Quality Account
2017-18

saint
francis
hospice

living with dignity

2017/2018 Innovations

We are proud of the work that's been carried out by our staff and volunteers at Saint Francis Hospice. This graphic gives a brief introduction to some of our successful projects from the past 12 months.

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living with dignity

- **Schwartz Center Rounds**
- **Now a dementia friendly hospice**
- **CNS prescriber training**
- **Carers' Café**
- **OrangeLine**
- **Pemberton Place**
- **Young adults group**
- **Strengthening the user voice**
- **Children's bereavement services**
- **Real Time IT**
  - e-referral
  - Cyberlab
  - Summary care record
- **Equipping our community and Hospice at Home team with technology and remote working**
- **Strengthening our Redbridge Services**
- **Partnership with St Luke's Hospice**
- **Outpatient clinics**
- **Diversity and equality training**
- **Reviewing induction and mandatory training**
- **Increased group sessions**

PART 1

INTRODUCTION

About Us

Our Approach

Saint Francis Hospice is an independent charity and one of the largest adult hospices in the UK.

Our team of specialist consultants, doctors and nurses, along with a range of other health and social care professionals, provide care and support to individuals with a life-limiting illness, as well as their carers and family members.

Serving the populations of Havering, Brentwood, Barking and Dagenham, Redbridge and West Essex, we need to raise £7.8 million in voluntary income in order to continue to provide all our services, completely free of charge. Every donation from individuals and organisations is important to us, and we value our supporters immensely. We also have a team of 840 skilled and committed volunteers who help us keep our costs down and add huge significance to the work we do.

Our Vision

Saint Francis Hospice is committed to helping anyone in our communities affected by life-limiting illness, and to ensuring they receive excellent person-centred care when they need it, ideally in a place of their choosing.

Our Values

These values underpin all that our charity aspires to do, as well as shaping our external and internal behaviour:

Support: share ideas and respect one another, encouraging everyone to succeed

Fairness: treat everyone as we ourselves would wish to be treated; be courteous and aware of how our words and actions affect others

Honesty: be open and accountable, working together for the benefit of our local community

Chief Executive Officer Statement

On behalf of the Board of Trustees and the Senior Management Team, I am delighted to present the Saint Francis Hospice Quality Account for 2017-18. We are an independent charity that last year provided palliative care and support to 1,693 people across Brentwood, Havering, Barking & Dagenham, Redbridge and West Essex.

The document is put together to help the public, patients and other interested parties to understand what we're doing well, where improvements in service quality are required, and what are our priorities for improvement during the coming year.

Last year's Quality Account prioritised three key projects – the introduction of the Hospice UK Falls Toolkit; the incorporation of the Outcome Assessment Complexity Collaborative into our patient assessments (assessments of complexity); and the implementation of OrangeLine (our support helpline). I am delighted to confirm that all three priorities were actioned and are now part of the daily way of working in our Hospice. There is still a little work to do on all three to fully embed them into our work, but we are very pleased with the results.

As an 18-bed hospice, we carry out around 85% of our care in the community, supporting people in their own homes. Our Hospice at Home team made 2,839 visits last year and a further 15,578 face to face consultations and calls were delivered to patients, relatives and carers by our Specialist Community and Crisis Support team. I am so proud of the work our staff do and passionately believe it's important to educate everyone not only about hospice care generally but also the amount that we, and other hospices, do outside of the main building.

As always, income remains a priority for us – we only receive 28% of our funding from the government which means we need to raise 72% of our running costs through fundraising, donations, gifts in Wills and our Retail section. I encourage our staff to always remember that we are a charity, that we should always ask "can we get it cheaper, or even better, for free?" before purchasing anything. This would never be to the detriment of patient care but, with our desire to keep all services free at the point of delivery, we need to watch every penny. Our regular supporters, and corporate and community advocates, make this possible, and I thank them all for their continued support.

In July 2016, we received an 'Outstanding' assessment by the Quality Care Commission (CQC), something we are extremely proud of. This is all down to the hard work, dedication and passion from our staff and volunteers ensuring we always demonstrate the highest quality of care. I would like to thank them all for their continued dedication to providing excellent patient and family care along the End of Life care pathway.

I hope you enjoy reading all about our developments and plans for the coming year.

Pam Court
Chief Executive Officer

Statement of Assurance from the Board

On behalf of The Board of Trustees, I am delighted to present our Quality Account for 2017/18.

The Board of Trustees' clinical and corporate governance role is fulfilled through delegated governance committees: Clinical, Audit and Investment, Voluntary Income and Corporate Governance. These committees meet quarterly and receive updates on work done to maintain, improve and evidence the high quality services provided to our patients, their carers, our supporters, volunteers and staff. The Board of Trustees also carries out its own informal inspection, speaking to patients, relatives, staff and volunteers.

Review of Services

During 2017/18 Saint Francis Hospice delivered the following specialist palliative care provision to the communities we serve in Barking & Dagenham, Havering, Redbridge, Brentwood and West Essex.

- Inpatient Unit services
- Day Therapy services
- 24/7 Community and Crisis Support services
- 24/7 Specialist Contact Centre and helpline
- Hospice at Home service
- Education and training
- Physiotherapy service
- Occupational Therapy service
- Complementary Therapy service
- Pastoral Care service
- Bereavement support service
- Child bereavement service
- Family and carer support including welfare advice and psychological support
- Carer support services
- Psychotherapy service
- Outpatient clinics
- Community equipment loan service
- OrangeLine

All the data available on the quality of care provided for these services has been reviewed. The income generated by the NHS services provided over the last financial year represents approximately 28% of Saint Francis Hospice's total income. The remaining income is generated by fundraising, investments and retail activity.

The hard-working teams at the Hospice continue to deliver our five year strategy. The Board of Trustees appreciates that the staff and volunteers at our Hospice often go above and beyond the call of duty as they are passionate about providing excellent care, and I would like to add my personal thanks and gratitude for all that they do.

Dr Robert Weatherstone
Chairman, Board of Trustees

PART 2

REPORTING ON OUR PRIORITIES

Identifying and sharing our priorities for quality improvement in the forthcoming year is the main reason for the production of the Quality Account. It also provides us with a mechanism for reviewing and reflecting on the progress we have made on the identified priorities for quality improvement at the beginning of last year.

This section reports on the progress of those identified priorities. All were chosen for their direct impact on the quality of care that patients and families receive either through patient safety, clinical effectiveness or patient experience.

Priority 1: Patient Safety Improvement

Falls Toolkit

The implementation of the Hospice UK Falls Toolkit (2016), an evidence-based document that relates to national guidance and supports the application of best practice in relation to prevention and management of falls.

HospiceUK developed this toolkit to help organisations to "... manage and even prevent falls in an individualised, multidisciplinary and person-centred way", and to "... identify falls that are preventable and provide the information for falls data analysis" (Hospice UK 2016).

Standards

Our Inpatient Unit supports and cares for many people who are highly vulnerable to falls. We were keen to do all we could to secure best practice. We regularly audit falls and near falls as part of broader incident recording. In 2016-17 we had an average of 12.5 falls per quarter – most without serious injury but nevertheless this illustrates the vulnerability.

We had no standard tool for documenting falls vulnerability beyond a 'moving and handling' tool which focus is more on equipment needed to support movement than on vulnerability to and prevention of falls.

We introduced the HospiceUK Falls Toolkit as a new standard tool to expand our Inpatient Unit documentation/care planning as a new, quality, evidenced tool to help assure us of best practice in preventing falls.

Summary of actions

The toolkit includes an incident form specific to the reporting of a fall within the Hospice inpatient unit (IPU) setting which required amendments to enable us to capture demographics pertinent to our service.

