St Helena

# Quality Account

## 2018 – 2019

sthelena.org.uk StHelenaHospice @sthelenahospice

**Acknowledgements**

Thank you to the following St Helena staff who contributed to this Quality Account. Thanks also to Cari Grossi at iWantGreatCare and Vantage Technologies Ltd.

| | |
|---|---|
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| David Traynier | Head of Quality & Compliance |
| Peter Vergo | Chair of the Board of Trustees |
| Caroline Vince | Head of Learning & Development |
| Sara Warnes | Infection Control Lead Nurse |
| Lee Welland | Community Team Lead |

Throughout this Quality Account, we have included excerpts from patients' feedback on our services, gathered either from their cards and letters or via iWantGreatCare (see Pages 48 & 49 for details). In all cases, it is anonymised and reproduced with only minor edits for length and clarity.

# Table of Contents

To all of the most amazing caring staff & volunteers at St Helena Hospice. We would like to thank you for going above & beyond in the care that you gave P.S. really enjoyed the homemade cooking also.

Always treated with respect and positively. It's my go to place for safety. Don't need to explain how I feel.


*Figure 1 Our values*

# 1.0 Statement on Quality

## 1.1 CEO Statement

St Helena helps local people facing incurable illness and bereavement. Our four strategic priorities are:

1. Reaching out based on need, regardless of diagnosis and circumstances.
2. Empowering people to plan ahead, share their choices, and achieve their wishes.
3. Providing more excellent personalised care in hospice beds and in the home.
4. Helping life go on in the face of dying, death, and bereavement.

We provide expert care and support to people living in North Essex, in inpatient and community settings, as well as a wide range of day therapy services through our centres in Colchester and Clacton. Our 24/7 SinglePoint service coordinates care across a range of local providers and hosts the My Care Choices Register (MCCR).

Over the last year, we have worked increasingly closely with a range of NHS, local authority and voluntary sector partners as part of the North East Essex Health and Wellbeing Alliance, working to ensure a system wide focus on good end of life care for our local communities.

Safety and quality are at the heart of our commitment to excellence in all the services we provide, and we welcome the opportunity to share our progress and priorities in this report.

For further information about St Helena, including Strategic Plans, recent CQC inspection reports, and patient surveys, please visit our website: [www.sthelena.org.uk](http://www.sthelena.org.uk)

**Mark Jarman-Howe**
**Chief Executive**

> The words I write here cannot convey my thoughts and feelings about your service. Firstly without your service I could not have got my dad home before he passed. He always wanted to pass at home with his family and you made that possible. At this very hard time we can find great comfort in the fact that we followed his wishes and he passed in the way he wanted to.
>
> Every single nurse and carer that we met were incredible, they treated my dad with the utmost respect and dignity at all times, their support to my family was amazing... Without a shadow of a doubt the care he received from you was amazing...
>
> It must be an incredibly hard job but honestly you all make such a huge difference at the most important time in our lives.

## 1.2 Statement from Board of Trustees

The Board of Trustees is responsible for ensuring the quality and continuing development of the excellent care and support that St Helena provides for patients and families.

To support the different aspects of our work, the Board is organised into sub-committees representing all the main hospice activities. These meet regularly with staff and management to review current services and future developments. These sub-committees report directly to the Board.

A corporate governance sub-committee, also reporting directly to the Board, monitors the overall compliance of current practices with policies and procedures and has responsibility for risk management, especially those risks that may have an impact on patient care.

Among the best things about St Helena are the sense of dedication and the firm belief in what we do. Staff set an uncompromisingly high standard: not only our wonderful healthcare professionals but also those behind the scenes, including our fantastic army of over a thousand volunteers. Our patients and families may never meet these people, but they make an incredible contribution to our success. The Board acknowledges the efforts made by so many people to ensure that the care and treatment provided by St Helena is of the highest quality, that it remains cost effective, and that it can be sustained into the foreseeable future. We fully endorse this Quality Account.

**Professor Peter Vergo**
**Chair of the Board of Trustees**

I was treated with much compassion, understanding and dignity. I felt safe and confident to discuss my deepest thoughts and emotions. The service I received was very much a great help in a time that I felt very low and lonely.

## 1.3 Executive Summary

In this Quality Account, we look back on the work we have done to improve patient care during 2018-19 and forward to our plans for 2019-20. In Part One, we look at our strategic priorities for the coming year:

- Reaching out based on need regardless of diagnosis or circumstances.
- Empowering people to plan ahead, share their choices, and achieve their wishes.
- Providing excellent personalised care to more people in hospice beds in the home.
- Helping life to go on in the face of dying, death and bereavement.

In this section, we discuss our plans to develop our Virtual Ward and additional bed capacity, expand our teaching of the Gold Standards Framework (GSF), widen access to the My Care Choices Register (MCCR), our streaming teaching system, Project ECHO,™ and our plans to reduce waiting times.

We also review our priorities from last year, including our work with the North East Essex Health and Wellbeing Alliance, our promotion of the MCCR to help patients record their end of life preferences, and our work around promoting the GSF to improve care and expertise in other organisations. In this section, we also talk about our work to identify dementia suffers who wish to record their care preferences, and our cooperation with St James Place to better support Heart Failure sufferers.

Finally, we review our outreach work, helping to bring end of life care to marginalised communities with Safe Harbour.

In Part Two, we discuss our funding and detail the services we provide. We also provide a summary of the clinical audit work we have done during the year to improve the care we give to our patients. On Page 21, there is a diagram of our internal clinical governance structure. Finally, here we discuss two research projects with which we have been involved.

In Part Three, we provide a review of our quality performance. There are updates from teams across St Helena, including our Inpatient Unit (IPU), our Community Clinical Nurse Specialist (CNS) Team, our doctors, and our Therapies teams. There is also an update from our Head of Estates and Facilities on the improvements we have made to our sites and our plans to refurbish our IPU. Our Head of Learning and Development discusses the training and education we have provided to staff and others during the year. There are also updates on volunteering, incidents and complaints, and specific quality markers such as how deal with pressure ulcers, falls, and medicines errors.

Towards the end of this report, we also discuss what other people say about our organisation: our feedback from patients, our most recent CQC inspection, and a statement from Healthwatch Essex.

# 2.0 Priorities for Improvement in 2019-20

## 2.1 Priority One: Reaching out based on need regardless of diagnosis or circumstances.

We will work to balance the rising number of referrals we receive with our perennial aspiration of keeping waiting times low. We will ensure that each of our teams is equipped to meet agreed target response times. To achieve this, by the end of the year, we will require all our teams to institute their own standard operating procedure (SOP).

We will develop our Virtual Ward (see Page 24) and continue our policy of providing a 16th bed to help manage wider winter pressures.

We are continuing to provide Gold Standards Framework (GSF) training. A first cohort of care home staff will be accredited by the end of November 2019. We have also begun to provide workshops to a second cohort, and these will be complete by September 2019. Finally, a second cohort of domiciliary care workers will begin in April 2019 and finish by September.

We are currently working with Professor Muir Gray's team at Triple Value Health Care to develop the first atlas of value in end of life care to drive an integrated population-based commissioning model for the future. Our aim is to have clear set of information on quality and value in end of life care across our community. This is in order to promote ongoing improvement, spending resources on services that people really need from which they can get the maximum benefit'

## 2.2 Priority Two: Empowering people to plan ahead, share their choices and achieve their wishes.

As mentioned above, we will further develop our Virtual Ward and continue our policy of providing a 16th bed to help manage wider winter pressures.

We will also develop and widen access to the My Care Choices Register (MCCR) in order to pursue our target that, by 31st March 2020, it holds current data on 1% of the population of North East Essex (approximately 3,500 people). We also plan to enable ten care homes to access the system directly by the same date.

## 2.3 Priority Three: Providing excellent personalised care to more people in hospice beds and in the home.

- We will create a business case for a version of Project ECHO™ for GPs (see Page 33).
- We will deliver our 2019-20 education prospectuses.
- We will increase our collaboration with other local hospices and providers.
- We will continue to prepare for a CQC inspection at some point during 2019-20.
- We will deliver a regional palliative care conference.
- We will deliver further GP training

## 2.4 Priority Four: Helping life to go on in the face of dying, death and bereavement:

- We will reduce the waiting list for bereavement triage.
- We will increase the number of bereavement volunteers we have.

- We will reduce the waiting list for counselling and Family Support services.
- We will deliver Dementia Tier 2 training.
- We will continue to deliver Dementia Friends information sessions.

## 2.5 Priorities for Improvement from 2018-19

In this section, we review the progress we have made on our priorities from last year. We present the text from the previous year in *italics*.

### 2.5.1 2018-19 P1 Reaching out based on need regardless of diagnosis

**What We Wanted to Achieve**

*We will work within the framework of the Health and Wellbeing Alliance in North East Essex to deliver high quality palliative and End of Life Care across North East Essex, working collaboratively with system partners to address inequality in palliative and End of Life Care.*

*We will deliver projects to reach out to people with palliative care needs with heart failure and dementia across our community demonstrating increased access to My Care Choices and hospice services.*

*We will work collaboratively with Macmillan to deliver the Safeharbour project with an outreach clinical nurse specialist and a team of volunteers to meet the palliative care needs of under-served groups such as the homeless and others living with deprivation.*

**What we have achieved.**

We have been engaging constructively with the North East Essex (NEE) Alliance and Sustainability and Transformation Partnership (STP). This is further supported by our Chief Executive Officer (CEO) leading the local Alliance part time and our Clinical Director & Deputy CEO chairing the End of Life Alliance Board.

The Alliance is a group of health and social care organisations, including representatives from the third sector. It includes the local acute trust, community services, the mental health trust, county and district councils, the ambulance trust, primary care, a patient representatives' group and St Helena.

The North East Essex Health and Wellbeing Alliance End of Life Board was launched in February 2018 to take shared accountability for the quality of health and social care delivered across our community for people in the last year of life. It brings together local providers and commissioners within the Alliance to pursue a joint strategy for end of life care. It is committed to safe, high quality, equitable, patient centred health and social care that promotes choice and dignity for people at the end of life. The Alliance End of Life Board's strategic aim is 'Working together to promote dignity and choice at the End of Life.'

