St Peter & St James Hospice

St Peter & St James Hospice Care Strategy

2026-2029

Registered charity no. 1056114

Registered with FUNDRAISING REGULATOR

Executive Summary

St Peter & St James Hospice serves a diverse population of around 260,000 people across the local area districts of Mid Sussex, Lewes and parts of Wealden incorporating the towns of Lewes, Haywards Head, Burgess Hill, Uckfield and surrounding rural areas. The catchment is experiencing rapid population growth, rising complexity, increasing cultural diversity, and a significant expansion of older age groups.

Early reports from the 2025 Joint Strategic Needs Assessment highlights rising demand for palliative and end-of-life care, with Palliative and End of Life Care (PEoLC) expected to increase by up to 29% in Mid Sussex by 2044. Multimorbidity and dementia rates continue to rise, while inequalities across Sussex impact access and outcomes. Advance Care Planning and the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) completion remain low in home settings. Hospital deaths and avoidable admissions persist, and ambulance services report frequent inappropriate resuscitation attempts where ReSPECT guidance is absent.

The hospice's strategic direction aligns with NHS Sussex plans to deliver integrated, neighbourhood-based care through Integrated Community Teams (ICTs). These teams focus on prevention, coordinated local services, community resilience and reducing inequalities. Use of John Hopkins population segmentation* supports personalised care, improved resource allocation and better coordination across primary, community and social care. High levels of emergency admissions related to frailty and end-of-life care identify significant opportunities for the hospice to strengthen anticipatory care, provide in-reach to care homes and contribute to admission avoidance.

National drivers, including outputs from the Commission on Palliative and End-of-Life Care, the NHS Long Term Plan and the forthcoming Modern Service Framework for PEoLC emphasise a consistent, equitable, personalised system of palliative care. Hospice UK's service models and the proposed modern service framework further supports standardisation, quality and clarity in hospice care delivery. These shifts create opportunities for St Peter & St James Hospice to align service provision, strengthening the case for commissioning consistency and equitable funding.

Clinical transformation focuses on developing each of the service offers to patients through increased skills, strengthening strengthening Multidisciplinary Team (MDT) working as well as seeking to offer more home-based interventions and pilot new commissioned service models.

*Johns Hopkins Population Segmentation refers to the Johns Hopkins ACG® (Adjusted Clinical Groups) System, a population health tool that groups people into clinically meaningful segments based on their overall health needs, complexity, and expected use of healthcare services. The Highest and Ongoing needs group is where there is a particular focus to seek to identify patients who would benefit from involvement and support from teams providing Palliative and End of Life care

Contents

Chapter 1

The Population We Serve and Our Catchment Area

Overview of the Catchment Area

St Peter and St James Hospice provides specialist palliative and end-of-life care to an estimated 260,000 people across Mid Sussex, Lewes, Wealden and surrounding areas. Our footprint extends north towards Crawley and includes Lewes, Uckfield, Haywards Heath, Burgess Hill, and neighbouring rural villages. The geography spans urban centres, market towns and rural communities, creating varied needs related to age, deprivation, transport access, and long-term conditions.

Key Population Centres

Mid Sussex forms a central portion of our catchment, with population growth and an ageing profile that is outpacing national averages. Burgess Hill and Haywards Heath contributes a younger, more diverse urban population with differing cultural expectations and health inequalities. Lewes district and the Uckfield area include older, more rural populations, with an increased need for home-based and flexible outreach.

Demographic Trends Shaping Need

Across the catchment, older age groups are expanding, particularly 70–79 year-olds. New housing growth in Mid Sussex and surrounding towns continues to increase demand for palliative and end of life care including rapid response and earlier palliative intervention. Burgess Hill and Haywards Heath's increasing diversity underscores the need for culturally responsive care, language support and sensitive spiritual care provisions.

Rurality and Access to Care

Large areas around Lewes, Uckfield and the South Downs increase challenges related to transport, isolation, and digital exclusion. This context shapes our emphasis on responsive targeted support to people at home through our community clinical team as well as access to Wellbeing support through the Living Well Centre within the Hospice.

Joint Strategic Needs Assessment

NHS Sussex ICB and Sussex Hospice Alliance commissioned a Joint Strategic Needs Assessment in the Autumn of 2025 to inform future service planning and commissioning of Palliative and End of Life Care services. Early outputs have identified:

Growing demand

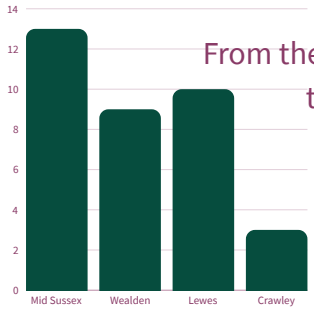
Sussex's ageing population will drive a 25% increase in PEoLC needs by 2044 with Mid Sussex expected to see as much as 29% growth in the population. Rising complexity and population growth indicate a larger older population with each person having an average of 5.7 long term conditions and dementia prevalence.