Implementing the toolkit required more clarity around care of people with dementia/ cognitive impairment so developed and rolled out a Dementia Policy, and teaching to all of our staff about dementia care.

An incident form, specific to the reporting of a fall within the Inpatient Unit was developed and is now in use. Of note we had to re-define 'fall' to meet with the HospiceUK definitions – essentially requiring slight adjustment to existing paperwork. This change was introduced in Quarter 4 2017-2018

The Falls Toolkit was introduced onto the IPU in July 2017. The primary challenge was to support and train staff to complete a new Falls Prevention Care Plan, now required for every person admitted, and to complete the following goals:

- The Falls Prevention Care Plan is regularly reviewed
- Individual interventions to reduce the risk of falls are documented in the patients' Falls Prevention Care Plan
- The patients are assessed for individual falls risk factors that can be treated, improved or managed
- Any incidents of falls are correctly reported, recorded and actioned

Two audits have been undertaken since to monitor progress and impact of change, one in January 2018 and one in March 2018. In the first audit 94% of admissions had a Falls Prevention Care Plan generated; in the second audit 71% did. In almost all cases the Plan was generated within the first 24 hours of admission.

However both audits showed that the Plan tended not to be reviewed as a routine practice.

By March '18 71% of admissions' "individual risks" were documented with a clear plan for care, but there remained no documentation for the remaining 29% into the Falls Prevention Care Plan documentation. There was documentation elsewhere (e.g. in the body of the notes) ... but the Falls Toolkit recommends a defined place for documentation of vulnerability and care plan to improve communication, so that we still have work to do to embed the tool.

For those who fell, documentation as to re-evaluation of risk/risk prevention review was done and actions were fully made; the incident form itself was well completed on 100% of occasions. However the learning from the incident and changes made did not always get documented into the Falls paperwork, risking loss of key communication of vulnerability and good plans made throughout the ward care team.

Overall an average 83% of patients across both audits had a fall prevention care plan generated and an average 63% of patients across both audits had individual interventions to reduce the risk of falls documented on the new paperwork.

In terms of falls themselves the average number of falls per quarter reduced over the implementation period to 11.5 falls/quarter.

Audit findings have been shared with Clinical Governance in May 2018 and will be shared at our Clinical Audit Presentation Forum July 2018.

Work outstanding

Further embedding of the use of the Falls Toolkit is required. This will be supported by our Ward Sisters and the Moving and Handling Special Interest Group.

A re-audit will be conducted in July 2018 to track the embedding of the tool.

Report compiled by: Hazel McGwyne, Michaela Sen and Dr Corinna Midgley.

Priority 2: Clinical Effectiveness Improvement

OACC Project

Aim: to introduce a way of describing the challenges our service users face, their complexity when we first meet them and what difference hospice care makes to them.

The OACC (Outcome Assessment Complexity Collaborative) is a suite of measures devised and developed at Kings College Hospital to do just that. The measures have been adopted by a number of palliative care services nationally over this last year or two.

Our task was to introduce and embed the measures into our practice and documentation. If we could achieve this then we could go on to analyse the data to identify when and how we are involved in care and the difference we make.

This data would help us to share our work and the impact it makes with our staff, our partners in care, our public and Commissioners to make hospice care more understandable for all.

If done in line with other hospices, then we and our Commissioners would be able to benchmark our care against other similar organisations.

Standards

A nationally accepted quality tool; the OACC tool. Hospices are encouraged, but not obliged, to adopt these measures with a view to eventually analysing and reporting to relevant departments where decisions about whether further teaching or training is required will then be made.

Summary of actions

An OACC focus group was set up to lead the introduction of OACC measures into our day to day assessments.

The OACC focus group included expertise from Quality and Care, Medical and IT departments.

OACC measures were implemented into all of our clinical services using a stepwise approach, with application across all services over a six month period.

Since introducing this way of working, our staff have embraced the project, providing positive feedback on the usefulness of the measures, because they give everyone a common language to understand a patient's complexity. They also help give staff rapid understanding of where patients are with regard to their illness.

We now refer to each patient's Phase of Illness and Performance Status (two of the OACC measures) in our daily handovers, giving staff an immediate understanding of the patient's stability or otherwise, and their dependence on others to support their care needs.

At our weekly Multi-Disciplinary Team (MDT) meetings we also look in detail at the latest IPOS (Integrated Palliative Outcome Scale) questionnaire, which helps us to understand what is most important for the patient, physically, practically, emotionally and spiritually.

These tools together help us to agree on a plan of care for patients. For those patients admitted to IPU, the nurses also complete a measure of the patients' independence (the Barthel index) and the Family Support team measure carer burden using the Zarit carer interview.

As a result of our success in embedding the OACC measures into the culture of care at Saint Francis Hospice, we were honoured to be invited to present our work on OACC at the Hospice UK Annual Conference in November 2017.

An audit of three months of OACC data for IPU (April to June 2017) was completed and presented at a regional audit meeting (PLAUDIT) in November 2017. This was also presented to Saint Francis Hospice staff. The audit confirmed that the OACC measures are being used, though we have work to do to collect as often as the national OACC team recommend.

Results included the presentation of OACC data for a quarterly cohort, as well as for individual patients, in different visual ways. It stimulated ideas for how to present complex data meaningfully towards our ultimate goal of being able to see and demonstrate complexity, impact of illness and impact of interventions.

Work outstanding

OACC measures are now in daily use but require more consolidation and embedding into the organisation. In particular the timing of collection of measures needs to be developed.

We need to find a way of easily producing regular reports to give robust, meaningful, real-time data about the people we serve. Ideally, there would be functionality developed within our software database (currently iCare) to enable OACC data to be reported on with ease as a quarterly norm and to be easily interpretable (e.g. by use of graphics such as graphs and trend lines).

The focus group will continue to lead the OACC project.

Report compiled by: Dr Mark Howard, Michaela Sen, Hazel McGwyne and Dr Corinna Midgley.

Priority 3: Patient Experience Improvement

OrangeLine

Developing OrangeLine – a service initiated in 2016, with support of a three-year Big Lottery grant

Standards

To create a friendly contact point for local people, where they can converse, seek help and come together socially to lend support to one another.

The project would provide engagement with local people and service users affected by life-limiting illness and help to understand their needs outside a clinical framework. New opportunities for volunteers to connect to and support people with need would be created, and if successful in connecting and supporting people, to then share our experience with the wider hospice world.

Connecting people in our community

OrangeLine

by Saint Francis Hospice

01708 758649

Summary of actions

1. OrangeLine – a friendly contact point

OrangeLine has had a year of learning and development. It was originally created to be a non-clinical helpline for people isolated and/or bereaved, but has become much more. An internal process of sending condolence cards to family members during the first week of their bereavement journey commenced as a pilot, and staff and volunteers followed this up with a welfare telephone call after 7-10 days. Over 60% of the people we spoke to asked if they could be called again, weekly or fortnightly, as they welcomed the friendly comfort and support of the calls. OrangeLine has now become the contact point for people when they need to talk to someone and share their grief and worries. In April 2017, 130 people were surveyed.

Do you feel less lonely or isolated knowing that you can call OrangeLine, or have OrangeLine call you?

99% said yes

Has your mood improved following contact with OrangeLine, either emotionally, spiritually or physically?

100% said yes

Would you recommend our service to your family and friends?

95% said yes

Testimonies

"I was in denial - both my daughter-in-law and I found it really helpful to talk to someone outside."

"It's difficult talking to my family - getting your calls make my day. You just seem to always call when I am feeling low."

2. A Social group

When contacting OrangeLine service users, we learned that in addition to having support calls, they would like to attend a friendly social group to be with people, like themselves, who have lost someone close to them. In response we created a 'Friendly Faces' social group.