Most people do not wish to spend the last days of their life in a hospital and the Programme Board supports the Alliance's aim of halving the number of people who die in hospital when they would prefer to be somewhere else.

The Programme Strategy is based on the model for end of life care agreed in 2017 by all the organisations within the Alliance. The intention is to embed an integrated end of life care model within future Alliance funding and contracting arrangements across NE Essex.

Key priorities for the board include:

**Advance Care Planning**

We aim for everyone in our community living with a life limiting illness or frailty to know they can record their priorities for care, and for healthcare professionals to be confident to support them and have the necessary conversations.

**Community Assets and family support**

We believe that health and social care providers collaborating with community and voluntary groups will enhance family support and bereavement care.

**My Care Choices**

We will widen the scope of the My Care Choices Register (MCCR), so that it will also become a register of preferences and priorities for people living with frailty, dementia, and other life limiting illness. We will take a systematic approach to increasing access to the Register for health and social care professionals, as well as widening the opportunity for people across the community to record their preferences, irrespective of their diagnosis or social situation.

**Best Practice in Primary Care**

We will build on the well-established Gold Standards Framework principles, which have been embedded in primary care practice within our locality. We will continue to facilitate patient choice by supporting the commissioning of mechanisms to promote the early identification of people approaching the end of life, timely assessment of their needs, and effective care planning and coordination.

We will develop End of Life Care Champions within the Primary Care hubs to advance the importance of high-quality palliative and end of life care within General Practice.

**Crisis response and rapid discharge**

We will continue to support high quality rapid response services for people at the end of life. We will promote collaboration and, where appropriate, integration of services to ensure that people receive consistently high-quality care; in their preferred place where possible.

We will collaborate with others and, where appropriate, integrate funding and services for the rapid discharge of patients. This will build on the trusted Assessor and Discharge to Assess models. We will explore the potential of pooling fast track Continuing Healthcare (CHC) and social care budgets.

We will work with colleagues in the East of England Ambulance Trust to use the MCCR to share patient preferences, facilitating the right care for the patient in the right place.

**Specialist Palliative Care**

We will continue to support access to 24/7 specialist palliative care expertise. We will develop outpatient and day case palliative care consultations and procedures to maximise patients' access to high quality palliative care in the community.

We will work with all the organisations within the Alliance to promote palliative and end of life care education, so that all healthcare professionals are enabled to offer high quality care.

We will link specialist palliative care services to the integrated neighbourhood teams.

We will increase the provision of community beds for palliative and end of life care, enabling more people to be cared for in a place they prefer. We will continue to work collaboratively to support high quality care in the community

hospital beds on the coast. These enable people who cannot be cared for at home to be stay as close to their families as possible.

**Improved Care Market Standards**

We will use the Improved Better Care Fund (iBCF) to deliver Gold Standards Framework (GSF) training and accreditation throughout the care home and domiciliary care market. St Helena is working towards becoming a regional training centre for the Gold Standards Framework (GSF).

We will embed the principles of the GSF and the MCCR in the CHC and social care contracts and quality assurance.

**Communities of practice**

We will create a Project ECHO™ hub (see Page 33) to support the care homes GSF programme and scope a similar project to develop a GP Community of Practice.

We will offer advanced communication skills training to empower healthcare workers to have end of life discussions.

We will develop joint / rotational posts to support cross-organisational cooperation, learning, and development.

We will develop shared educational opportunities across the Alliance organisations to share expertise, build inter-organisational relationships, and to stimulate creativity in joint working.

**Inequity**

We will promote equity of access to palliative care, based on need rather than diagnosis.

We will identify people with conditions entailing palliative care needs who are currently under served by palliative care, such as those suffering heart failure and Chronic Obstructive Pulmonary Disorder (COPD).

We will continue our joint Safe Harbour project with Macmillan, which reaches out to marginalised groups traditionally under served by palliative care, such as homeless people, people living with deprivation, Lesbian, Gay, Bisexual, and Transsexual (LGBT) groups, ethnic minorities, refugees, and the travelling community.

We recognise the increasing prevalence of dementia as a life limiting illness and the importance of adequate palliative care and advance care planning for people living with this condition.

**Outcomes**

Alliance members share accountability for the following agreed outcome measures:

- Increasing the number of people with access to the MCCR.
- Increasing the number of people with a recorded Preferred Place of Care on the MCCR.
- Increasing the proportion of people who are cared for at the end of life in a preferred place.
- Decreasing the number of people who die in hospital.
- Decreasing the proportion of people who have three or more admissions in the last 90 days of their life.
- Reducing the number of days that people spend in hospital in the last 90 days of their life.

The Alliance members will share responsibility for delayed transfers of care and will agree an achievable target for timely hospital discharge for people at the end of life.

**Heart failure**

During the year, thanks to a grant from St James's Place, we were able to invest in services and cooperate with other providers to change the way in which local people with heart failure receive palliative and end of life care. We did this by appointing link roles and freeing up clinical time to allow improved access to hospice services for heart failure patients. We also held inter-organisational education events to share knowledge between heart failure and palliative care services.

The immediate results of these activities was an increase in palliative care referrals for people with heart failure, an increase in use of the MCCR (see Page 25) and improved diuresis[1] procedures for patients. The most important impact has been on the culture of the organisation. During 2019, we will prepare a new business case for a community diuresis service.

**Dementia**

Our Clinical Director & Deputy CEO has been working with GP Primary Choice Ltd. and the Primary Care End of Life Champions to promote identifying dementia suffers who wish to record their choices on the MCCR. Our target was to increase the number of patients with dementia on the MCCR by 150.

This work has included providing a training session to the Essex Partnership University NHS Foundation Trust (EPUT), a study day, and ongoing weekly palliative care sessions to the dementia wards in Clacton. We also have clinical staff who attend the EPUT dementia wards one morning per week to promote the identification of palliative needs and the Gold Standards Framework. Over 30 staff have undertaken Tier 2 Dementia Awareness and our Head of Clinical Operations is undertaking a master's degree in Dementia, which she expects to complete in 2020. The final report for this project will be available during the summer of 2019.

**Macmillan/Safe Harbour**

Our Safe Harbour project with Macmillan, which provides hospice services to disadvantaged groups, continues and has funding for three years. A dedicated Clinical Nurse Specialist (CNS), who reports to Macmillan, provides this service. This CNS is also undertaking a counselling course in order strengthen the service she provides. The project is proving very successful at bringing people into hospice care who would otherwise have been missed, and referrals have increased over the previous year. Next year, this role will focus on reaching out to those with learning disabilities, chronic enduring mental health, and Improving Access to Psychological Therapies (IAPT).

### 2.5.2 2018-19 P2 Empowering people to plan ahead, share their choices and achieve their wishes

**What We Wanted to Achieve**

*We will launch the new My Care Choices Register system and work with Alliance partners to build the register further, widening access to the recording of choices for people with non-cancer diagnoses and frailty.*

*We will work with the Gold Standard Framework to deliver education to care homes across our community to facilitate the identification of people approaching the end of life to enable*

[1] Diuresis is the increased formation of urine.

*them to record their choices and for their care to be coordinated.*

*We will work with Colchester and Tendring Borough homes to improve the access to My Care Choices for those who live with chronic health conditions and / or frailty within their sheltered housing schemes.*

*We will deliver Gold Standards Framework teaching to domiciliary care agencies to improve the access of people receiving domiciliary care at home to the My Care Choices Register.*

**What we have achieved.**

We launched the new version of the MCCR with local primary care providers in September 2018. We also use the system in-house, embedding it in our Multidisciplinary Team caseload review process and our IPU Board Round. CareIS, EPUT, Anglia Community Enterprise (ACE), and the ambulance service can also access the MCCR. We encountered some difficulties in making the system accessible to staff at Colchester General Hospital and we are resolving some problems with reporting and software functionality.

We provide education on the MCCR to other providers in order to promote patient choice of Preferred Place of Care (PPC). At St Helena, we provide staff training on the MCCR and advance care planning as part of our induction for doctors, as well as on our Learning & Development curriculum.

The total number of people who have at some point been enrolled on the MCCR has increased steadily over the past five years of operation and now stands at 11,110.[2]

St Helena is working towards becoming a regional training centre for the Gold Standards Framework (GSF). The Learning and Development Team has delivered both the Care Home and Domiciliary Care programmes during 2018.

We will be taking part in Project ECHO™ later in the year, which will involve streaming live training out to Care Homes. For more details on Project ECHO™, see Page 33.

### 2.5.3 2018-19 P3 Providing excellent personalised care to more people in hospice beds and in the home

**What We Wanted to Achieve**

*We will develop a business case for a further 4 beds on the inpatient unit and continue to support the people receiving End of Life care in St Osyth Priory ward in Clacton.*

*We will develop a Nurse Consultant post to broaden the medical team, enabling more community visits and senior clinical support.*

**What we have achieved.**

Our project, to increase our beds from 15 to 21, continues. St Helena is about to embark on a capital fundraising programme to support this project by refurbishing our Inpatient Unit (IPU). We have now finalised the design and we hope to finalise the project by late 2020.

We continue to support the St Osyth Priory Ward at Clacton Hospital; however, there are plans for this hospital to close. St Helena has worked closely with local providers and the Clinical Commissioning Group (CCG) to agree to replace these end of life beds and increase the number in the Tendring area.

The nurse consultant role is now embedded within the Medical Team.

[2] The number of active patients is approximately 3600.

There are plans to develop a further post, when the new beds are ready, to support the Medical Team on the IPU, thereby making senior nursing expertise available to community and inpatient services. These new roles also support retaining our nurses, help them develop their careers, and plan for succession when they move on.