Demographics and inequalities

Sussex health inequalities influence access and outcomes and these need to be explored further. Coastal areas (e.g. Hastings) face high deprivation: Rother has one of the oldest populations; Brighton and Hove has a large LGBTQ+ community; Crawley is the most ethnically diverse.

Advance Care Planning

Only 13% of people on Palliative Care Registers have an Advance Care Plan recorded across Sussex.



From the 13% , this is the area split

ReSPECT

Overall 53% of people on the Palliative Care Register have a ReSPECT form recorded. Completion rates are much higher in Care and Nursing Homes at 79%. However only 40% of people living in their own home has ReSPECT plans.

Place of Death

Hospital deaths account for 39%, however Hospices account for only 6% of deaths, which appears low and data does not reflect community palliative support and whether a good death is achieved.

- **Hospital Specialist Palliative Care Teams.** ***Snapshot audit in October 2025 found 12% of admissions avoidable/inappropriate***
- **South East Coast Ambulance Service.** ***Inappropriate resuscitation attempts, often at home is a common adverse incident in End of Life Care for the Ambulance service where over 20% of these patients did not have a ReSPECT form in place.***

Implications for Service Planning

The demographic profile indicates growing demand and complexity, the need for equity of access and culturally adapted care. In addition to a high volume services delivered through integrated partnerships with primary care, social care and the voluntary sector.

For St Peter & St James Hospice, as the specialist Palliative and End of Life Care service, there is a need to Palliative and End of Life care service there is a need to lead and support patients and organisations across the health and social care system to increase uptake with Advance Care Planning and ReSPECT form completion. Strengthening the focus on supporting patients to be cared for, at home, or in the hospice, will also enable further reductions in unnecessary admissions to hospital.

Chapter 2

Strategic Alignment & Enablers - Working with NHS Sussex and Neighbourhood Health

Policy Context and Why It Matters

National policy prioritises a shift from hospital to community, personalised care, and digital-first approaches delivered through Integrated Care Systems (ICSs) and neighbourhood teams. Statutory guidance gives Integrated Care Boards (ICBs) a legal duty to commission palliative and end-of-life care, strengthening the foundation for formalised commissioning relationships with hospices. NHS Sussex & Surrey Heartlands is moving to strategic, multi-year commissioning, with Integrated Community Teams (ICTs) as the local engine for neighbourhood health.

Neighbourhood Health and Integrated Community Teams (ICTs) in Sussex

NHS England's Neighbourhood Health guidance sets out core components for place-based multidisciplinary teams, including population health management, standardised community services, integrated intermediate care (Home First) and urgent neighbourhood services. Sussex is implementing ICTs across places, with with Voluntary, Community, and Social Enterprise sector (VCSE) partners embedded to address inequalities and provide proactive, person-centred support.

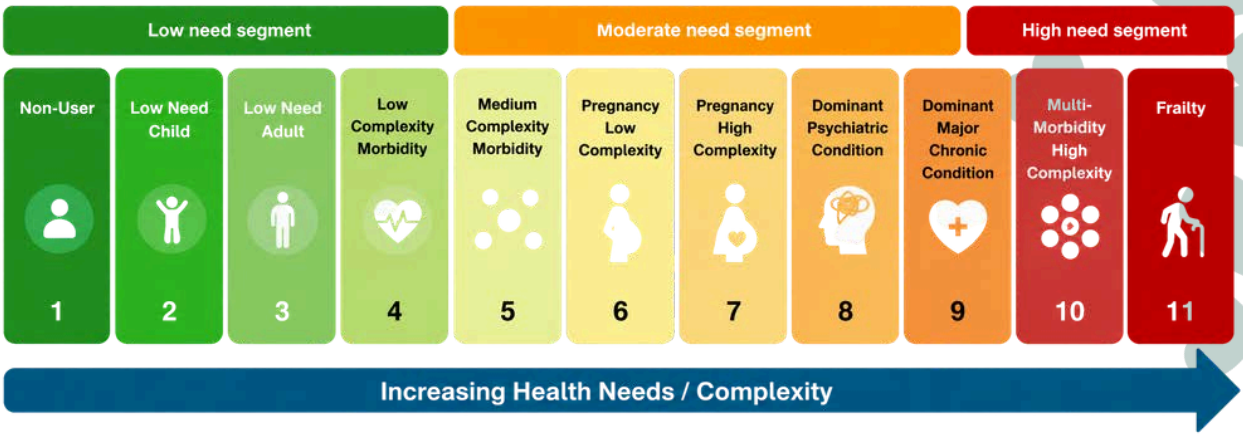
We are active within East Sussex on the Lewes District ICT Management and Planning Group and Wealden ICT Management and Planning Group and working towards further engagement within West Sussex for Mid Sussex ICT group that covers our catchment area within Haywards Heath, Burgess Hill and the area south of Crawley. Strategic priorities for these Neighbourhood ICT's are identified as:

- **Prevention first with joined up approaches to prevent ill-health and empower people to take control of their health and reduce avoidance illness.**
- **Integrated local services to deliver person centred, joined-up care closer to home.**
- **Community resilience to strengthen community assets to reduce loneliness and support wellbeing.**
- **Target Inequalities to close health gaps for vulnerable and underserved populations.**

Strategic priorities are being developed by each of the ICT's where there is a different focus dependent on the population needs and services able to meet these needs. St Peter and St James Hospice has a unique opportunity to enable greater engagement and access to services through this neighbourhood approach with our Community and Living Well services.