The group has been meeting in our day services space, Pemberton Place, on a Saturday afternoon once a month. Responders to feedback have shared that "95% of people felt less lonely and isolated having attended the social group." Up to 40 people now attend each month.

The OrangeLine team work very hard to create a warm and friendly atmosphere and arrange either entertainment or speakers for the group. The group is also self-funded, as members voluntarily give donations, allowing us to provide refreshments, which included a buffet and wine at their Christmas social.

3. Volunteers in OrangeLine

Volunteer numbers have steadily grown over the last 12 months. We now have 25 regular volunteers. Each volunteer has completed a three-day training programme, which includes the principles of the practice of palliative care, understanding ageism and loneliness, understanding challenging and emotional behaviour, and learning new communication skills.

Volunteer feedback has shared hugely positive gains from volunteering - for example, how they feel rewarded when they have supported a very emotional person who, by the end of the call, feels much more in control. The volunteers are also enjoying a social side to their role and often meet up with each other for outings. We were delighted that our OrangeLine volunteers received a Havering Mayor's award this year where they were presented with certificates and chocolates!

4. Publicising and working in partnership

OrangeLine services have been promoted to all staff in our Hospice's clinical services as well as external colleagues who give clinical support to people with advanced life-limiting illness.

We have developed posters, which have reached all local GP surgeries, hospitals etc, and have had an advertisement about OrangeLine printed on 30,000 NHS appointment cards. Referrals have come from internal colleagues, external clinicians, local social services departments and other voluntary sector groups.

Work outstanding

More partnership working is needed. The OrangeLine team have achieved some exceptional partnership outcomes so far.

This has included working with Silverline to promote their Pen Pal project (for the people we support who are housebound), supporting the local Di's Diamonds members, joining up with other voluntary sector agencies, jointly promoting services at local events, and supporting local cancer support groups. Finding partners and working together will be work ongoing.

We need to properly evaluate the reach and impact of OrangeLine and to identify who we meet through earlier referral to OrangeLine, and also who we have supported and moved to OrangeLine for on-going support when they no longer need specialist or clinical input, but continue to need support.

Our biggest challenge will be to find sustainable funding for OrangeLine as we have had such positive feedback - we want it to embed, not lose it.

Report compiled by Jan Scott.

PART 3

PRIORITIES FOR IMPROVEMENT

The delivery of high quality care is at the core of everything we do. Our staff, volunteers and Trustees are committed to ensuring that the care we give is safe and effective, and provides patients and carers with a positive experience.

This section highlights the key quality improvement projects we are going to be prioritising throughout 2018/19 to support this.

Priority 1: Patient Safety Improvement

More responsive referrals receipt and action service to better meet need

How was it identified as a priority?

Eighteen months ago, we reviewed our referrals form and developed new ways for people to refer into our Hospice services.

This was in response to a changing environment where we see moves away from paper systems towards web-based and electronic systems, as well as taking into account feedback from those who refer into our services a lot, such as GPs and hospital palliative care services.

The current form is now at the end of its pilot phase and requires feedback and a review, as does the broader referrals process.

Meanwhile our service offer has increased, with the recent addition of a volunteer and peer-to-peer support service (OrangeLine).

We now offer Hospice volunteer-led community support groups for carers, people living with the impact of life-limiting illnesses, and people who are at an earlier stage of illness. This group of people can feel isolated and worried; they could benefit from rehabilitation or therapeutic support, or could simply appreciate an early introduction to our services. Learning about what we can do to support them, and also about what palliative care is, may help them to plan for the future.

Our staff worry that the current referral form is not helpful in informing prospective referrers about what hospice services are available.

We want to offer the right support at the right time. The current system of reviewing all referrals once a day risks missing a crisis needs.

What do we want to achieve?

- To establish a more responsive referrals process to better meet demand
- To re-invite feedback on the referrals form, now at the end of its pilot
- To re-invite feedback on the referrals process
- To establish a hub for referrals with an on-receipt review of requests and triaging to establish the urgency of need
- To establish a consensus on the pros and cons of a separate or more detailed form to help referrers, as well as to help us identify whether an introductory service is needed

How will this priority be achieved?

Through mobilisation of a focus group to project manage and audit the impact of changes.

How will progress be monitored and reported?

Through oversight of activity and feedback, regulary reporting to clinical governance.

Report compiled by Hazel McGwyne and Lesley Burrows.

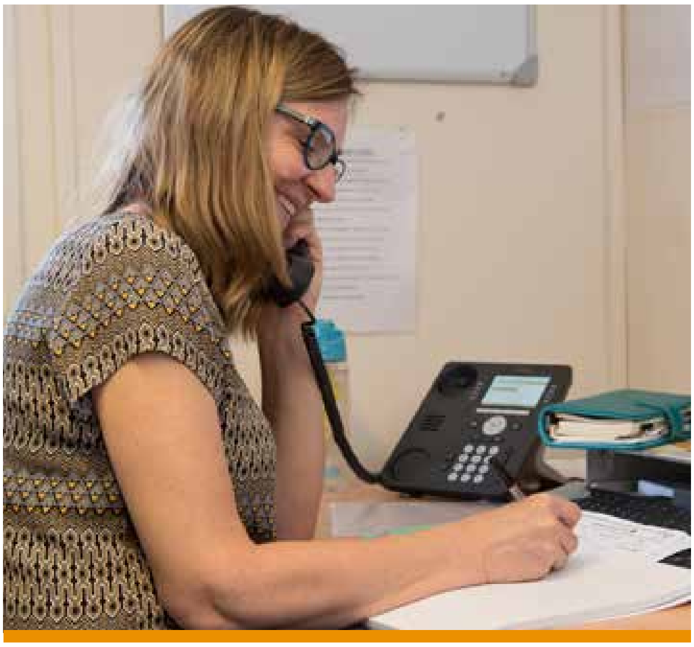
Priority 2: Clinical Effectiveness Improvement

Non-medical prescribing

The proposals for Non-Medical Prescribing were first introduced after the Review of Prescribing, Supply and Administration of Medicines, chaired by Dr June Crown CBE in 1998, when district nurses and health visitors were allowed to prescribe from a limited list of medication.

In 2001, Non-Medical Prescribing (NMP) was extended and the Extended Formulary for Nurses was introduced which allowed trained nurse prescribers to prescribe for a limited list of conditions from an extended formulary. In April 2003, regulations came into force for Nurse and Pharmacist Supplementary Prescribing so that after an initial assessment of a patient by a doctor, the NMP could prescribe for that patient in accordance with a clinical management plan (CMP).

In 2006 regulations allowed pharmacists and nurses to practice as Independent Prescribers and to prescribe, within their competency, licensed Prescription Only Medicine (POM), Pharmacy medicine (P) and General Sales List medicine (GSL) on the FP10 database, which provides information on commonly queried medicinal products.



How was this identified as a priority?

In 2007 staff at Saint Francis Hospice voiced a concern about the delays that palliative care patients, and their families, experienced when getting the prescriptions that they needed from their GP.

The Clinical Nurse Specialists undertook two retrospective audits, providing information about the length of time that palliative care patients had to wait.

Audit demonstrated that only 10-24% of requests generated as a prescription on the same day from the GP. Furthermore, 42-50% required chasing up, with repeated phone calls by the Saint Francis Hospice team.

In 2013 there was a move towards a new model of working for the Community Specialist team, now named as the Specialist Community and Crisis Support (SCCS) team. This highlighted and supported the need for crisis face-to-face visits, either at home or in an outpatient setting. It was felt that if the SCCS team were able to prescribe in these (crisis) situations, this would avoid hospital admissions by reducing delays in obtaining and commencing medications for urgent symptom control needs at home.