### 2.5.4 Helping life go on in the face of dying, death, and bereavement.

**What We Wanted to Achieve**

*We will work collaboratively within the Health and Wellbeing Alliance to support people living with life limiting illness and their carers to live as well as possible.*

*We will coordinate with social care and voluntary agencies, as well as the care advisors in primary care to enable people to access the support that they need.*

*We will develop carer support and information sessions called 'Dealing with Dying' that will inform and enable people caring for loved ones at the end of life.*

*We will develop disease specific support groups for people and their carers who are affected by heart failure and lung cancer to enable them to live as well as possible with their condition and to help them plan for the future.*

*We will continue to develop our bereavement services offering counselling or group support to people across the community.*

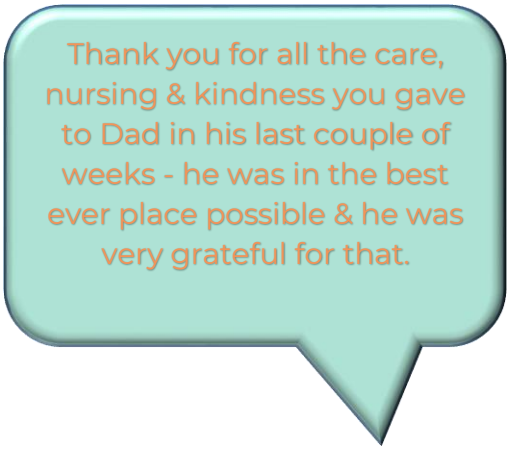
**What we have achieved.**

Through the Alliance, we have begun to work more closely with social care providers, and this is helping to improve care pathways for patients at the end of life.

We ran a Dealing with Dying workshop in October 2018, which had 70 attendees.

Increasing lung cancer referrals has been one of the three focuses of our Safe Harbour project. At the end of the year, we reviewed lung cancer referral rates and achievement of Preferred Place of Care. This work is ongoing, and our CNS Team are improving collaboration with the hospital lung cancer team to support early referral to hospice services.

We have separated our Bereavement Service from our Family Support Team in order that the service can review and refine its operation to meet increasing demand for bereavement support from external sources.




## 2.6 Mandatory Statements Relating to the Quality of the NHS Service Provided

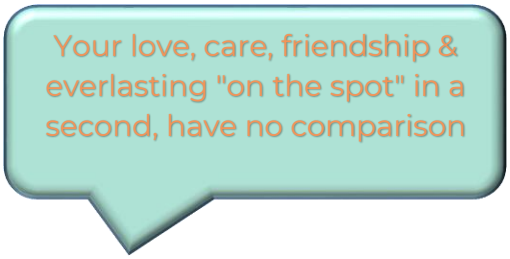
### 2.6.1 Review of Services

During 2018-19, St Helena provided the following services:

- Inpatient – 16 beds.
- Day Services (Therapies and Wellbeing) - at Colchester and Clacton-on-Sea.
- Community Services – including SinglePoint RNs with Virtual Ward support, and Clinical Nurse Specialists.

Also working in the community are rehabilitation (Occupational Therapy, Physiotherapy), Family Support, Social Work, Complementary Therapy, and Medical staff.

- Bereavement Services for both adults and children.
- Chaplaincy
- Counselling
- Education and training.
- Family and carer support.
- Outpatients
- Rapid response to symptom or care problems within the last three months of life for people in the community.
- SinglePoint – advice, support and information 24 hours a day.
- Therapies – including Gardening, HOPE,[3] Cancer Group, Fatigue, Relax and Move, and Walking.




## 2.6.2 Funding of Services

St Helena is an independent charity, which during 2018-19 provided its services largely free of charge to the end user. Our income from the NHS in 2018-19 constituted approximately 27% of our total income. The remainder came from voluntary charitable donations, legacies, hospice shops, hospice lottery, and our corporate and community fundraising.

[3] Helping Overcome Problems Effectively.

## 2.6.3 Clinical Audits

### 2.6.3.1 National Audits

During 2018-19, there were no national clinical audits or National Confidential Enquires relevant to us.

### 2.6.3.2 Local Audits

Our Quality Assurance and Audit Group (QAAG) meets monthly to monitor our annual programme of audits, quality reporting, and patient experience. During 2018-19 we updated our infection prevention and control audit tools. We also streamlined how we manage the resulting actions. We have also held a clinical audit teaching session for our MDT Team. From April 2019, we will be extending our annual programme with regular monthly record-keeping audits.

Below, we present summaries of a selection of clinical audits conducted throughout the year.

#### Audit of Discharge Summaries

The purpose of this audit was to cross-reference the information on our discharge summaries with the information that local GPs say they would find the most useful.

Ten local GPs/GP trainees were asked via a questionnaire about the information they would consider most and least useful on a discharge summary. The answers were collated and 20 patient discharge summaries from admissions between December 2017 and February 2018 were audited in April 2018 against these criteria and against NHS England discharge summary standards.

The audit found that documentation was generally poor, and that for planned/procedure admissions the standard was not met for an adequate discharge summary.

Recommendations included amending the discharge summary templates to include more detailed information about a patient's admission and future planning. A working group has been set up to manage this.

Re-audit should be in one year, so that changes can be made and implemented.

### Re-referrals audit

Following our introducing the New Model of Care in June 2017, we wanted to look at its impact on re-referrals; specifically, the intervals between the original referral and the re-referral and the re-referral and the patient's death. We also wanted to look at whether there was any pattern to the primary diagnoses for which patients were being re-referred into our services.

To gather this information, we audited the SystmOne[4] records of patients re-referred into the hospice during May, August, and November 2017. We found that 91.4% of the re-referrals were deemed appropriate and were accepted for ongoing support.

The average time between referrals was 80 days, with the shortest being one day between referrals and the longest being 289 days (an outlier of 789 days was excluded).

56 of the 78 re-referrals were for patients with a primary diagnosis of cancer.

Of 47 patients who died following re-referral, 35 died within 90 days of the re-referral.

Recommendations:

- Ensure prior to the period of care being ended that all the clinical information is up to date; e.g. that a copy of the latest clinic letter has been received and reviewed.
- Ensure all advance care planning is in place prior to care being ended. This may not always be possible; e.g. if a patient is not engaging with end of life care discussions.
- If a patient is likely to die within a month, do not end the period of care and continue to support the patient and their family.
- Re-audit was scheduled for six months' hence.

### Accountable officer Self-Assessment

This is an annual audit completed by the Controlled Drugs Accountable Officer (CDAO) to evidence compliance with current legislation and standards. The audit was completed using an audit tool provided by Hospice UK.

It has highlighted excellent compliance with standards, with a compliance rate of 100% across all four areas.

### Management of Controlled Drugs

This is an annual audit completed by the Controlled Drugs Accountable Officer (CDAO) to evidence compliance with current legislation and standards.

The audit highlighted small areas of improvement required in the labelling of opened bottles of CD liquids, signature for receipt on delivery, and that our current signatory list required updating.

### Corneal Donation Audit

In the UK, there is an annual shortfall of around 500 corneas needed for transplant. Corneal donation from

[4] SystmOne is our electronic patient records system.

patients admitted to St Helena has been very low. This audit was carried out to examine the documentation regarding the discussions had with patients about corneal donation, with a view to improving the process and increasing donations.

Discussion of corneal donation is recorded on SystmOne via a questionnaire. A sample of 66 patient records was audited and, from this, only five showed a documented discussion about corneal donation with the patient (four of whom agreed to the donation).

During discussion of the results with the Medical Team, it was noted that staff can find these discussions difficult and they may not always be appropriate. In order to increase the number of discussions, and so the number of donations, recommendations from the audit included a teaching session for junior doctors on communication/ technique for corneal donation discussion and that such discussion becomes a routine part of the admission process. The audit also recommended that amendments be made to the corneal donation questionnaire to enable clearer documentation of any discussions had.

Re-audit will be in April 2019, allowing time to embed changes into practice.

### Length of Stay Audit

Average length of stay (ALOS) is a widely used indicator of hospital and hospice performance and is commonly viewed as a measure of efficiency. The ALOS of patients in St Helena Hospice has been generally regarded as being 10-14 days. In the reporting years 2016-17 and 2017-18, the average length of stay was 13 days; however, Q4 2017-18 saw our average stay rise to 15 days (from 11 days in Q3).

The Head of the Inpatient Unit (IPU) was asked by the Chief Executive Officer (CEO) and the Director of Care to undertake an audit to establish the reasons for this increase. A small working party was formed from the multi-disciplinary team working within the IPU to audit the records of 40 patients who had stayed more than 20 days. The team comprised the Head of IPU, a Medical Consultant, a Social Worker, and a Care Coordinator.

After auditing ten records each, the team met to decide, using their professional judgment, whether each patient's length of stay was appropriate. Of the 40 patients audited, nine were deemed to have had an unduly long stay. The auditors looked further at those records to try to establish a root cause for the extended length of stay. Seven reasons were found:

- One delay was attributed to Mid Essex CCG.
- Two delays were attributed to Adult Social Care.
- One delay was attributed to the St Helena Hospice Team.
- Two delays resulted from the patient changing their Preferred Place of Care (PPC).
- One delay was caused by a family disagreement.
- One delay was attributed to a nursing home.
- One delay was attributed to Continuing Healthcare (CHC).[5]

The audit was productive, and each participant wrote recommendations

[5] NHS continuing healthcare is social care arranged and funded by the NHS, for people with long-term complex health needs (see https://www.nhs.uk/conditions/social-care-and-support/nhs-continuing-care/ for further information).

from their professional perspective and an action plan was formulated.

### PLANC Documentation

In April 2018, we launched a new nutrition and hydration care plan on IPU. The Patient Led Assessment of Nutritional Care (PLANC) was designed by Dorothy House Hospice for the palliative setting. St Helena adopted an adapted version of PLANC in April 2018, following a visit from colleagues from Dorothy House. The purpose of this audit was to see whether we were using the new care plan in accordance with our internal standards, and to identify any areas that needed further training/ improvement.

Our Nutrition Link Nurse audited 20 patients to examine:

- Whether the care plan was launched on admission.
- Whether the correct stage of the plan (early/late) was launched.
- Whether consent was documented on every update.
- The number of times patient intake was recorded during admission.
- Whether the care plan was changed in line with any change in Phase of Illness.

The audit highlighted areas for improvement, such as increasing the number of times patient intake is recorded during admission. Currently, the standard at St Helena is that this should be done daily. A re-audit was planned for April 2019 following further staff education.