Frailty and Palliative and End-of-Life Care

To deliver the NHS 10-year plan NHS Sussex is undertaking service transformation at a neighbourhood level through Multidisciplinary working utilising patient level data stratified through the John Hopkins Model into 11 segments/patient needs groups (PNGs) as can be seen in the image over page.



The benefits of patient needs group segmentation are

Personalised Care
By understanding the needs of each group better, we can personalise care for those people. This means patients receive the specific type of care they need, whether it's more frequent monitoring, specialised treatment, or preventive care.

Resource Allocation
By using the best treatment for each group, it helps us make the best use of our resources and staff. It also means we can direct people to the right place first time.

Improved Coordination
PNGs help healthcare teams coordinate more effectively. If a patient has complex needs, the care team can work together to ensure all aspects of their health are addressed, from medication management to lifestyle support.

Improved Health Outcomes
Identifies those who need early interventions or tailored care plans. This leads to improved health outcomes, particularly for patients with chronic conditions.

Preventative Care
Identifies people who may need treatment before issues occur. By preventing complications, we can keep people healthier for longer.

Enhanced Communication
PNGs facilitate better communication between patients and healthcare providers. By understanding which group a patient falls into, together they can have clearer discussions about what to expect from the care they receive and what actions they can take to manage their health.

Multidisciplinary meetings within and across GP practices utilising this John Hopkins Data are actively getting established and focusing initially on groups 10 and 11. Whilst there has been a drive from the outset .to include hospices, there is more work for St Peter and St James Hospice to be involved at meetings, or gaining feedback of patients, that are appropriate to be referred to the Hospice to access the range of services we offer.

System level data related to emergency admissions to hospital for frailty and End-of-Life Care

Care Homes A recent NHS Sussex review of attendance and admissions at hospitals for people from care homes for the period of June to August 2025 identified that within our three ICT's numbers of Wealden, Mid Sussex and Lewes, Lewes ICT had the one of the highest number of attendances and admissions across Sussex.

ICT	Number of Care Home beds	Rate per 100 beds, attendances. Analysed period 3 months Jun 25-Aug 25	Rate per 100 beds, admissions. Analysed period 3 months Jun 25-Aug 25
Wealden	2634	12.2	7.6
Arun	2626	11.8	8.7
Worthing	2168	10.4	7.3
Rother	1687	12.2	9.0
Mid Sussex	1667	13.8	8.3
Hastings	1501	14.2	10.0
Chichester	1488	11.2	8.9
HorshaM	1179	10.2	8.5
Brighton West	1104	13.3	7.7
Eastbourne	1030	15.3	10.3
Lewes	887	17.7	13.7
Crawley	598	19.9	16.0
Adur	526	14.5	10.5
Brighton Central	491	12.2	7.8
Brighton East	472	15.6	7.3

Frailty In relation to emergency admissions to hospital for frailty, data over the past 12 months has shown that for Wealden this accounted for 2953 patients (10%), Mid Sussex accounted for 2550 patients (9%) and Lewes accounted for 1628 patient (6%)of all Emergency Admissions.

End of Life Care

In relation to emergency admissions to Hospital for end of life care data over the past 12 months has shown that for Wealden this accounted for 587 patients (11%), Mid Sussex accounted for 450 patients (9%) and Lewes accounted for 326 patient (6%) of all Emergency Admissions.

ICT	All Emergency Admissions		Frailty Related	
	Volume	Percentage	Volume	Percentage
Arun	11,393	12%	3,722	13%
Wealden	10,068	11%	2,953	10%
Chichester	8,213	9%	2,591	9%
Mid Sussex	8,642	9%	2,550	9%
Worthing	7,116	8%	2,354	8%
Horsham	6,426	7%	2,142	7%
Eastbourne	5,789	6%	2,032	7%
Rother	6,203	7%	2,007	7%
Crawley	5,056	5%	1,660	6%
Lewes	5,015	5%	1,628	6%
Hastings	5,018	5%	1,543	5%
Brighton	3,688	4%	1,223	4%
West Adur	3,714	4%	1,193	4%
Brighton East	3,774	4%	1,110	4%

ICT	All Emergency Admissions		Frailty Related	
	Volume	Percentage	Volume	Percentage
Wealden	10,068	11%	587	11%
Arun	11,393	12%	570	11%
Mid Sussex	8,642	9%	450	9%
Horsham	6,426	7%	382	7%
Eastbourne	5,789	6%	376	7%
Chichester	8,213	9%	371	7%
Crawley	5,056	5%	367	7%
Worthing	7,116	8%	367	7%
Rother	6,203	7%	329	6%
Lewes	5,015	5%	326	6%
Brighton	3,688	4%	255	5%
West Hastings	5,018	5%	247	5%
Brighton East	3,774	4%	235	5%

Role for St Peter & St James Hospice

We will pursue opportunities for joint working with neighbourhood ICT's to promote our offer of Wellbeing and Supportive care through the Living Well Centre offering holistic support and anticipatory care planning. We will also seek to provide greater care care closer to home through our community service and working closely with community MDT's looking at the highest and ongoing needs of patients identified through the John Hopkins data model to support early identification of patients. We will also seek to offer in-reach to care homes and deliver education to upskill the broader workforce. Together these actions will enable a comprehensive approach that meets the needs of patients and supports admission avoidance.