Another prospective three month audit from January to March 2018, recorded information about 39 prescription requests in the Barking and Dagenham, Havering and Brentwood areas from the SCCS team to GPs. Preliminary data demonstrated 11 incidences of missed opportunities where the presence of a non-medical prescriber could have written the prescription to speed up the process of getting the right medications to the individual patient's home. In addition there were two instances of significantly prolonged delays (two to three days).

Involving an out-of-hours GP can lead to holdups because they may not be familiar with the patients or with the manner of prescribing these symptom-control medications.

Many areas across the country have specialist palliative care teams prescribing to their community patients - for example the Redbridge community palliative care nursing team. However, in areas such as Brentwood, Barking and Dagenham, and Havering, there is not always consistent availability of community district nurse prescribers.

These prescribing gaps cause delays and affect patient care (as evidenced by our audit), and therefore it has become a priority for us to train our community specialist palliative care nurses to become independent non-medical prescribers.

How will this priority be achieved?

We now have nine Clinical Nurse Specialists in the Community Crisis Support team at Saint Francis Hospice who are qualified as non-medical prescribers.

We are working closely with our key partners- chief pharmacists, district nurse leads, senior management and the Clinical Commissioning Groups (CCG) for North East London Foundation Trust (NELFT). The latter requested the three-month prospective audit, now complete.

The prescribing policy for non-medical prescribers has been completed and all other relevant policies relating to medicines management are in place. The current Clinical Nurse Specialist non-medical prescribers have all had their annual updates for 2017/18. Clinical Nurse Specialist job descriptions have been amended to reflect non-medical prescribing roles.

The recent audit results need to be finalised and shared with the Hospice's senior management team, medicines management group, clinical audit group, the CCGs, and their lead Pharmacist. We aim to explore a time frame for implementation following discussion and agreement from the NELFT CCGs.

How will progress be monitored and reported?

Finalised data from the audit will be collated and shared with the CCGs and lead Pharmacist. Outcomes from the audit will be used as part of the discussions to take the project forward.

There will be ongoing audits, annual updates and monthly one-to-ones with all non-medical prescribers to provide oversight by team co-leads. This will ensure safe, effective and efficient prescribing, adhering to local guidance and policy.

The team leaders for SCCS are non-medical prescribers themselves, so will be a valuable and experienced resource for the SCCS team. SCCS non-medical prescribers will have read and adhered to the competency framework for all non-medical prescribers (Royal Pharmaceutical Society 2016).

Jane Elmer, SCCS co-team leader, will be leading on this initiative, attending and updating the medicines management team and wider organisational groups quarterly. She will also be reporting to the Hospice's Clinical Governance Committee.

SCCS team leads will maintain links with key partners and attend regular meetings with district nurse leads to feedback and update on non-medical prescribing and share good practice, linking with any CCG requirements.

Report compiled by Maria Stripe, Jane Elmer and Lesley Burrows.

Priority 3: Patient Experience Improvement

Supporting children: building their resilience and how we make a difference

Standards

Losing a close relative can be devastating for a child or young person, and can affect their schooling, social life and family dynamics, with the effects possibly lasting long into adulthood.

Young bereaved people need support when they are experiencing the loss of a loved one. Much of this support will be from close relatives or friends, but in some instances professional guidance through the grief process is essential. This is a standard recognised by Saint Francis Hospice.

Parents, teaching staff, and health and care professionals involved in childcare services, welcome the proactive and reactive guidance we can offer them in supporting young people who are facing a loss, and are in their care.

How was it identified as a priority?

Recognising that children and young people are part of the grief process was identified as referrals to the Family Support Team rapidly increased year on year; referrals received were for both pre and post bereavement support. A significant increase was the referrals received for young children aged four years and under.

The care for children and young people's mental health is a Government priority which proposes that mental health support should be provided, and early intervention is available to promote good mental health and wellbeing.

Children in Need also recognised the need to give young people bereavement support by approving our grant application for a three-year project; this has enabled us to employ two dedicated Child and Family Support Therapists.

What do we want to achieve?

Our aim is to improve the wellbeing for children and young people under the age of 18.

This will be achieved by increasing a young person's emotional understanding of grief, loss and bereavement.

We aim to reduce a young person's feelings of isolation by improving family communication, and to reach young people at their time of need to help prevent negative outcomes such as self-harming or addictions.

To achieve improved health and wellbeing for young people, we will provide advice to families, health and care professionals, and teaching staff on issues around death and dying, and ensure that the child is at the centre of the care and support that they need.

How will this priority be achieved?

Referrals received by the Family Support team for young people requiring bereavement support will be prioritised as urgent, and the young person will be contacted within a one week timeframe.

The Therapists will see young people for six one-to-one sessions; this will then be followed by a family session. Activities will include creating their own personalised support plan and thinking of ways to improve communication skills, increasing self-confidence and self-esteem, and ways of humanising emotional wellbeing by normalising the grief they feel. Young people are often overwhelmed by their feelings and they find these difficult to articulate or understand. Therefore the designed activities are aimed at encouraging the young person to build coping strategies to help increase their resilience and inner strength.

Our work with families, teachers, and health and care professionals involved in child care services will demonstrate how to be proactive and reactive in child grief. We will explore ways of recognising signs of grief in a child, and by giving them the necessary tools and techniques or strategies to enable them support the young people.

How will progress be monitored and reported?

Every child will be asked to complete an assessment tool on their first session which will create a base line (during their last session they will complete the same assessment tool). This will evidence any significant differences in the young person's health and wellbeing, their self-esteem and isolation, and their family communication. This will highlight whether the young person has experienced significant progress, some progress, or is yet to experience any progress.

Having worked closely with the young person's school, we will ask for clinical outcome measures which will determine progress in their learning environment

Parents or carers will be also be offered a similar measurement tool to assess their child's communication and relationships within the family environment.

Report compiled by Shahina Haque and Jan Scott.

PART 4

PARTICIPATION IN CLINICAL AUDITS

Clinical and Service Audits Programme

As a voluntary sector organisation, Saint Francis Hospice is unable to participate in NHS-led national clinical audits and national confidential enquiries. However clinical audit is high on our priority list.

We recognise that for our services to keep up with best clinical practice, and to develop in quality and reach to support people with an increasingly wide and more complex range of life-limiting conditions, we need to be constantly evaluating our practice against the best standards possible.

Our Hospice has a dynamic annual audit programme, which is monitored by Michaela Sen (Quality and Audit Facilitator), who reports to the Head of Quality and Audit.

Audit activity is reported:

- monthly at the Quality and Care Directorate team meeting
- bi-monthly at Clinical Audit Group
- by a quarterly written report from the Quality and Audit Facilitator to the Head of Quality and Audit
- bi-annually to the Clinical Effectiveness Group
- annually to the Clinical Governance Committee

1. Annual Audit Programme

We run an annual 'rolling programme' of audit both in-house generated and against nationally recognised excellence standards which have been researched and developed by Hospice UK.

As a national charity, Hospice UK has developed supporting audit tools to enable specialist palliative care services, such as ours, to benchmark against best standards of excellence for a large range of health, safety and care delivery standards.

Number	Name
01	Hospice UK - Infection Prevention - IPU - Inpatient Unit
02	Hospice UK - Infection Prevention - Pemberton Place
03	Hospice UK - Pre-bereavement
04	Hospice UK – Self-Assessment; Accountable Officer
06	Hospice UK - Admission IPU
07	Hospice UK - Admission Visiting CNS - Clinical Nurse Specialist
08	Hospice UK - Admission Telephone CNS
09	Hospice UK - Ongoing Support CNS
10	Hospice UK - General Medicines
11	Hospice UK - Controlled Drugs
12	Saint Francis Hospice in-house - Resuscitation policy
13	Hospice UK - Management of Pressure Ulcers IPU
14	Hospice UK - Nutrition and Hydration
15	Hospice UK - Pain Management
17	Hospice UK - Medical Gases
18	Hospice UK - Safety Matrix Benchmarking Tool
19	Saint Francis Hospice in-house - SCCS Standards - Specialist Community and Crisis Support Service

2. Short Observational Framework Inspection (SOFIs)

We undertake short observational audits which are done on an annual basis unless concerns are identified. SOFIs are particularly useful for evidencing compliance against Care Quality Commission (CQC) key lines of enquiry (KLOE). They are also useful in evidencing gaps not sufficiently covered by larger annual audits.