### Nutrition Documentation

This audit was carried out in order to identify what nutrition advice and treatment the Community Clinical Nurse Specialist (CNS) Team were documenting, with a view to improving it. Several years ago, a Nutrition Steering Group was in place to encourage sharing of knowledge and experience to benefit patients, but this had since lapsed

A CNS audited 33 patient records and used the findings to identify the work currently being done. This showed that, overall, documentation was consistent; however, where general dietary advice was given, this was not documented in any detail.

CNS assessments are generally documented in thorough detail, so in order to minimise the need for extra documentation in this area, it was recommended that a nutrition booklet be developed, which would encompass all the dietary advice given. In order to facilitate this, it was proposed that the Nutrition Steering Group be reinstated.

A further recommendation was to consider the use of a nutrition screening tool that would be suitable for community patients, in order to comply with NICE[6] Quality Standard 24 (Nutrition Support in Adults).

Re-audit was planned for one year later, so that the booklet could be developed and embedded into practice beforehand

### Patient Story Documentation

This audit was carried out to measure the effectiveness of a care plan (Patient Story) used on IPU, the purpose of which is to evidence that nurses are meeting patients' psycho-social needs. This care plan should be completed daily. 15 records were audited.

The audit showed that the Patient Story care plan was not always being completed daily. The audit also

[6] National Institute for Health and Care Excellence.

showed that the information being entered was sometimes more suited to other symptom control related care plans and that information was often duplicated. The Patient Story care plan was being used to summarise a patient's day and included information that would be more relevant to other care plans. However, the quality of the psychosocial data entered was good.

Recommendations included commending nursing staff on their good data entry and to remind them staff to complete the Patient Story care plan daily, to name the patient, and only to use this care plan to capture the appropriate psychosocial information.

Re-audit was planned for April 2019.

Thank you for everything that you have done for my father during his last battle, I will never forget everything that was done for him.

CNS Bereavement Referrals Re-audit

This re-audit examined how well the Community Clinical Nurse Specialist (CNS) Team was undertaking bereavement support. An original audit in December 2017 showed that not all members of the team were following the agreed standard: that they contact relatives and offer support within two weeks of death.

The audit was carried out by two members of the CNS Team, who audited 36 patient records from a sample of patients who died on a CNS caseload between 1st April and 30th June 2018.

The results showed that there was a significant improvement in making contact within two weeks compared with the previous audit. The CNS Team will discuss the audit results, to encourage 100% compliance with the standard, and re-audit in September 2019.

My family and I would like to convey our most sincere thanks for the love and attention you gave [dad] during his time spent in the hospice and for moving all 6 of us, plus.....into one room was something special.

### 2.6.4 Participation in Research

During the year, St Helena has been involved with two pieces of research.

**Talking about death: Exploring the psychological outcomes of talking, and psychological barriers to talking**

In this research, the University of Essex and St Helena are trying to understand more about the conversations people have about death and dying (e.g. what people expect will happen during a conversation about death, how people feel after talking about death). The aim of this study was better to understand how to improve conversations about death and dying, and therefore allow us to improve the care we provide in the future.

**Supporting Hospice trustees to carry out their role**

The aim of the survey is to discover how trustees can be supported to carry out their Charity Commission duties:

- Act in your charity's best interest.
- Manage your charity's resources responsibly.
- Act with reasonable care and skill.

### 2.6.5 Use of the CQUIN Payment Framework

SH income in 2018-19 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because we are not party to any NHS National Standard Contracts.

## 2.7 Clinical Governance Structure

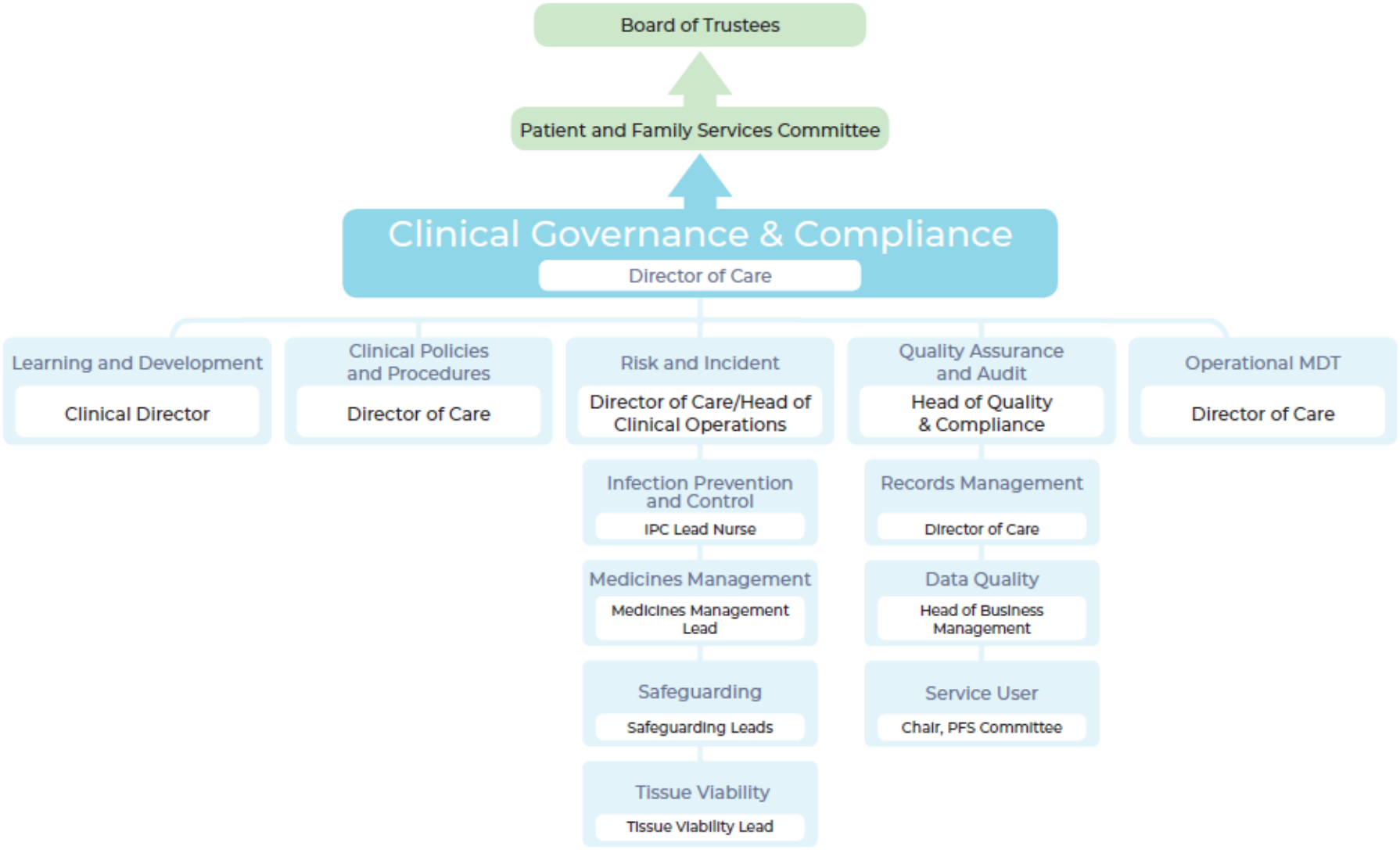



Figure 2 Clinical Governance Structure, as of April 2019

# 3.0 Review of Quality Performance

You have enabled me to see things clearly again and continue with my very demanding caring role with a sense of purpose and the strength to carry on supporting .... the best I can.

## 3.1 Overall referrals to St Helena

Table 1, below, shows the overall number of referrals St Helena received during 2018-19 with the two previous years for comparison. Referrals have increased 9.8% over the previous year

| Quarter | 2018-19 | 2017-18 | 2016-17 |
|---|---|---|---|
| Q1 | 2032 | 1820 | 1930 |
| Q2 | 2209 | 1809 | 1919 |
| Q3 | 2082 | 2059 | 1928 |
| Q4 | 2052 | 1940 | 2094 |
| Total | 8375 | 7628 | 7871 |

*Table 1 Overall referrals*

## 3.2 The Hospice

Following a successful pilot in the winter of 2017-18, we managed to secure additional funding this year for a 16th bed to help support the Colchester hospital with winter pressures.

Despite the challenges of managing an ever-increasing waiting list, our occupancy levels have remained steady. This means people spend less time waiting for admission.

The support from the SinglePoint Virtual Ward (See Page 24) has meant that those who have chosen to remain at, or return to, home, to die have been able to do this.

Reducing the time people spend on the waiting list prior to admission and providing suitable and timely care packages when they are waiting for discharge, remain challenging. This is a consequence of the broader trends in health and social care funded packages.

We have begun a project to increase our beds from 16 to 21, by repurposing our central courtyard. We are currently working to fund this and hope to have done so by the end of the year.

Words cannot express my gratitude for your help and support during this difficult time. Not only have you helped me to heal from my losses. You have helped me to see a future.

## 3.3 Medical Team

This year, the Medical Team welcomed Kathryn Davies as the first nurse consultant at St Helena. This move has enriched the Team and offers senior nursing expertise to The Hospice and SinglePoint.

Over the past year, the Medical Team has worked with the IT and Nursing teams to implement electronic prescribing on IPU. We think that St

Helena is one of the first hospices to modernise prescribing in this way, and we are confident that this will decrease medication errors on the unit.

Dr Thaluvankateswaran passed his Membership of the Royal College of Physicians (MRCP) exams in spring 2019 and Dr Sexton has completed a secondment to a London hospital. Two GPs passed palliative medicine qualifications at Cardiff University following their placements with us.

The junior doctor placements continue at The Hospice, offering learning and audit opportunities in palliative care, which will benefit them in their future hospital and community roles.

We presented a poster written by the Medical Team on the GP fellowship scheme at the annual Hospice UK conference.

We are continuing to work with Essex Partnership University Trust (EPUT): Dr Sexton supports their ward teams with Gold Standard Framework accreditation.

Dr Tempest has taken on the team lead role, as Dr Chumbley has become the North East Essex Health and Wellbeing Alliance End of Life Senior Responsible Officer.


## 3.4 Hospice in the Home

Our Hospice in the Home services complements other local health and social care providers, such as GPs, community nurses, and social services. To help people to stay at home, the wider community team plays an important role.