Chapter 3

Key drivers in Palliative and End of Life Care

Palliative Care Commission

The **Commission on Palliative and End-of-Life Care** was a UK parliamentary-linked initiative established to address significant gaps and inconsistencies in palliative and end-of-life care provision across England. It has been led and supported by key figures including Rachael Maskell MP and chaired by Professor Sir Mike Richards. It was formed in the context of national debate following the **Terminally ill Adults (End of Life) Bill**, which highlighted deficiencies in consistent, equitable access to high-quality palliative care.

The Commission has involved clinicians, academics, and sector leaders and worked closely with stakeholders across the NHS, hospices, charities, and patient groups. Through evidence gathering and expert evaluation, it has published two reports with the aims of transforming Palliative and End of Life care through the following aims:

- **Identify strengths and shortfalls in current palliative and end-of-life care**
- **Improve consistency, access, and quality of care**
- **Promote early, personalised, holistic care**
- **Strengthen coordination between services**
- **Support carers and families**
- **Provide policy recommendations to government**

Expectations for Palliative and End-of-Life Care

The NHS Long Term Plan commits to boosting out-of-hospital care, personalised care planning in the last year of life, Enhanced Health in Care Homes, and reducing 11 emergency pressures via timely community support. NHS England's PEoLC programme emphasises equity, personalised care and collaborative commissioning. Public Health profiles show persistent changes in place of death since the pandemic, reinforcing the need for resilient, integrated community provision.

At the same time the government has committed to developing a Modern Service Framework for Palliative and End of Life Care with an ambition of:

'By 2035, every baby, child, young person and adult will have timely, equitable access to high quality, sustainable, and personalised palliative care and end of life care, delivered in any setting, shaped by what matters to them, their families and carers, so that they can live well and die well.'

Role for St Peter & St James Hospice

Currently there is an increased focus on the needs of people approaching the end of life and meeting their care needs through specialist and generalist services that are described through the Hospice UK service models.

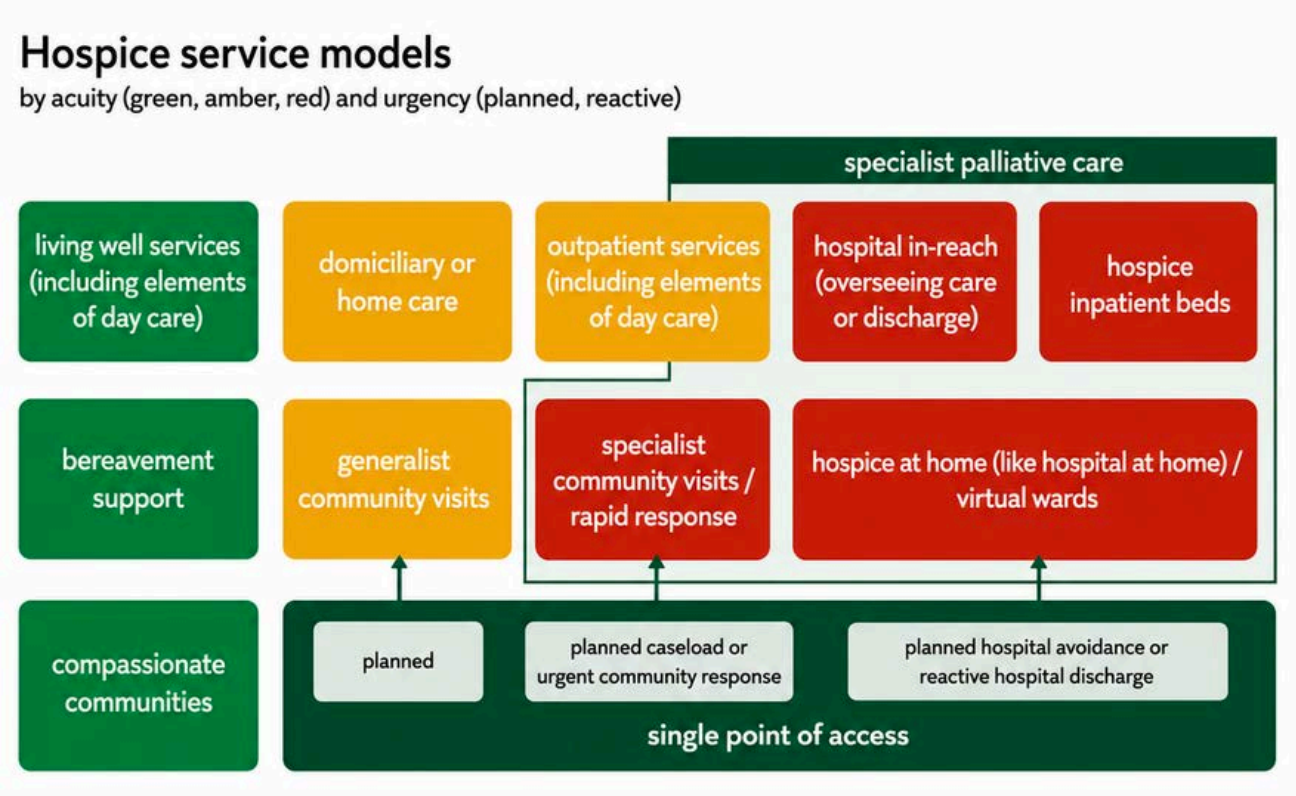
The National commission, NHS Ten Year Plan and Modern Service Frameworks have the potential to strengthen the understanding of services and support greater consistency in commissioning and funding of these services as well as equity of services for patients. St Peter and St James Hospice must utilise the opportunities presented by these documents and policy drivers to strengthen the service offer to be consistent with other Hospices across Sussex and nationally as well as continue to seek ways to be funded equitably.