> **"I would like to say a huge thank you to Hospice at Home who were there for my dad's last days - don't know what me and my brothers would have done without you all. Every person we met was so kind, caring and compassionate and the support was amazing you go above and beyond! Thank you."**
>
> (Service user questionnaire, February 2018)

25 SOFIs undertaken in 2017/2018

Number	Name
02	Care plans - IPU
03	Care plans - Community
04	Mental capacity
05	Environment Supports; Privacy and Dignity
07	Informed Consent - IPU
08	Assessment of risk within clinical and non-clinical areas
09	Reception Area
10	Documentation - IPU
12	Safeguarding People who use Services
13	Using Clinical Equipment
14	Discharge Planning
15	MDT - Multi disciplinary team - meeting effectiveness - IPU
16	MDT meeting effectiveness - Community
18	Hand Hygiene
19	Nutrition
20	Whistle Blowing
21	Uniform/Dress Code: Hands-on Clinical
22	Uniform/Dress Code: Domestic
23	Maintenance and Renewal
24	Documentation - Personalised Framework for the Last Days of Life
25	Catheter Care
26	Storage of M&H equipment and spot check on Servicing Tool
27	Diabetic Management
28	IPU Mattress Audit
29	Quarterly Controlled Drugs Check

3. Clinical Audit Group (CAG)

The Clinical Audit Group meets bi-monthly and, under the guidance of the Clinical Governance Committee, oversees all audit activity.

Audits completed are presented to the multidisciplinary team at the Clinical Audit Group and an audit notice board is maintained, providing information on presentations and news about audits. The overall aim is to foster a culture that continuously encourages the merits and value of audit within our organisation.

> **"The service I received from the Hospice was absolutely first class. Nursing style was superb, food very professionally cooked and cleaned. Staff always around to make sure corridors and wards were clean. Nurses and doctors very thorough and made sure medication was correct. A very high standard of care."**
>
> (Service user questionnaire, January 2018)

Audit Undertaken and Presented at CAG 2017-2018

Audit Number	Date	Audit Title and Presenter
128	5 July 2017	Are patients and GPs satisfied with Saint Francis Hospice clinical encounter letters? Dr Talib Shah
132	5 July 2017	Health Analytics and User Participation - Dr Ali Jawad
134	6 September 2017	DNACPR Documentation Across Healthcare Setting - Dr Emily Adam
126	1 November 2017	An audit to better understand the support provided by SCCS to telephone contact patients - Nicola Stananought, Jeneba Belewa, Maria Stripe, from SCCS and Michaela Sen, Quality and Audit Facilitator
133	1 November 2017	Improving prescribing of steroids in palliative care - Dr Patrice Baptiste
121a	3 January 2018	IPU Discharge Audit July 2017 - Maria Bishop, Service and Discharge Coordinator for the IPU
135	3 January 2018	Hepatic Failure and Palliative Care - Dr Lucy Bemand-Qureshi, Specialist Registrar in Palliative Medicine
136	7 March 2018	Audit on the data quality of the Integrated Palliative Outcome Scale (IPOS) collected over three months on the Saint Francis Hospice Inpatient Unit - Dr Mark Howard, Consultant
109a	7 March 2018	Re-audit Hospice at Home Referrals - Julie Bateman and Dawn Chaplin from Hospice at Home

As an organisation, we are committed to making continuous improvements. All results following an audit are presented and discussed within our relevant teams; they are used to develop an action plan specifying who the overall owner of the audit is, what actions are required to be undertaken, how this is to be achieved and who is responsible for the actions to be implemented.

Examples of changes made this year following audit include:

- development of a policy specific to the management of pressure ulcers
- the creation of a task and finish group to review the admission process for people being admitted to IPU
- further embedding and review of the use of IPOS in IPU
- review of the oral assessment tool
- creation of a document called "This is me" for people admitted to IPU
- review of standards and processes for people who are receiving telephone contact from SCCS

It is vital that actions taken are reviewed to ensure that they have been effective or whether further improvements are needed. Re-audit is always considered.

> **"Thank you. Thank you. Thank you, we as a family truly found you amazing. I spent several days and 4 nights with you and found every person who I encountered so caring and compassionate; they did their upmost to make my mother in law as comfortable as they could. Nothing was too much trouble. They not only looked after the patient they were always ensuring that I was ok. What a truly amazing standard."**
>
> (Service user questionnaire, January 2018)

PART 5

REVIEW OF QUALITY PERFORMANCE

Quality Performance Overview

Saint Francis Hospice's accountable people are:

Pam Court
CEO and CQC Responsible Individual

Hazel McGwyne
Head of Quality and Audit, Registered Manager.

Use of the CQUIN Payment Framework

Saint Francis Hospice income during 2017/2018 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework. We will continue to look for QIPP opportunities for the year ahead.

Statement from the Care Quality Commission

Saint Francis Hospice is required to register with the Care Quality Commission and is currently registered for Treatment of Disease, Disorder or Injury and Diagnostic and Screening procedures. We await the new CQC standards framework expected 2018/2019.

Saint Francis Hospice has the following conditions on registration:

- The service may only be provided for persons aged 17 years or over
- A maximum of 19 patients may be accommodated overnight

Notification in writing must be provided to the Care Quality Commission at least one month prior to providing treatment or services not detailed in the Statement of Purpose.

The Hospice was inspected by the Care Quality Commission in April 2016 and awarded an 'Outstanding' for 4 of the 5 key lines of enquiry with a 'Good' for safety.

Information Governance Toolkit Attainment Levels

Saint Francis Hospice has maintained the Information Governance Toolkit level 2 for 2017/18.

Duty of Candour

We have a Hospice Duty of Candour policy including a template letter that can be sent out to all families /carers of a patient who has experienced an adverse incident.