### 3.4.1 CNS Team

St Helena has a team of eleven Clinical Nurse Specialists (CNSs) who are based at either our Colchester or Clacton sites and operate across NE Essex. During 2018-19, they dealt with 1258 referrals and recorded 14,646 individual contacts with patients; 6,000 of which were face-to-face visits in patient homes. The CNS Team are the main link with other community services, such as GPs and District Nurses. They support and advise GPs about putting people on the My Care Choices Register and often are the ones to add their own consenting patients to it. All our CNSs are now trained in advanced communication skills and advanced care planning and are designated as senior responsible clinicians.

As well as clinical work, CNSs also have an educational role, teaching relatives about how to deal with their loved one dying. They address practical issues, such as recognising when someone is dying, as well as how to look after oneself during a difficult and emotive experience. CNSs also have a public education role, working with other hospice teams to produce videos and printed material explaining more about the CNS role within palliative care and how people with life limiting conditions and their families can access their services.

During 2018-19, St Helena has worked to increase non-cancer referrals to the service and, following a review of CNS safe-staffing data, we are pleased to have recruited an additional two full time CNSs, who will be starting during 2019-20.

### 3.4.2 SinglePoint and Virtual Ward

Over the course of the last year, SinglePoint has worked to enhance the visiting service we provide to people in crisis or in need of symptom control. With our new Virtual Ward pilot, we have been able to offer personal care for up to four patients at any one time, combined with input from SinglePoint Registered Nurses and Clinical Nurse Specialists. This ability to offer a wrap-around service for patients at the end of life allows us to manage complex situations, enabling patients to be discharged from hospital promptly with appropriate care at home already in place. It also allows existing patients in their own homes to stay there with the appropriate level of support, to prevent them having to move into an alternative care setting.

We have introduced a new shift pattern, which consists of a long day and a long night, to make best use of our staffing in providing a 24hr service.

We have also increased our focus on working with other community health care providers, including community nurses. We work alongside these providers to support patients with complex care needs and making rapid response visits when a situation demands it.

> [The] whole family were treated with dignity, kindness, compassion and respect. Your staff and volunteers are simply amazing, and we cannot thank them enough for all they did to support us all.

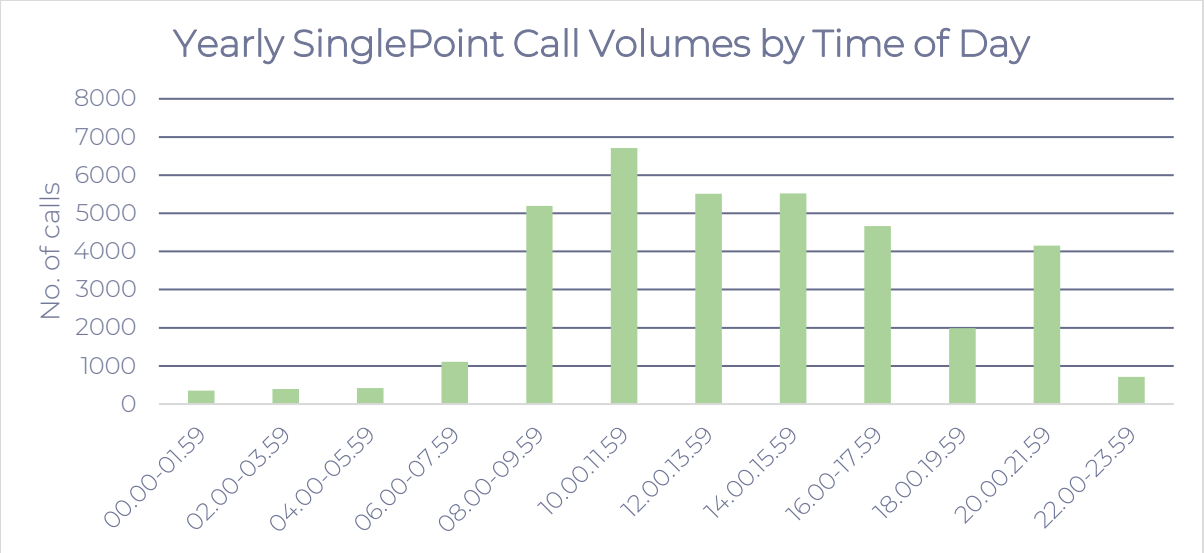



*Figure 3 2018-19 SinglePoint call volumes*

## 3.5 My Care Choices Register

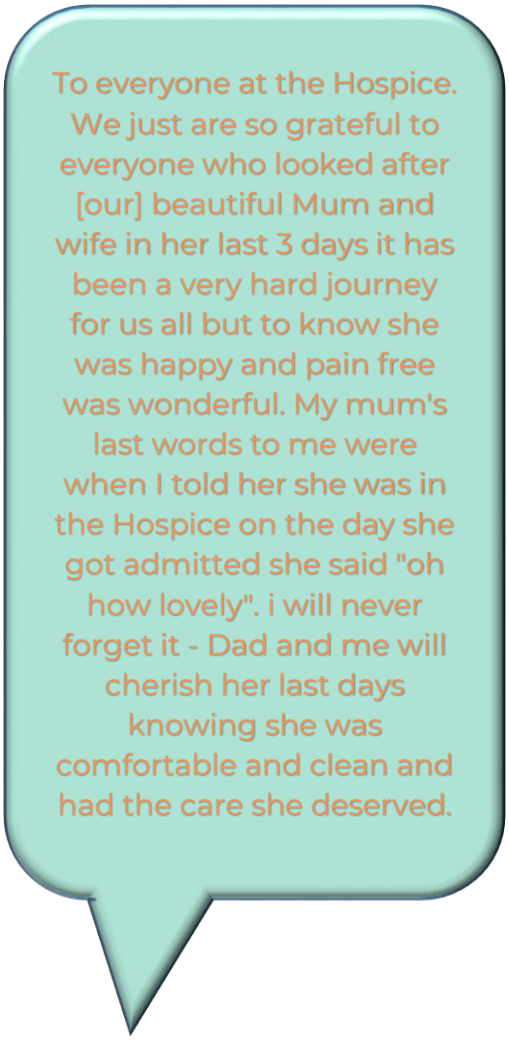
St Helena continues to host the My Care Choices Register (MCCR), a secure database for people faced with chronic ill health or life limiting disease in NE Essex to record their choices about future care. This year, Tim Clifton (Head of IT) has led a project to transfer the Register to a new system, embedded within GP records. We have also widened access to the Register, with the ambulance service now able to use it to inform their management of patient care.

The NEE Healthcare Alliance allocated some funding to promote My Care Choices across the community and there has been a 20% increase in Register entries over the last year to over 3600 people now having recorded their priorities for the future. Over 1400 people living with frailty and dementia have recorded their choices for future care.

Most people on the Register are cared for in their place of preference at the end of their lives and their chance of dying in hospital is almost half that of people who do not discuss and record their future preferences. The Register continues to be successfully embedded across our community and is routinely used by primary care, the hospital, and St Helena. This success has encouraged other providers to consider using it.

> Both Mary and Judy were excellent at facilitating and enabling the group to discuss feelings and thoughts encouraging us to express yourself. When attending the group first time I was in a very dark place almost giving up. I would not have survived if it wasn't for both Mary, Judy and the group. It enabled me to come to a space once a week where I felt safe and allowed me to realize that my thought process was not abnormal and indeed I wasn't alone. The death of my mum almost destroyed me but the group helped me to survive.


*Figure 4 MCCR bus poster*




## 3.6 Day Therapies

The aim of our Day Therapies is to help people regain confidence and independence through empowerment, rehabilitation, education, and friendship.

We provide several groups that offer support, education, and self-management strategies.

We have well-equipped treatment and therapy rooms, a salon, bathing facilities, and arts & crafts areas. We also have activity rooms and equipment to support empowerment and rehabilitation.

We offer clinic appointments for those requiring expert advice from our counsellors, social workers, and rehabilitation and family support staff. These focus on complex physical, emotional, and spiritual needs.

### 3.6.1 Bereavement Service

The Bereavement Service continues to be in high demand from bereaved adults in the North East and Mid Essex area. We take referrals from six weeks after a death has occurred and these can be made directly to us by bereaved individuals, community practitioners, GPs, or anyone who is supporting someone who is bereft. Our work has changed markedly over the past five-and-a-half years since the Bereavement Service was opened to the local community. We support people who are assessed as needing our help, however they have been bereaved and with no limit on interval since they were bereaved. As well as deaths that could be described as expected (through illness, for example), we also take referrals for sudden and traumatic deaths, neonatal and child deaths, suicide, and accidental deaths. We pride ourselves on being able to support bereaved clients at this most difficult time.

There have been several changes to the structure and staffing of the Service, and we now have two team leads who share the full-time role, both of whom are experienced counsellors. We have one other experienced counsellor and are currently advertising 48 hours, mainly for two additional counsellors. We also have a full-time bereavement support worker, who works with individuals but also manages a large caseload through bereavement support groups in Colchester and Clacton. These groups are accessible with a minimal wait.

The support we offer remains within the St Helena Model of Care and we use the Adult Attitude to Grief Scale to assess ongoing need. We provide counselling or bereavement support in accordance with the Nice Four Tier Model of Psychological Support.

To stay informed on current developments, our staff attends local meetings of Association of Bereavement Service Coordinators (ABSCO). We are continuing to streamline the service and the referral process, in line with best practice as defined by the National Bereavement Alliance, current research evidence, and recommendations from British Association for Counselling and Psychotherapy (BACP), the largest professional body for the counselling profession. We will soon be trialling a self-assessment tool for clients to complete on referral, which has previously been successful at Farleigh Hospice in Chelmsford.

We also intend to set up several Bereavement Help Hubs; an idea that has been trialled successfully around the country. These will be run by trained bereavement volunteers, and we are fortunate that we have a number who wish to be involved. Our first Help Hub will be opening in the coffee shop at our new retail outlet on Peartree Road, Colchester. It is our hope that we can then find suitable venues for other Help Hubs in local communities, such as Halstead, the Colne Valley, Harwich, Frinton, and Walton. We also continue to try to direct bereaved people to existing support in their local communities, where a suitable service or group exists.