The Policy Research Unit had initially proposed 12 interventions to enable delivery of this ambition that have since been prioritised to focus on four:

Alongside this, other Modern Service Frameworks for Cancer Care and Frailty and Dementia are also being developed, that have the potential to interface with aims of the Palliative and End of Life Care Modern Service Framework.

Hospice UK – Service Models

Hospice UK published guidance on the service models for Hospice services in September 2025 that provides a structured framework for understanding how hospice care should be organised and resourced across the UK. Their service models are designed to guide hospice providers and commissioners in planning, staffing, and delivering palliative and end-of-life care for adults and children. The models aim to provide a standardised way of describing hospice services, ensure services are planned according to acuity and urgency of patient needs and outline principles, components, populations served and required staffing skill mix.



Clinical Transformation of Our Care Model

We will deliver a seamless, neighbourhood-embedded palliative care model that:

(1) Provides specialist inpatient care for complex symptom management and end of life care supported by safe, caring and effective nursing and expert medical care with a wide range of skills to meet patient needs;

(2) Ensures timely access to Nurse Led end-of-life bedded care via Continuing Healthcare (CHC) where home is not feasible or preferred;

(3) Expands our community specialist palliative care capacity to meet the increasing demand of Palliative and End of Life care to respond quickly and safely at home and in care homes through a Virtual Hospice Ward; and enable support with symptom management and conversations to increase the numbers of patients with advance care plans and ReSPECT.

(4) Incorporates skills development to expand the numbers of nurses in the community and inpatient unit working towards advanced practice roles able to undertake non-medical prescribing and advanced physical assessment and clinical history taking.

(5) Offers a Living Well service that promotes function, rehabilitation, resilience, personalised care planning, clinical review with holistic symptom management, advance care planning, each underpinned by multidisciplinary supportive care.

(6) Offers carers of anyone known to the hospice support with practical, emotional and psychosocial needs.

(7) Provides bereavement services to anyone affected by a hospice patients death, including anticipatory and post bereavement.

(8) Offers Supportive Care Services a shared resource across all services, Living Well Centre, IPU and the Community. The services comprise of rehabilitation services, counselling, social work, Complementary therapy, welfare advice, spiritual care, bereavement and trained volunteers.

(9) Offers provision of a variety of educational and training events into community settings such as nursing and care homes on a range of Palliative and End of Life Care related topics to build expertise and confidence, promoting evidence based practice across our network.

Four new Continuing Healthcare Beds

Patron, radio and TV presenter Katie Derham, on behalf of St Peter & St James Hospice, officially opened four new Continuing Health Care (CHC) fast track beds on Monday 15 June 2026.

Chapter 4

Inpatient Care

Specialist Palliative Care Inpatient Beds (SPCIPU)
Our 8 bedded specialist palliative care inpatient unit provides support of patients who require complex symptom management, reversible crisis management and short-stay stabilisation with clear, time-limited goals before supported discharge or end-of-life care. The IPU also acts as a clinical hub for advice and step-up/step-down coordination with community and acute providers and has the potential to work more closely with ambulance and care-home providers.

End of Life Bedded Care via CHC
The four new dedicated rooms that opened in Q3 2025 to care for patients with continuing healthcare needs, provides time critical End of Life bedded care when death is imminent or home care is unsafe or misaligned with preference. Our service model offers fast-track CHC pathways with same/next-day decision-making; integrated triage with community SPC/UCR and acute trusts; single point of coordination to prevent default hospitalisation; embedded family and carer support.

Clinical transformation projects include:

Expanding the clinical skills of our team through continued development of clinical skills by nursing staff to undertake intravenous medication including antibiotics and fluid administration, blood transfusion and other clinical interventions such as catheterisation and tracheostomy care. In addition the medical team have access to PoC ultrasound and are able to perform paracenteses in the ward environment where clinically appropriate.