CQC Rating

Overall
Outstanding

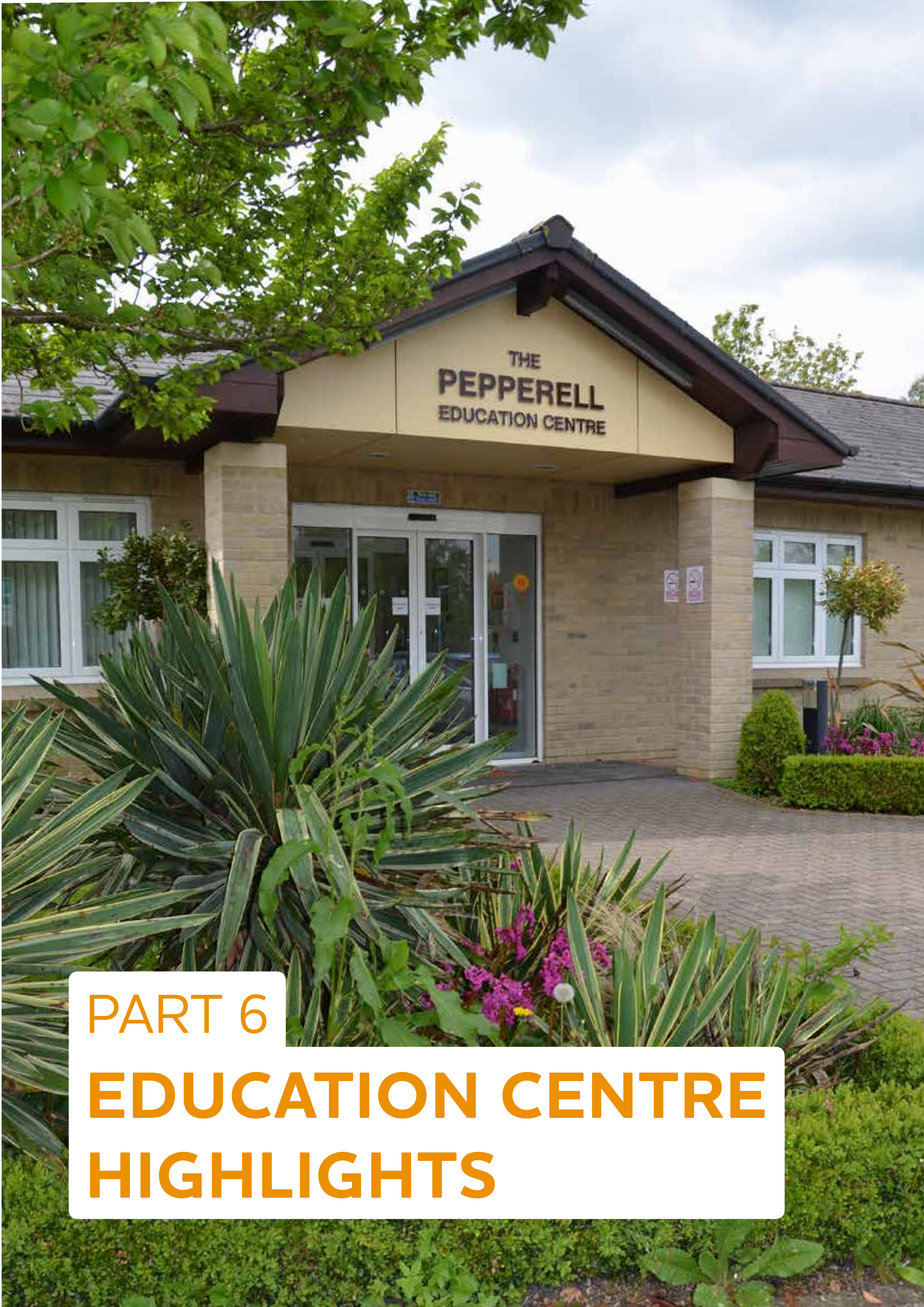
Safe	Good ●
Effective	Outstanding ☆
Caring	Outstanding ☆
Responsive	Outstanding ☆
Well-led	Outstanding ☆

Review of Quality Performance

Activity based on the National Council for Palliative Care: Minimum Data Sets criteria	2017/18	2016/17	2015/16	2014/15	2013/14	National Median 2015/16
OVERALL SERVICE						
Patients cared for by the Hospice	1,693	1,614	1,573	1,523	1,476	
% Patients cared for with non cancer primary diagnosis	28.8%	28.8%	25.9%	26.4%	21.5%	
% Patients cared for with cancer primary diagnosis	71.2%	71.2%	73.9%	73.6%	78.5%	
INPATIENT UNIT SERVICES						
Total number of admissions	371	373	374	362	371	
Total number of patients cared for	336	343	338	335	341	351
% New patients	92.9%	93.0%	92.6%	93.7%	93.5%	90.9%
% Occupancy	77.9%	81%	85%	80%	83.8%	79.4%
DIAGNOSIS						
% Inpatients cared for with non cancer primary diagnosis	14.3%	17.5%	9.8%	14%	13.2%	13.1%
% Inpatients cared for with cancer primary diagnosis	85.7%	82.5%	90.2%	86%	86.8%	86.9%
OUTCOME OF INPATIENT STAYS ENDING						
% Died	65.2%	64.9%	65.8%	68.3%	69%	62.6%
% Discharged to home (including care home)	33.2%	34.5%	32.6%	31.2%	29.4%	
% Discharged to an acute hospital	1.4%	0.5%	1.6%	0.6%	1.6%	
% Discharged to another setting	0.3%	0%	0%	0%	0%	
Average length of stay (days)	13.2	13.6	14.1	14.4	13.7	14.7
PEMBERTON PLACE						
Total number of patients attending	257	230	262	253	237	249
% New patients	73.5%	64.4%	76.7%	71.5%	80.4%	62.6%
SPECIALIST COMMUNITY & CRISIS SUPPORT SERVICE						
Total number of patients supported	1,326	1,254	1,246	1,226	1,206	1,275
% New patients	77.5%	77%	79.2%	77.2%	77.9%	69.9%
% Patients with non cancer primary diagnosis	27.5%	26.6%	25.4%	23.2%	20.7%	16.8%
% Patients with cancer primary diagnosis	72.5%	73.4%	74.6%	76.8%	79.3%	83.2%
Number of face-to-face or telephone consultations with patient or relative /carer	15,578	12,456	11,872	11,933	11,868	
Number of face-to-face or telephone consultations with a health professional	7,824	7,259	7,820	8,942	9,207	
Average length of care (days)	90.2	92.1	64.3	68.1	77.9	109.1

Review of Quality Performance

Activity based on the National Council for Palliative Care: Minimum Data Sets criteria	2017/18	2016/17	2015/16	2014/15	2013/14	National Median 2015/16
HOSPICE AT HOME						
Total number of patients looked cared for	557	466	479	469	420	467
% New patients	95.3%	95%	95%	96.2%	94.5%	90.1%
% Patients cared for with non cancer primary diagnosis	28.7%	27.9%	25.9%	27.9%	19%	26%
% Patients cared for with cancer primary diagnosis	71.3%	72.1%	74.1%	72.1%	81%	74%
Total number of visits	2,839	2,756	2,852	2,670	2,486	
% Patients who died at home (including care homes)	92.3%	92.9%	98.5%	99.4%	99.4%	84.9%
Average length of care (days)	11.1	12.0	16.0	13.5	15.2	25.2
BEREAVEMENT SERVICE						
Total number of clients						
Adult	529	451	354	346	372	
Children	106	102	101	91	109	
Total	635	553	455	437	481	405
Number of support/counselling telephone or face-to-face consultations (including health professionals)	3,912	3,368	4,046	3,308	3,147	
SPECIALIST MULTIDICIPLINARY SUPPORT SERVICES						
Number of face-to-face consultations with patient or relative/carer by service:						
Pastoral care support	1,572	1,394	2,608	2,388	1,876	
Complementary therapy	985	1,145	1,183	1,186	1,121	
Family services (excluding bereavement)	1,662	1,448	2,185	1,955	1,645	
Occupational therapy	1,767	2,743	2,266	2,269	2,578	
Occupational therapy equipment	524	378	443	455	445	
Physiotherapy	1,554	2,002	1,974	1,443	1,382	



PART 6

EDUCATION CENTRE HIGHLIGHTS

Education and training highlights

In October 2017, we celebrated the 10th birthday of our purpose-built Pepperell Education Centre and this made an incredibly busy year all the more significant. Our aim is that all who access teaching and learning at Saint Francis Hospice are prepared to care to the highest standard through evidenced-based, quality-assured education and training.

Teaching and learning has been provided for our own staff, care home staff, external stakeholders including commissioners, as well as academic students and those on placements. The extensive range of subjects within our portfolio of learning events has continued this year.

Study days and masterclasses

The range of study days and masterclasses have addressed topics such as Pain Assessment and Management, Psychological Distress and Therapeutic Responses, Liver Disease, Communication Skills, Mental Health, Spiritual Distress and Cultural Diversity and Legal Advice.