We hope that there may be some grant opportunities this year to support our much-needed service. We applied this year for funding for training and support of an additional 20 bereavement support volunteers but were not successful.

> When [he] felt scared, unsure or closed you offered him safetly and reassurance... He trusted you immensely you made him feel like he was not alone in his fight.

### 3.6.2 Family Support

St Helena's organisational restructure during 2018-19 meant considerable change for the Psychosocial Team, splitting it into separate but closely cooperating Bereavement and Family Support teams.

Referrals for both teams continue to grow and some counselling and family support hours have been transferred to the Bereavement Team to assist with their large waiting list. Social work hours have also reduced as a social worker left and funds were re-directed elsewhere, meaning the post was not replaced.

The Family Support Team continues to provide psychosocial support to patients and families (including children) pre- and post-death. We also provide bereavement support to children who have not been known to St Helena and have been bereaved suddenly and unexpectedly.

The organisational changes have meant that Family Support has had to review the service we provide. As the external children's bereavement referrals continue to increase and staffing has decreased, we now have a waiting list of 2-3 months. We have identified that we need additional staff to support the children and

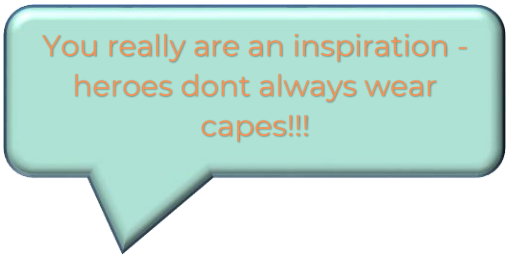
families work, so we are currently looking at possible grant funding for this specialist work.

The Family Support Team works across all clinical areas and the current need is with children and families within The Hospice and community. Regrettably, we have had to make the difficult decision to close two therapeutic patient groups – Art and Friendship. However, we were able to direct members to other specialist groups facilitated by both our Rehabilitation Team and other voluntary services within the community. Currently, the unique Side by Side group, aimed at couples, has been put on hold, but we aim to provide this again later in the year.

On a positive note, the successful Carers group continues to be needed and we are planning to offer this more frequently next year. This group runs over eight weeks and provides advice, information, professional and peer support to the many family members/ carers we support. We have developed joint working with the hospital Palliative Care Team. One of our counsellors co-facilitates a family members' 'drop-in' session weekly at Colchester General Hospital with one of the specialist palliative care nurses. This helps to decrease some of the fears families have about The Hospice and eases the transition from the hospital to St Helena.

As life limiting illness is a 'family affair,'[7] we continue to provide family focussed assessment and intervention, which ensures we identify the needs of the whole family. This involves one to one, couple, and family therapy, and support to help children pre- and post-death. We also provide specialist social work to support complex patients and families whose needs are not met by statutory services.

We continue to provide the Sharing, Talking and Remembering Someone Special (STARS) young families bereavement programme and, after a year of the new format of activity days followed by monthly sessions, we are about to review the programme. This is to ensure we meet our objectives, but also the needs of the children and families.




### 3.6.3 Complementary Therapy

The Complementary Therapy (CT) service offers treatments to support patients and their families and carers through periods of anxiety and stress associated with illness. We take a holistic approach to sustaining the whole person, easing their symptoms, improving their sleep and general comfort in a therapeutic and compassionate environment. Patients can also use our therapies safely alongside any medical treatments they might be receiving.

Complementary Therapies at St Helena is provided by dedicated and professionally qualified complementary and beauty therapists who work on a voluntary basis. The service is led by a professionally qualified CT Team Lead. The Team also includes volunteer chiropodists and the

[7] Christ, G (2000) Healing Children's Grief: Surviving a Parent's Death from Cancer. Oxford University Press

owners of our Pets as Therapy (PAT) dogs, who both support day centre activities.

The therapies we provide are massage, Indian head massage, aromatherapy massage, the 'M' technique, aromatherapy inhalers and diffusers, reflexology and Reiki, as well as nail care. Referrals to our service are made from the Hospice, Rehab, Family Support, Bereavement, the CNS Team, and SinglePoint. We also accept self-referrals. Individual appointments are booked according to the Model of Care with regular reviews of progress. We also provide support to staff and volunteers.

We also offer our services through Day Therapies groups, such as the Supporting Togetherness, Empowering Positivity (STEP) Group, which is led by the Rehab Team.

During 2018-19, we received 402 referrals for patients or their families. We provided 1955 individual treatment sessions to 441 individual patients, plus support therapies for our staff and volunteers.

We have hosted several Look Good, Feel Better (LGFB) workshops for selected patients, who go home with beauty and skincare products. These groups are very popular, and we receive very positive feedback.

### 3.6.4 Rehabilitation Service

The Rehabilitation Service is staffed with Occupational Therapists, Physiotherapists, Registered Nurses, and Rehabilitation Assistants and includes our multi-professional Breathlessness Service. We work across Day Therapies, the Hospice and in the community. All our work with patients and families is aimed at 'restoring the patient into a person.'

The Team provides a range of patient-focused groups through the Day Therapies service; for example, STEP, Fatigue and Breathlessness (FAB), Mindfulness and Table Top Gardening. These groups operate from both the Joan Tomkins and Tendring Centres.

The Rehabilitation Team continues to lead on the management of breathlessness as a symptom. The Breathlessness Service offers specialist breathlessness and fatigue management through clinics, support groups, and home visits. We now offer specific workshops to those with Heart Failure. We hope to be able to expand the Breathlessness service further in the future

We continue to work with patients who have complex rehabilitation needs, both within the Hospice and within the community, working closely with NHS and Social Care colleagues.

The Rehab Team deliver lectures to Occupational Therapy and Physiotherapy students and regularly support students undergoing clinical placements.

## 3.7 Safeguarding

St Helena social workers are involved in various safeguarding concerns; supporting staff and working with the police and local children's services. They carry out preventive safeguarding work with patients in the last few days of life, which can involve complex family dynamics. In these situations, social workers gather all the necessary information and are often able to devise safety plans and resolve concerns without having to refer to the local authority (which would not be ideal in last few days of life).

This year, the Children Safeguarding Lead left the organisation; unfortunately, a lack of funds meant we were unable to recruit a replacement. Therefore, the Adult

Safeguarding Lead has taken on responsibility for both adults and children.

We have a part time social worker who is the lead for learning disabilities and mental health. She supports the safeguarding lead with additional face to face training for all clinical staff and any safeguarding concerns that staff members may raise.

St Helena social workers have completed online and face to face adult and children safeguarding training provided by Essex County Council. They have attended Level 4 domestic violence, and adult and children safeguarding conferences.

We now require all clinical staff to complete an online Prevent training module. This is a strand of the Government's 'Contest' counter terrorism strategy, which has the stated aim of preventing and detecting radicalisation. This has also been included in the face to face safeguard training

We have amended our Safeguarding (Adults) Policy to incorporate the updated Southend Essex and Thurrock Adult Safeguarding Guidelines (April 2019). We have also updated our Safeguarding (Children) Policy to incorporate Prevent.

We continue to update our safeguarding templates on SystmOne to ensure they are up to date and in line with Essex County Council safeguarding policies. In addition to the templates, staff can record a Mental Capacity Assessment, Best Interests Decisions, and Deprivation of Liberty Safeguards (DoLS) within SystmOne.

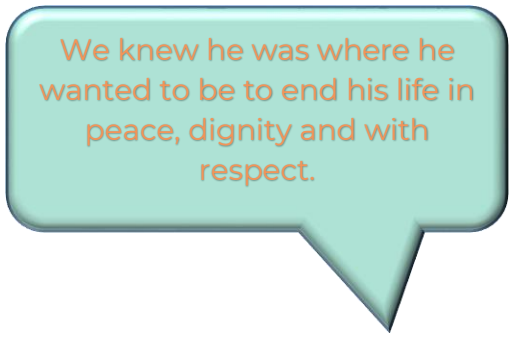
The Essex Children Safeguarding Board has amended its referral process, and we have updated SystmOne to accommodate this, advising all clinical staff of the changes.

We have updated the safeguarding noticeboards across all St Helena sites. These boards provide information and guidance to patients, families, and visitors on how to report a concern.

We have increased face to face training to five hours in order to incorporate mental capacity assessment, DoLS and Prevent.

The Safeguarding Lead chairs quarterly safeguarding meetings with staff across the organisation to discuss risks, policy changes, and complex cases.

Hospice social workers continue to attend safeguarding forums to ensure they are up to date with legislation and best practice. This information is shared within the organisation.




## 3.8 Chaplaincy

The Chaplaincy Team leads on spiritual care within the organisation and raising the spiritual awareness and responsiveness of all staff. The team works across the organisation to meet the spiritual, pastoral, and religious needs of all patients, families, and staff.

This past year, as well as being active in The Hospice, we have seen steady growth in number of community referrals we receive. We have also been regularly running spiritual wellbeing sessions for day therapy

groups. This opportunity has helped us to build relationships with a wider group of patients who might not ask for a referral but later find they appreciate having some spiritual support when they are admitted to The Hospice or other issues arise.

We have had several new volunteers join our team, increasing our size and diversity. We have invested time in training our team in palliative pastoral care and they have been of invaluable service visiting patients with less complex needs.

We continue to contribute to the holistic care of The Hospice through having input in several meetings and forums. We also provide inductions and regular Spirituality Awareness training sessions to equip staff to be aware of our patients' spirituality and to feel confident to support them in this area. These sessions have been well attended by staff across all departments and feedback from them has been positive.


This year we have also worked on a re-audit of spirituality to assess the impact of the training that we implemented following the initial audit. Our findings were that this work has increased the amount of spiritual need being recognised and care provided.

## 3.9 Learning and Development

As part of the St Helena rebranding, we renamed the Education and Research Centre the Learning and Development Centre. The Learning and Development (L&D) Team has revised and relaunched many of the pre-existing courses and have also created several new learning opportunities aimed at both St Helena staff and the wider North East Essex community.