Over the next 12 months we will increase the numbers of staff able to undertake additional clinical skills to meet patient needs.

High Quality Care Patient safety incidents and feedback provide valuable insight to further improve the quality and safety of our practice. Key areas of practice where quality improvements will be undertaken are:

- **Focus on patient falls though the use of new falls aids, falls debriefs, reviews of policies reducing risk in relation to patient falls and utilizing safety crosses as a key initiative to promote greater awareness and ownership**
- **Pressure Ulcer management through the use of implementing Purpose T evidence based risk assessment tool to measure, manage and reduce the incidence of pressure ulcers through a new policy, training for all ward staff as well as having the tool embedded on SystmOne**

- **Medicines Management we will seek to reduce medication incidents through key initiatives that include implementing singe CD checking and administration as well as supporting patients, where assessed as safe to independently self administer medications from within their own room.**

Safe and Effective Care through 2026 we will implement a SafeCare nursing tool on the Inpatient Unit to evidence the levels of patient dependency and articulate staffing levels require to make the most effective use of our resources whilst more effective meeting patient needs.

Delivering the benefits of digital transformation two key pieces of work will be undertaken over the next 12 months enabled through digital transformation that are:

- **The use of AI digital scribe in the ward setting will reduce administrative burden on all clinical staff, improving quality of notes and efficiency**

- **Implementing Electronic Prescribing for the Inpatient Ward over the next year**

Implementing Advanced Practice Roles through establishing Advanced Nurse Practitioner (ANP) roles on the Inpatient Unit (IPU) multidisciplinary team, providing advanced clinical leadership, expert assessment, and timely decision- making to enhance patient care, safety, and flow.

This will enable the delivery of Nurse Led care with particular focus on supporting patients receiving Continuing Healthcare we will support the expansion of skills to include Non-Medical Prescribing, Physical Assessment and Clinical History taking.

Over the next 2- 3 years we will establish Advanced Nurse Practitioner roles within the Impatient Unit.

Chapter 5

Community Specialist Palliative Care: Expanded Capability, Responsiveness and Scope

The Hospice Community Team consists of a Community Nurse Manager and 5.9 FTE CNS's with 1.8 FTE Registered Nurse Associates supporting the team. Each CNS has a dedicated caseload within a geographical area and works alongside another CNS to provide cover for days off and annual leave. The service also has a CNS on triage each day working with a dedicated clinical admin to respond to patient calls and urgent request for visits. The team is supported by the Medical Director and a Specialty Doctor who have dedicated PA's to work in the Community alongside access to a Physiotherapist and other members of the supportive care team including counselling, carer and welfare support. The current total caseload is around 400 patients of which around 200 are on open access and 200 on active caseloads.

Work is currently being undertaken to implement new approaches to Multidisciplinary team meetings to enable new patients to be routinely discussed as well as other complex patients. Deaths are also discussed and reviewed on a regular basis through the MDT for both reflection and any learning.

The team also manage a Red List of patients being supported daily at home with complex symptom control needs or at the very end of life. A key focus over the past six months has been increasing the clinical skills of the team to support patients at home. This is also being developed further with two of the team planning to undertake Non Medical Prescribing over the next 6 – 12 months. This work also supports admission avoidance to hospital where there has been an increased focus to provide additional support, interventions and referrals. The team has also linked up with the Macmillan Digital Transformation Lead to access and view patients who are using the comfort tracker.

Clinical transformation projects include:

A more robust specialist palliative care community workforce
through increased establishment with a wider skill mix to include CNS's, Doctors, Paramedics, Registered Nurses, Registered Nurse Associates and Palliative Care Assistants, with support from therapists to assess, treat, advise and care for patients at home.

We will develop a rolling training and education programme to upskill the current workforce, so they are qualified Non-Medical Prescribers, have Advanced Physical Assessment, and Advanced phlebotomy competency. Pilot Virtual Hospice Ward to increase clinical service offering to our patients Access funding to deliver a pilot project of a Hospice Virtual Ward in the Lewes area during 2026, working closely with General Practice and Community Services. Key to this project will be changes of practice, working hours, increased skill mix, overall medical responsibility of VW patients in the community. As well as close working with our colleagues in the community services, and effective data capture and evaluation to demonstrate the benefits and effectiveness of a Hospice Virtual Ward.

Improved efficiencies in working – evaluation of the use of AI scribe through Heidi has identified a key benefit of releasing time that has provided additional visits enabling a more responsive service. Realisation of further digital support improvements will ensure improved quality of documentation in all patient interactions, and MDT meetings, as well as increased recording of informal patient discussions such as the team huddle Communicating our offer as part of the changes to our service and offer to patients we need to clearly communicate to our referrers and population the nature of our service and revisit the name and terminology used to describe our service to enable a common understanding of our purpose and aims.