One example was a stakeholder event in Integrated Person-Centred Dementia Care, where local care providers shared good practice with over 70 delegates.

Summer School

Another was a Summer School where we delivered a three-day course for 16-19 year olds who are considering a career in health and social care. Over 94% of delegates gave an overall rating of 8 (or above) out of 10 for all the study days in 2017/18.

Hospice training

Our own Mandatory Training programme includes topics such as Fire Safety, Moving and Handling, Safeguarding, and Equality and Diversity. Some of this is delivered in the classroom and some is eLearning.

This year we achieved 96.7% completion of mandatory training by all Hospice staff. The learning material on Information Governance and Data Protection has been updated in readiness for new legislation 2018.

Last year we piloted eLearning for volunteers. This went well and now all new volunteers complete the eLearning before commencing their role. In turn, this means we have a greater number of modules (subjects) being completed, and over 600 staff and volunteers accessing eLearning. Looking ahead, we will continue to develop the mandatory training programme, in response to need and evidence.

Other education specifically for our staff has included fire warden training, teaching skills workshops and 'green champion' training to ensure we are environmentally friendly.

OrangeLine

We continue to train OrangeLine volunteers in communication skills, palliative care and the management of support groups.

Schwartz Center Rounds

This year has seen the firm establishment of Schwartz Center Rounds as part of the support that is offered to staff and volunteers. Rounds involve a safe, confidential space for staff to listen, share and reflect on each other's experiences at work.

The evidence shows that rounds help to keep working relationships strong, and support staff in giving compassionate care.

In addition staff have attended training on 'Culturally Competent Palliative and End of Life care for LGBTQ People' and this work will be built on organisationally in the year ahead.

Gold Standards Framework

We have been a Gold Standards Framework (GSF) Regional Training Centre since 2013 and to date have supported 92 care homes to deliver more personalised End of Life care, tailored to a person's wishes.

Each home has sent between two and four staff to a series of workshops and support sessions, and some have gone on to become GSF accredited care homes.

This year we have been closely involved with the national team in updating the course. Next year we will be offering this, together with a course for domiciliary care workers.

the gold standards framework

Bespoke training

We have delivered training on Syringe Drivers and Their Use in Symptom Management at a number of care homes.

We were commissioned to deliver End of Life care training for social workers in Barking and also a Specialist Palliative Care Update for a group of advanced nurse practitioners from a neighbouring Clinical Commissioning Group. Feedback from one commission was "Saint Francis Hospice was kind enough to compile a study day for our specific learning needs. The sessions were informative and very relevant to our practice."

Annual Conference

A highlight of the year is our conference. This year we welcomed 70 delegates to an event titled 'Access, Equality, Integration and Innovation in Palliative and End of Life Care'.

A range of speakers shared their work, research and practice developments on homelessness, learning disabilities, prisons and LGBTQ.

There was a lot of new learning for the attendees and one delegate said **"the content was extensive; I learnt so much and have loads to take away".**

We are often commissioned to deliver education and training in the community and these are a few examples from this year.

London South Bank University

Our partnership with London South Bank University (LSBU) remains strong and we have delivered three specialist modules that form part of the Master's degree in Palliative and End of Life Care, which began in 2016.

This year we have welcomed 42 students from a range of backgrounds and employers. We have also delivered degree level modules and have contributed to the BSc (Hons) Nursing course.

We continue to have cohorts of student nurses on placement, as part of this course, who are mentored by our registered nurses.

London South Bank
University

Value of education

The quote below illustrates the value of education and training, which goes far beyond gaining new knowledge.

"Days like this, hearing of challenges and innovative practice feeds the soul and provides opportunity for development and renewed interest. Very good for re-engaging staff raising morale and also providing opportunities for staff development."

End of Life Conference

In September 2017 Barking and Dagenham's first conference dedicated to End of Life Care was organised in partnership with Barking and Dagenham CCG; NELFT; Barking Havering and Redbridge University Hospitals NHS Trust; the London Borough of Barking and Dagenham and Saint Francis Hospice.

The conference was funded by the Big Lottery's Reaching Communities Fund and Barking and Dagenham Adult Social Care. The event was a huge success and we welcomed over 150 delegates and speakers.

A great deal of new learning was evident from social media activity and evaluation forms, and new working relationships were forged. Within the next year we are looking forward to developing a similar event in Havering.

Research

Last year Saint Francis Hospice led on a funded research project, developing a training programme (mentioned above) for professionals providing end of life care for LGBTQ people.

This work is going to be included in a forthcoming national publication as a best practice example; the document will be a national resource for the whole sector.

The implementation of this work will be built on within the organisation in the coming year to ensure care is inclusive of and accessible to everyone in our community.

Both Research and Ethics committees are getting established and aim to support the Hospice in becoming more research active, and study days on such themes are planned for the year ahead.

Sharing of good practice and findings is an element of research activity, and this year we presented at the Hospice UK national conference.

There was one oral presentation on OACC, four posters were displayed and one was selected (out of over 300) as the best at the conference. In addition one member of staff chaired a plenary session.

All of this work has led to new links with other hospices.

Report compiled by Bridget Moss.

PART 7

FEEDBACK ABOUT OUR ORGANISATION

Service user feedback

About our organisation

We all learn through feedback and having the right methods of evaluating that feedback, as well as the processes in place to react to it, are vital.

Feedback – both positive and negative – is essential for our organisation to ensure that we continue to deliver high quality services to our patients, their families and loved ones.

The Individual Experience Management Group (IEMG) was formed in 2016 to bring together the previous Service User Group, User Feedback Group and Hospice Information Group (Patient Information Group) under one remit.

The aim is to ensure equal sharing of information and provide a forum for this to be communicated, changes agreed and taken forward within one meeting group.

In total 175 feedback surveys were completed and returned. This number is significantly lower than in 2016/17 when 314 were submitted. However this is due to an older version of the form being used between April and September 2017, and there were significant changes in the personnel inputting the information, resulting sadly in some data being lost.

To mitigate these challenges, additional resources were employed through other forms of data collection. For example:

- Real-time interviews with individual patients, families, carers and staff
- Bespoke questionnaires on behalf of third parties e.g. Redbridge Healthwatch
- Oversight and review of social media feedback
- Comment boxes were placed in the Family and Visitors Lounge and Pemberton Place.

The year ahead looks exciting as we will have an opportunity to plan a full year of the new style surveys.

> **"The level of care by my dad was faultless. In the last few weeks of my dad's life he was cared for so well. Every single nurse was wonderful."**
>
> (Service user questionnaire, October 2017)

Questions asked of all our service users 2017/18

You said... We did...

You said...

The Kiosk in the main Saint Francis Hospice building is not open enough hours - could we open during the evenings and weekends more?

We did...

Due to the Kiosk being volunteer-run, we had to find a solution that wasn't as reliant on manpower. Therefore we have installed a mirror so that our team of Receptionists can see from their base if there is a customer at the Kiosk. This has led to the Kiosk being accessible even when a volunteer is not present.

You said...

Feedback to Family Support and OrangeLine - I would like to see more social events available in the evening or at weekends.

We did...

Our OrangeLine Friendly Faces group occurs monthly on a Saturday, and our Bereavement Support Groups run monthly on a Wednesday evening.

You said...

I would like to see more people getting bereavement support, to include people who haven't used Saint Francis Hospice services.

We did...

We have recruited into a new Bereavement Development and Support role. They will research and scope the feasibility of extending the service in our catchment area for people not under Saint Francis Hospice services, with a view to funding being sought.