In 2018, we published two Learning and Development prospectuses. The external prospectus provides opportunities for other organisations to access education and training via St Helena: for example, advanced communication skills, syringe pump or nurse verification of expected death training.

The internal prospectus provides St Helena staff with a varied selection of both mandatory and non-mandatory education and training opportunities including;

- Line management.
- Complaints and concerns.
- Dementia Friends information.
- Basic life support.
- Moving and handling.
- Advance care planning.
- Communication skills (Intermediate and Advanced).
- Clinical supervision.
- Fire extinguishers.
- Stay safe.

We encourage all St Helena staff to refer to the prospectus for inspiration when preparing for their annual appraisal.

In July 2018, St Helena hosted a GP Community of Practice. In total, 16

GPs attended this event supported by the Hospice Medical Team.

Also in July, we closed the Millie Hare library and replaced it with an organisational membership with the East Anglia's Children's Hospices (EACH) library.

The L&D Team hosted a selection of study events in October 2018. The speakers represented a variety of organisations, including St Elizabeth Hospice, St Nicholas Hospice, East Suffolk and North Essex NHS Foundation Trust, and Anglian Community Enterprise. These events were not only well attended but also very well evaluated:

- Monday, October 1st, 2018 – Dealing with Dying workshops. Attendees: 70.
- Thursday, October 4th, 2018 – Heart Failure Study morning. Attendees: 63.
- Tuesday October 9th, 2018 – CNS Conference titled Palliative and end of life care for non-malignant conditions. Attendees: 44.
- Thursday October 11th, 2018 – Allied Health Professionals Conference, titled Rehabilitation in Palliative Care. Attendees: 48

St Helena introduced Schwartz Rounds during November 2018. These are a multidisciplinary forum designed for staff to come together once a month to discuss and reflect on the emotional, social, and spiritual challenges associated with working in healthcare. Rounds provide a confidential space to reflect on and share experiences. In total, to date, 130 attendees from both clinical and non-clinical groups have engaged.

In November 2018, our team presented four posters at the annual Hospice UK conference:

- End of life care education within the nursing and residential home setting
- The implementation of Project ECHO™ (Extension of Community Healthcare Outcomes)
- End of life education for East of England Paramedic Service – A collaborative approach.
- Breaking down the barriers to mandatory training.

Other St Helena teams presented an additional five posters:

- Dealing with Dying Workshops.
- Are stress, compassion fatigue, and/or burnout preventable in hospice nurses?
- Collaborative specialist palliative care beds.
- Increasing cyber security awareness in the hospice environment.
- Review of a GP Fellowship scheme in palliative care.

The L&D Team has been delivering advance care planning education sessions to nine care homes across NEE as part of a funded project. The early indications suggest that, as a result, there has been an increase in the number of residents signing up to the My Care Choices Register.

The Team is now working with 'Compassion in Dying' as part of a funded project. Compassion in Dying will deliver a series of advance care planning workshops for eight care homes across NEE

St Helena is working towards becoming a regional training centre for the Gold Standards Framework (GSF). During 2018, the L&D Team delivered both the Care Home and Domiciliary Care programmes.

St Helena is working with Project ECHO™ (Extension of Community Healthcare Outcomes), a virtual

environment learning tool, used within a community of practice to facilitate a more comprehensive, seamless experience for care staff, patients, and families (see Page 33).

St Helena has launched Tier Two Dementia Awareness training. This training is in addition to the varied dementia training already in place. The Team also initiated The Alzheimer's Society's Dementia Friends Information Session for all staff and promoted Dementia Awareness Tier 1 training offered via E-Learning for Health.

Staff have been encouraged to complete a Certificate in Principles of Dementia Care delivered via The Skills Network. St Helena now has 90 Dementia Friends and 35 staff attended the Tier 2 training delivered during January and March 2019.

The L&D Team has been invited to present a poster at the Inaugural International Conference on Palliative Dementia Care, hosted by the Northern Ireland Hospice in Belfast.

St Helena has engaged with government funded courses via The Skills Network more generally. In total, 28 members of St Helena have completed courses.

Twelve members of staff are completing higher level study. The courses include Non-Medical Prescribing, BSc Palliative Care, PGCE, MSc in Dementia Studies, and BSc in Business Management.

### 3.9.1 Project ECHO™

The Extension of Community Healthcare Outcomes Project (Project ECHO™) is intended to deliver virtual training to the community. Training is delivered via a network link, enabling people located over a wide area to participate in learning without the disruption of travel. Each session offers an expert speaker who delivers a 20-minute presentation. We also ask participants to send us a case study on the subject matter. This promotes good learning for the audience, as they not only learn from the expert speaker but also from their peers.

We have targeted our GSF cohorts to be our first groups to join the ECHO™ sessions. We started delivering ECHO™ training in July 2018 to Cohort One. We offer one session per month, which runs for 1.5 hours. Originally, we had 12 different care homes express an interest, but the most that have ever participated has been six. These numbers have declined to three or four care homes. We have just introduced the second cohort of GSF to ECHO™ and only two care homes joined us for the first session. Problems arise because the homes cannot free-up staff to take part.

The project lead plans to visit all the care homes in the new cohort to promote the project's benefits and work with them to improve attendance.

Participating care homes suggest the topics for the sessions in order to support them obtaining their GSF accreditation. Topics have included:

- Anticipatory medications.
- Nausea and vomiting.
- My Care Choices Register.
- Difficult conversations with families.
- Pain and agitation.
- Respiratory secretions.
- Symptom management.

Some of these topics will be repeated in 2019 with new ones including:

- Holistic assessment.
- Bereavement & Grief.
- Mouth Care.

- Dementia Friends.
- Building relationships with GPs.
- Complementary Therapies.

Future plans:

- To grow the audience numbers.
- Create an ECHO™ cohort for GPs.
- Utilise ECHO™ for further clinical teaching to reach the wider community.

## 3.10 Quality of the Environment

Following on from the approval of the Five-Year Estates Strategy, commenced last year, we continue to make environmental improvements at the main hospice site. Projects completed over the past 12 months include:

- Redecoration of Side Rooms 2, 4, 7, and 8, which included infection control paint and LED light installation.
- Programme of LED light installation in IPU bathrooms and bedrooms and in corridor sections to improve quality of light for service users and cleaning standards.
- Rolling programme of corridor redecoration.
- Conversion of bathroom in IPU Side Room 4 to wet room with shower.
- Redecoration of IPU dining room and replacement of drinks station. An electric worktop riser improves access for all service users.
- Relocation of Bereavement Team to a dedicated room.
- Creation of a dedicated, secure offsite archive facility for record keeping, to facilitate General Data Protection Regulation (GDPR) compliance.
- External lighting improvements to strengthen safety and security for pedestrians visiting the site.
- Installation of traffic calming signage throughout the site.
- Installation of dedicated parking spaces outside IPU dining room to encourage safe parking.
- Introduction of a pedestrian crossing outside the main IPU entrance.

Progress has also been made with the Capital Programme:

- An architect and an interior design company have been appointed.
- A multi-disciplinary working group has been established to take account of best practice.
- Funding and planning permission are being sought.
- We are evaluating designs that would accommodate additional bed space.

The in-house Catering Team has successfully retained its five-star food hygiene rating for both our kitchen facilities. We continue to cook all food on-site from scratch and we source many ingredients locally, working closely with FairShare[8] to ensure a sustainable and cost-effective food supply chain. The Catering Team has also continued with its theme days throughout the year to celebrate food from different cultures. We are adding other dining facilities, such as a Fresh Bean coffee machine and vending machine to augment service options for visitors, particularly during unsocial hours.

[8] https://fareshare.org.uk/

The Maintenance Team continues to attract new volunteers, which increases the capacity and support for completing maintenance Helpdesk tickets, improving responsiveness. Replacing fluorescent lights with LEDs also reduces maintenance requirements. To focus on improvements to the physical environment of the IPU, an improvement group has been established with colleagues from Estates and clinical teams in order to identify, deliver, and review all improvement actions being made.


We continue to hold Health and Safety and Wellbeing Committee meetings each quarter, as well as the monthly non-clinical health and safety meetings. Monthly Estates team meetings review Estates related incidents and accidents on the Hospice site. The Health and Safety Team has delivered a wide spectrum of training, including fire safety, business continuity planning, risk assessment training, and lone working workshops across both clinical and non-clinical directorates.

The senior managers have approved the Business Continuity Plan (BCP), and training is currently being delivered across all teams. The preparedness for business disruption has been enhanced by the construction of a BCP storage facility, allowing enough space for the storage of key emergency supplies. We have also introduced scenario training to our Leadership Forum, and, in February, we workshopped a Brexit scenario to identify key risks.

The Estates Team continue to participate in the NHS Patient Led Assessment of the Care Environment (PLACE)[9]. The feedback from the second assessment was collated and reported to the Senior Management Team and several improvement areas have been addressed, including lighting improvements, changes to cleaning schedules, and information about food for patients. The organisation is also trialling dementia-friendly signage and several other dementia-friendly initiatives to help make the environment more accessible.

## 3.11 Volunteering at St Helena

St Helena volunteers are an integral and valued part of the organisation, who bring to us a variety of skills, interests, and individual experience. This complements the care we offer to patients, families, and employees.

The Human Resources (HR) Volunteer Services Team has continued to build relationships with line managers and improve communications over the last year, to ensure that volunteer procedures are followed. As part of this process, we

[9] https://digital.nhs.uk/data-and-information/areas-of-interest/estates-and-facilities/patient-led-assessments-of-the-care-environment-place

have continued to cleanse the volunteer database so that our volunteer figures are up to date, and we remain compliant with the GDPR. We continue to benefit from the support of over 900 dedicated volunteers who cover over 50 different roles and support 20 teams across the organisation. We receive on average two to three applications per day.

Working with line managers, we have introduced new types of roles such as Coppice Café, Telephonists, and Upcycling for the new House Clearance department in retail.

We are working with more external organisations in the community to promote volunteering, particularly mental health organisations. There is evidence that volunteering can help those suffering from mental health issues in rebuilding their confidence and giving them experience in the workplace to help them back into work. We are keen to support this and are now working with the Heads Up Charity and The Lakes at Colchester General Hospital, as well as continuing our relationship with Community 360.[10] The Volunteer Services Team is often side by side with volunteers, out and about in the local community to engage with the public to promote the benefits of volunteering.