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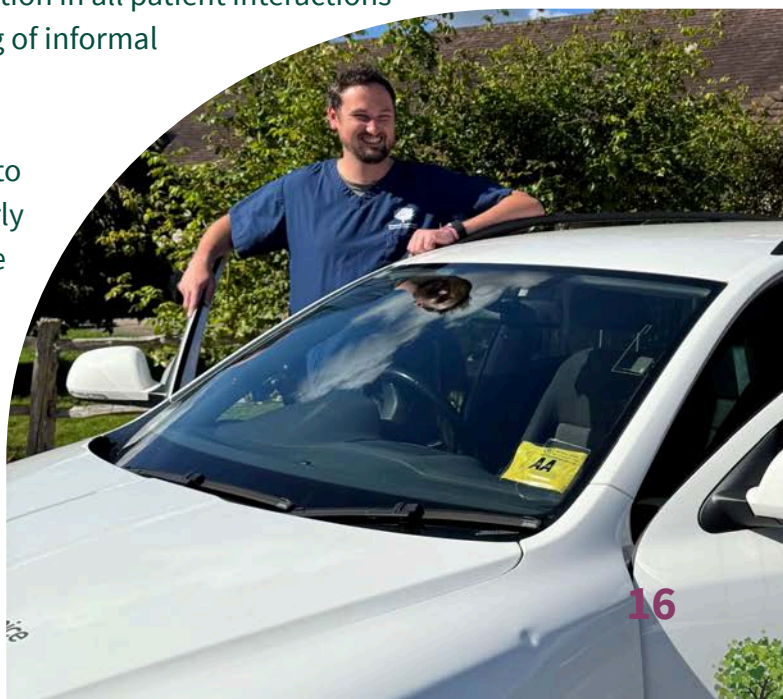

Chapter 6

Living Well Service

The Living Well Centre offers social and activity-based sessions for patients and carers, complemented by a range of supportive interventions, including rehabilitative input, counselling, complementary therapy and welfare advice, that help people to live well with serious illness.

A Living Well Workshop was held in November 2025 to explore the current service model and identify opportunities for development and enhancement.
It has been recognised for some time that the number of patients accessing the Living Well Centre remains relatively low, with referrals predominantly originating from the Hospice Community Team rather than a broader range of pathways. As a result, many patients are referred at a point of crisis or when they are already significantly unwell, which contrasts with our aim of a well being service that enable people to 'live well' and be supported much earlier in their disease trajectory.

Although work has been undertaken to broaden our reach within the constraints of current resources, the workshop highlighted that additional support and wider organisational collaboration are essential to engage patients earlier in their disease trajectory, as the current staffing capacity is not sufficient to deliver the level of service development required to progress the Living Well model effectively. The Hospice UK service model has further validated this direction and strengthened our focus on improving access.

Service transformation

Promotion and visibility of the service to strengthen awareness and understanding of the Living Well Centre to our population and among professional partners to increase access to the service to patients and carers.

We will do this through support from marketing with targeted communication to increase community awareness of our Living Well Centre services. To enable this we will increase staffing capacity to support professional engagement, ensuring referrers and partner organisations are fully informed about the support available for their patients and carers and how we can support and complement their care.

Working towards meeting the Hospice UK model of service for Living Well centres that includes the need to support patients with Personalised Wellbeing plans, Early rehabilitation, Future Care Planning and Holistic Symptom Management. We will seek to focus on ensuring that this is part of the care and support provided through the Living Well Centre and is documented within SystmOne. A key enabler of this is through establishing a Multidisciplinary team dedicated to meeting and discussing patients attending Living Well that commenced in March 2026.

Measuring Outcomes in Living Well Centre attendance and access to a wide range of supportive care services provides valuable evidence of the benefits to patients and carers of the service we provide. We will implement MyCAW through 2026 for our patients attending Living Well Centre embedded within SystmOne to demonstrate our effectiveness.

Integration of Carers support work through the Living Well Centre we will integrate Carer Support into the Living Well Centre to create a more streamlined, coordinated and cohesive approach to family support. This will increase capacity for targeted outreach, professional engagement, and increased earlier referrals for people with palliative care needs.

Use of AI to Enhance Efficiency and Quality we will work towards implementation of AI scribe technology within the LWC and Rehabilitation Services to reduce administrative burden to enhance consistency and quality of clinical notes across patient interactions and MDTs to support clearer documentation and strengthen patient safety.

Chapter 7

Supportive Care Team

The Supportive Care Team brings together a range of services, including:

- **Counselling**
- **Welfare Advice**
- **Spiritual Care**
- **Rehabilitation**
- **Complementary Therapy**

The team delivers interventions across:

- **Inpatient Unit (IPU)**
- **Continuing Healthcare End of Life (CHC EoL)**
- **Community Specialist Palliative Care**
- **Living Well**

All services are further strengthened by support from a substantial volunteer workforce, coordinated within each discipline.

Service transformation

Outcome Measures during 2026 we will work to have an integrated assessment framework and a standardised outcome measure to be used consistently across supportive care services, ensuring a unified approach to assessing patient needs, monitoring progress and demonstrating the impact of interventions.