7.2

Compliments and complaints

Compliments

		IPU	SCCS	PP	H@H	OT	FS	R
Apr-Jun17	🟩	48	1	1	1	1	2	2
	🟨	0	2	0	23	52	0	4
Jul-Sept 17	🟩	31	11	0	6	20	17	1
	🟨	0	115	0	1	1	11	1
Oct-Dec 17	🟩	18	119	4	25	0	19	1
	🟨	0	1	0	1	0	2	4
Jan-Mar 18	🟩	14	231	1	28	0	8	3
	🟨	8	1	0	1	0	1	5
		119	481	6	86	74	60	21

🟩 Compliments (in writing)

🟨 Compliments (verbal or through social media)

IPU: Inpatient Unit. **SCCS:** Specialist Community and Crisis Support Service. **PP:** Pemberton Place.
H@H: Hospice at Home. **OT:** Occupational therapy. **FS:** Familly Support. **R:** Retail.

Complaints

We learn from complaints. We learn about the things that we need to work on, and we can see if there are themes appearing. Our Executive Team reviews the Complaints Register regularly to ensure complaints are being managed, moved forward and resolved appropriately. Quarterly update reports are provided to the Corporate Governance Committee, detailing complaints throughout the year so that the Committee may consider and discuss any trends that may be developing.

The criteria for a compliment and the process for recording them is reviewed on a regular basis and amended as necessary to ensure the information is valid and the process robust.

We received four complaints concerning clinical care and communications in 2017/2018, all of which were investigated and explored thoroughly. All provided useful learning and practice changes which were identified within the responses.

7.3

Hospice UK benchmarking project

Saint Francis Hospice continued to take part in the Hospice UK national benchmarking of Hospice Inpatient Unit safety metrics.

Benchmarking enables hospices to report, share, compare and learn from each other. Falls and medication incidents were reported on in 2017/2018.

Unfortunately the comparable statistics were not available for year-end for this report. They will be published in the digital version, available on the Saint Francis Hospice website.

We have agreed to continue to take part in the benchmarking project for 2018/2019.

PART 8

STATEMENTS FROM OUR PARTNERS

A copy of this Quality Account was sent to: Brentwood Council Audit and Scrutiny Committee, Essex County Council Overview and Scrutiny Committee; Redbridge Council Health and Scrutiny Committee; Havering Council Health and Scrutiny Committee; Barking & Dagenham Council Overview and Scrutiny Committee; Redbridge, Havering and Essex Healthwatch; Barking, Havering & Redbridge CSU; and Brentwood & Basildon, West Essex, Barking, Havering, and Redbridge Clinical Commissioning Groups and St Luke's Hospice.

Statements from our partners

We appreciate the feedback from the following organisations.

The West Essex Clinical Commissioning Group

The West Essex Clinical Commissioning Group highlighted that providers are required to give all stakeholders 30 days to review the draft account and that our time frame was significantly shorter than that. Therefore they were unable to provide us with a statement. We have taken this feedback on board and will ensure that stakeholders have the 30 days required for the 2018/19 Quality Account.

Healthwatch Redbridge

Healthwatch Redbridge were unable to provide a statement due to the most appropriate person to comment being on long-term leave.

Redbridge CCG

Feedback compiled by Mark Gilbey-Cross, Quality Lead.

Thank you for the opportunity to review the Saint Francis Hospice Quality Account which makes for a very interesting and informative read. Having fully reviewed the Accounts we would like to provide you with the following feedback.

The accounts are very well presented and give a clear overview of the hospice's work during the reporting period. In an effort to provide additional clarity and explanation to the reader we would recommend that you consider the following points:

1. The Hospice is currently rated as 'Outstanding' by the CQC, although this is included within the body of the accounts, we are of the view that this is something that your should be very proud of and should be mentioned very early on within the Quality Accounts, perhaps within the Chief Executive Officer's Statement.

Thank you, we have now included a paragraph within the Chief Executive Officer's Statement.

2. Page 3: Contents Page – Part 2 identifies 'Reporting on our priorities for 2017/18' and mentions Patient Safety Improvement (Falls Toolkit), OACC Project and OrangeLine. Part 3 identifies improvement priorities for 2018/19. Within the body of the Quality Accounts you state that further work is required around the falls toolkit and the OACC Project; if this is this case, should you consider whether you identify just one new priority for 2018/19 and include the ongoing work around the falls toolkit and the OACC Project?

Thank you, a really good idea but our new priorities had already been set by receipt of suggestion.

3. Page 9: Priority 1: Patient Safety Improvement (Falls Toolkit) – It would be helpful if you were to include falls data including a trajectory comparison to previous years. Mention is made of the use of the Falls Toolkit and states that you are using the 2017 definitions when reporting and investigating IPU falls. It would be helpful to include the data so that we get a sense of the numbers of falls that are occurring. You in addition mention that two audits have been undertaken (Jan & Mar 2018), however, there is no mention of the audit findings (what does the information tell you?) nor any resulting actions; it would be beneficial to add the results as appendices.

Thank you - really helpful feedback. We have now included statistics and more detail of audit findings.

4. Page 11: Clinical Effectiveness Improvement (OACC Project) – as your Quality Account is a public document and therefore being read by lay people, it would be helpful to give an explanation of what the OACC Project is, how it came about and what its aims are. (i.e. for use with the deteriorating patient, who else is using it, and give a sense of what the outcome measures include).

Thank you, this has been rewritten to include a clearer explanation of the project.

5. Page 23: Clinical and Service Audits Programme: - it is reassuring that you are completing a vast range of audits to ensure that care to patients is monitored, however, as a commissioner of services we would require assurance in the form of sight of the audit schedule and a sense of what the audits have been revealing.

6. Page 29: Review of Quality Performance – the numerical data is helpful as an indication of activity levels; this would be enhanced with the addition of some narrative highlighting any exceptions or where Saint Francis may be an outlier. Examples may be; reasoning as to why % occupancy is showing a downward trend and is below the national median, or 5 of new patients attending Pemberton Place at 73.5% is higher than the national median. A sense of what these figures are telling you and us as commissioners would be useful.

7. Page 32: Education and Training Highlights – Saint Francis is to be commended on its 96.7% compliance of mandatory training. For further assurance it would be great to see mention of if and how you ensure that training has an appropriate impact on changes to staff practice for the benefit of patients. Some brief additional narrative regarding the Gold Standards Framework would be beneficial for the lay person.

8. Page 34: Education and Training Highlights – you mention conferences that you have hosted and facilitated. We would like to see some detail on feedback from delegates. What was their experience, what did they enjoy, how could the conferences have been improved?

Points five to eight are really valuable but it was difficult to adjust the Quality Account at this late stage. We will definitely bring this feedback forward to the Quality Account for next year.

Glossary

CBE: Commander of the British Empire

CCG: Clinical Commissioning Groups

CMP: Clinical Management Plan

CNS: Clinical Nurse Specialits

CQC: Care Quality Commission

CQUIN: Commissioning for Quality and Innovation

CSU: Commissioning Support Unit

DNACPR: Do Not Attempt Cardiopulmonary Resuscitation

GP: General Practitioner

GSF: Gold Standards Framework

GSL: General Sales List

H@H: Hospice at Home

IEMG: Individual Experience Management Group

iPOS: Integrated Palliative Outcome Scale

IPU: Inpatient Unit

KLOE: Key Lines of Enquiry

LGBTQ: Lesbian, Gay, Bisexual, transgender and queer

LSBU: London South Bank University

MDT: Multi-Disciplinary Team

NELFT: North East London Foundation Trust

NMP: Non-Medical Prescribing

OACC: Outcome Assessment Complexity Collaborative

POM: Prescription Only Medicine

QIPP: Quality, Innovation, Productivity and Prevention

SCCS: Specialist Community and Crisis Support Service

SOFIs: Short Observation Framework Inspection

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saint
francis
hospice
living with dignity