for an innovative App, 'The Memory Maker', which could host images of previous memories and enable new memories to be added.

The hospice contributed, participated, and led on system wide meetings to improve the palliative care offer and support the integrated care board. For example, the hospice had set up a hospice collaborative to learn across regional hospice organisations and draw on their strengths. They met once a month and looked at doing work on education and workforce. The hospice represented hospice issues on a national level and collectively lobbied local members of parliament regarding additional funding. As a result of this work hospices have been given special status locally as a group. A hospice leader was on the board to help develop the Integrated Care Board strategy, 'dying well' which was positive outcome of this initiative.

The hospice analysed patient and family surveys quarterly. Completed forms were digitalised to produce reports for review. We looked at a selection of surveys and feedback comments relating to the service from the last 12-months. The survey results showed patients and their relatives were very positive about the care and treatment they received. However, no overall annual report of service user feedback or themes and trends was provided for overall comparison or analysis.

The hospice had a service user group called 'VOICE' that met regularly and invited stakeholders to their meetings including local Healthwatch. Other work the group undertook was reviewing an initial draft 'Dementia 5-year Strategy' and 'Dementia Strategy Action Plan Template'. More specific to the hospice the group reviewed information leaflets for patients.

The 'VOICE' group undertook the annual Patient Led Assessments of the Care Environment which were assessments looking at the care environment from a patient's point of view. All areas of the hospice were assessed, and the findings were processed via the NHS England Estates and Facilities Management System and the national results of all organisations that had taken part should be available February/March 2024.

The hospice engaged with staff in team meetings, emails and posters asking what staff would like to see for the future of the hospice to ensure collective participation in the planning and delivery of services. Staff reported they were consulted and involved about required changes in the organisation.

The service conducted a staff survey every two years with the next survey scheduled in April 2024. The last survey conducted at the end of the COVID-19 pandemic showed an overall satisfaction score of 69%. This benchmarked lower than some other hospices in the region. However, the hospice had worked hard to address the issues raised by staff on the 2022 survey. An action plan was created following engagement. For example, 2 freedom to speak up guardians had been introduced. Other initiatives had also been introduced in addition to health and well-being and the hospice had invested heavily in learning, development and coaching for all teams. Staff told us they 'felt proud to work at the hospice' and that it was a 'fantastic place to work.'

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Good

Hospice services for adults

Staff told us the hospice had learning and improvement opportunities. We saw evidence of learning and improvement from audits and incidents and shared learning was cascaded to staff to improve the services provided.

The hospice said innovation started at the top with away days being held by trustees twice a year. In addition, there had been new trustee appointments and inductions.

The hospice had invested in a new clinical educator role whose specific remit was to work with care home and domiciliary agencies to improve their end of life care skills. Hospice staff also contributed to focus groups for research projects such as Ambitions for Palliative and End of Life Care and Access to Psychology Support in End of Life Care. Senior clinical staff hosted a range of innovating learning and sharing opportunities such as a lunchtime learning and a 'READ' group (journal club) where they discuss a specific article on a relevant subject of interest. The hospice had introduced a new 'Hospice Nurse Development Programme in Specialist Palliative Care' which was a bespoke training programme. 34 nurses had accessed the programme to date. A poster discussing the programme was accepted for exhibition at the Hospice UK 2023 Conference. Health care assistants were going to have specific training rolled out for end-of-life care.

The hospice made use of technology ensuring patients across a wide rural geographical area were not disadvantaged out of hours with their management and contribution to the senior advise line providing advice and support to general practitioners and local NHS palliative care doctors.

The hospice provided additional information regarding their commitment to system-wide collaboration and development of the next generation of clinicians. In 2022/23 they provided 43 placements in total for 4th and 5th year medical students and a wide range of allied health professionals. The hospice received a commendation from the local university for the hospice social workers support of social work students on placement. Evaluation from all placements were said to be consistently and continually excellent compared with other placement experiences.

Community staff had a team away day, which supported continuous personal development, an exploration of different working styles, reflection time, and to discuss the design of future community services.

Ward sisters and mid managers had gone through a leadership program for development aligned with external coaches.

The hospice had produced a short film called 'Last Days Matter'. It supported people without clinical qualifications to prepare for and help look after their loved ones. The program was being adopted by some teaching hospitals and other hospices locally and nationally. In addition, the hospice had produced pod casts with each episode discussing a different topic on palliative care and was delivered by experienced hospice staff. After regional feedback, a separate film has been produced to showcase the need to understand different cultural practices. The programme had been delivered throughout the UK to lay people and professionals. The hospice makes no charge for the materials, the aim was to create a social movement of change for the way we care for the sick and dying.

The hospice had an active sustainability group. There were 6 electric vehicle charging points on the car park and the hospice at home team's vehicle fleet was gradually being migrated to hybrid vehicles. Plans for the new hospice building included energy saving features such as solar roof panels and water saving features. There was an on-site allotment run by the volunteer garden team to produce fruit and vegetable.