Spiritual Care during 2026 the New Spiritual Care Lead will develop and coordinate a team of trained volunteers to provide high-quality spiritual and pastoral support across all areas of the hospice. This will ensure that patients and carers have access to personalised spiritual care, that reflects diverse beliefs, values, and cultural backgrounds.

Counselling A recent review of the Counselling Service has resulted in a reduction in the number of sessions offered, bringing provision in line with models used by other hospices. This ensures that the service remains sustainable while continuing to deliver high-quality, person-centred psychological support.

Further developments include:

Bereavement Support for Younger Adults: Exploration is underway to develop a workshop-based model for 18–25-year-olds, offering age-appropriate bereavement support in a group format.

Supervision Review: A review of current supervision structures is being undertaken to identify opportunities for delivering group supervision internally, improving resilience, and sustainability.

Referral Pathway Improvements: Referral criteria have been strengthened to ensure counselling is accessed appropriately, and is not perceived or used as a reactive service.

Integrated Family Systems (IFS) Training: The team is exploring opportunities for training and support in IFS counselling approaches. This development will be extended to the Social Worker once appointed, improving consistency in therapeutic frameworks across the service.

Rehabilitative Service we will continue to seek funding sources to strengthen the therapy services across the hospice, to be able to deliver group-based rehabilitation programmes within the Living Well Centre and support our community and outpatient clinics with targeted rehabilitative interventions.

Complementary Therapy - The complementary therapy service aims to continue expanding through recruitment, training, and support of volunteers. This will allow the hospice to offer a broader and more diverse range of therapeutic modalities, enhancing wellbeing, symptom management, and relaxation for patients and carers.

Carers' Support - A recent review of the carers' support service has identified opportunities to strengthen how support is offered. Changes are planned to improve consistency, accessibility, and the overall experience for carers, ensuring they receive timely, practical, and emotional support as required.

Chapter 8

Quality, Governance and Education Patient Safety, Quality and Outcomes

Evidencing the quality of our care and providing assurance to our patients, public and regulators is critical to providing a safe, effective, caring, responsive and well lead service. Through 2026 we will develop, embed and mature an organisational dashboard with key patient safety and quality indicators that are also aligned with local priorities.

These include:

- **Patient Safety trends and learning related to falls, pressure ulcers and medication incidents**
- **Place of death and preferred place of care and preferred place of death;**
- **Admission avoidance and avoidance of ED attendances in the last 90 days of life;**
- **Increased uptake of personalised care plans/advance care plans and ReSPECT coverage;**
- **Patient Reported Outcome Measures (PROMs) including Measure Yourself Concerns and Wellbeing (MYCaW),integrated Palliative Outcome Score (iPOS) , Adult Attitude to Grief (AAG) outcomes from patients and carers accessing all our services**
- **Inequalities in access/experience;**
- **Utilisation of CHC fast-track beds within our Inpatient Unit**
- **IPU length of stay;**
- **Patient and carer outcomes and bereavement support uptake.**

Education

Learning, Education and Development is critical for the continued improvement of our teams and services. Through our Learning, Education and Development team we will focus on a number of areas through 2026 and 2027 that include:

- **Design & deliver a multi-faceted Education Programme to support expectations for roles, as reflected in the Competency Skills Matrix.**
- **Measure Educational Program impact.**
- **Repeat the Learning Needs Assessment alongside collating feedback.**
- **Evaluate the education programme in terms of staff skills and confidence**
- **Develop & roll out a programme of support for Preceptee Nursing Associates.**
- **Build and implement a Clinical Induction Programme**
- **Review and enhance our offerings to HE Institutions for clinical placements.**
- **Explore capacity to run a series of external access training events**
- **Develop and deliver a series of training events to meet the needs of our community and hospital-based HCP network**
- **Facilitate interdisciplinary teaching & learning opportunities utilising in-house expertise.**
- **Coordinate the delivery of Resilience Based Clinical Supervision and its roll out across the hospice**
- **Undertake a staff survey in relation to the learning culture of the organisation.**

References

NHS Long Term Plan (2019) & 10-Year Health Plan hub: https://www.longtermplan.nhs.uk/

NHS England – Palliative and End of Life Care: Statutory Guidance for ICBs (Sept 2022):

https://www.england.nhs.uk/wp-content/uploads/2022/07/Palliative-and-End-of-Life-Care-Statutory-Guidance-for-Integrated-Care-Boards-ICBs-September-2022.pdf

NHS England – Palliative and End of Life Care Programme: https://www.england.nhs.uk/eolc/

Neighbourhood Health Guidelines 2025/26:

https://www.england.nhs.uk/longread/neighbourhood-health-guidelines-2025-26/

Sussex Health & Care – Integrated Community Teams:

https://www.sussex.ics.nhs.uk/ourwork/our-priorities/integrated-community-teams/

NHS Sussex – Strategic Commissioning Framework & Planning Papers (2024–2026):

https://www.sussex.ics.nhs.uk/

Pan-Sussex Palliative Care Medication Instruction Chart (MIC) resources:

https://www.sps.nhs.uk/

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