We have updated and re-issued the Volunteer policies, Volunteer Handbook and Volunteer Agreement. The volunteer line manager training sessions have proved invaluable to those who manage volunteers and feedback from staff has been very positive. The introduction of a new Volunteer Line Managers Forum has been well received. This is a new platform for line managers to share ideas on how to value volunteers, get the best from them, discuss any changes within the organisation that would impact on volunteers, share information on forthcoming events, and raise any general concerns or issues.

We encourage all staff who work with volunteers to be as inclusive as possible and an indication that communications to volunteers has improved is that we are now getting even more volunteers attending Share briefings and Induction Refresher days, so that they are fully informed of what is happening across the organisation.

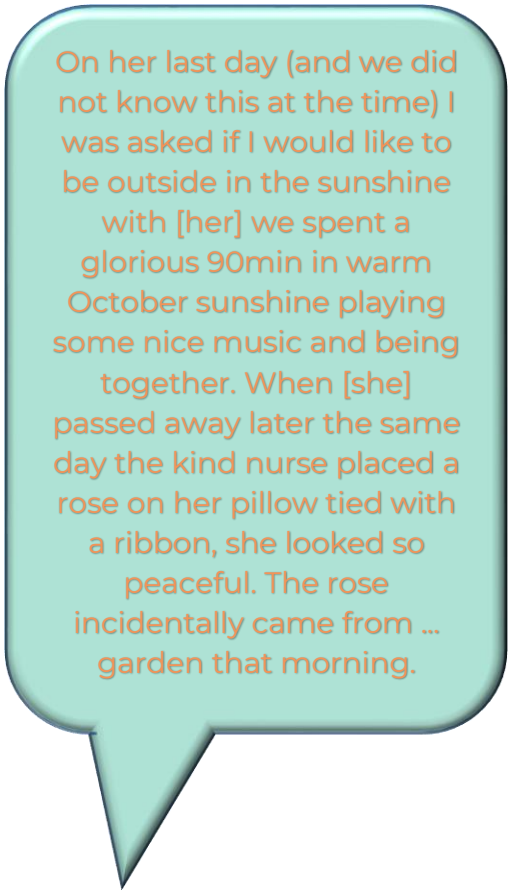
The annual 'Thank You' Day for volunteers will take place on Wednesday 16th October 2019 at the JobServe Community Stadium. This venue was successful last year and allowed us to increase the number of guests who could attend. As well as the long service awards, a special Recognition Award was introduced last year: Line managers are asked to nominate a volunteer who they feel has gone beyond the call of duty in their role. For the first time, at next year's Thank You Day, we will celebrate some volunteers who have been with us for 35 years.

Plans for 2019-20 include:

- Working with the Learning and Development Team to ensure that all volunteers complete mandatory training.
- Achieving 35% completion rate for volunteer engagement survey.
- Increasing volunteer numbers to 1,000 by March 2020.
- Introducing a new Skills Pathway.

[10] C360 is independent, charitable infrastructure organisation.

The Volunteer Services Team continues to work with both volunteers and their line managers to ensure simple and effective processes, so that all volunteers receive the best experience throughout their volunteering time at St Helena, from beginning to end.




## 3.12 Quality Markers

### 3.12.1 VTE assessments

Venous thromboembolism is a significant risk to people admitted to hospice. We require our Medical Team to risk assess each patient we admit for thromboembolism and discuss with them whether they wish to have a daily injection to help prevent it during their admission.

Approximately 90% of people admitted to SH during 2018-19 had such a risk assessment documented in their clinical record. We are working hard to achieve 100% in this area and have enhanced our reporting. Compliance figures are reported quarterly to our Clinical Governance and Compliance Group, and a senior doctor investigates each instance of non-compliance.

| Quarter | 2018-19 | 2017-18 | 2016-17 |
|---|---|---|---|
| Q1 | 91.7% | 90.9% | 84.1% |
| Q2 | 96.5% | 89.9% | 75.6% |
| Q3 | 92.4% | 85.9% | 88.1% |
| Q4 | 79.8% | 80.0% | 89.6% |
| Total | 89.9% | 86.6% | 84.7% |

*Table 2 VTE Compliance*

### 3.12.2 Tissue Viability

Although pressure ulcers are inevitable when caring routinely for patients who are near the end of their lives and have weakened skin, we record all pressure ulcers, regardless of origin or severity, as incidents on our Sentinel system.

All pressure ulcers are reported to the Tissue Viability Lead, who then investigates them and determines whether they were avoidable. Each is audited to ensure that all appropriate safeguards were in place. If not, we deem the ulcer 'avoidable.'

During the year, we introduced new Tissue Viability and Medical Photography policies to make our practice uniform. We also made several changes to monitoring and reporting documentation in order to reflect new guidance from Hospice UK (HUK). The main change was the introduction of a more stringent standard, that we should assess patients' pressure areas within six hours of admission. Our standard previously had been to assess within 24 hours.

Our Tissue Viability Lead also trialled some new products to assist with elevating patient heels and for patients in wheelchairs, to help them to be more comfortable when out of bed.


### 3.12.3 Falls

We strive to prevent our patients falling and recognise the challenge of keeping seriously ill patients safe while promoting independence, rehabilitation, privacy, and dignity. As 'Patient Safety 1st' put it in 2009, 'a patient who is not allowed to walk alone will very quickly become a patient who is unable to walk alone.'[11]

Despite our best efforts, however, falls do occur within the hospice. All our Nurses on the IPU are educated in falls prevention and, when patients do fall, how to assess risk and prevent any further injury. This includes taking a falls history as part of the admission process.

Our Falls Lead, a Clinical Nurse Manager, analyses fall incidents reported through our Sentinel system. They determine whether a falls plan had been created and correctly followed and all reasonable precautions put in place. Based on this, falls are categorised as 'avoidable' or 'unavoidable.' The Falls Lead checks that all necessary actions were carried out following the fall; for example, that the patient was seen by the Medical Team and that we fulfilled our duty of candour by informing the patient's carers.

The Falls Lead also determines whether any further precautions are required; for instance, using a 'low rise bed', or moving a patient to a different room where they can be monitored more closely.

During the year, we acquired a new low-rise bed, which can be lowered very close to the floor. This reduces the risk of patients injuring themselves if they fall from it. Aside from being very low, the new bed has several other safety features, so we decided to purchase another.

We now use pressure sensor mats when appropriate, and these have been extremely useful in alerting nursing staff when a patient at risk of falling is starting to mobilise un-aided. We did experience some problems with these devices failing from wear and tear much sooner than we expected, so we have also purchased several similar devices from an alternative manufacturer. We are very grateful to the Countess Mountbatten Hospice in Southampton for their advice with this matter.

Another improvement we have made during 2018-19 has been to put up signs in every bathroom to remind patients to ring for

[11] Patient Safety 1st (2009) "The 'How to' Guide for Reducing Harm from Falls", p. 6, available at https://www.rcplondon.ac.uk/file/927/download?token=tq5LdXuy. Accessed 18/04/2016.

assistance, emphasizing the point that the Nursing Team are very happy to help. Toileting is a recognised contributory factor to many falls, and we record this specifically in our falls data.

### 3.12.4 Medicines Management

Our Medicines Management Group supervises an ongoing programme of auditing of our prescribing and administration on the IPU and investigates all errors that are reported. This Group, under the leadership of one of our palliative care Consultants, regularly analyses and codes our medicines incidents to look for causes and trends. During 2018-19, we adopted the NHS Controlled Drug error coding scheme and introduced electronic prescribing.

For the numbers of reported medicines errors, see Page 39.

I couldn't speak more highly of the service I received. I felt incredibly fortunate to have had Lynda Smiths support on this journey.

### 3.12.5 Catheter Acquired Urinary Tract Infections

During 2018-19, three patients acquired catheter infections while in hospice. The poor health of the patients we admit to IPU – who often have several separate conditions and weakened immunities – means it is obviously not feasible to eliminate the risk of an infection resulting from a necessary catheterisation. We do strive, however, to reduce this risk to the absolute minimum.

It helped me see my way through what at first seemed like a life forever more suffocated in intense grief.
I have not completely lost my feeling of grief, but have learned what I need to do in order to better understand it and live with it

## 3.13 Risk and Incident

Our Risk and Incident Group (RIG) meets fortnightly and is chaired by either the Director of Care or the Clinical Director. The Group reviews all investigated incidents and monitors compliance with actions. It also monitors complaints and risk.

Incidents and complaints are reported and managed via our online Sentinel system. It is our policy that all incidents are reported within 24 hours of occurrence and that no more than ten working days elapse between the incident being logged and a completed investigation and recommendations being available to the RIG.

We define an incident as 'any event or circumstance arising during [St Helena] care that could have or did lead to unintended or unexpected harm, loss or damage'.

While regrettable, incidents and errors are inevitable in healthcare. Simply 'counting the number of incidents reported by an organisation does not tell you how safe they are

and should not be used to make isolated judgements about the safety of care.' As understanding the prevalence of incidents is an important part of safety and risk management, in cases of doubt, the presumption should always be to report. This way, we can build a more accurate picture of adverse events within the organisation.

During the year, we have bedded-in our new Complaints Module and made several modest improvements to our incident reporting in order to improve our handling of serious incidents and to better track referrals to third party providers.

We have also made a concerted effort to improve our response times for investigating and closing incidents in Patient and Family Services. We now generate regular reports on incidents that have been awaiting review for more than a month and send alerts to the incident owners concerned. By so doing, we have improved our compliance times.

Beginning in early 2019, we have also begun enrolling selected staff on a Root Cause Analysis training course provided by East Suffolk and North Essex Foundation Trust. This is part of a renewed focus on the quality of our incident investigations.

In Table 3 on Page 40, we present a breakdown of incidents affecting our Patient and Family Services directorate, which were closed during 2017-18.

Lorraine accurately assessed my character and personality and adapted my treatment to suit. I found her insightful, compassionate, and firm, quite often giving me much to "mull over" in just a few words. She has helped me to confront my pain and to realise that I don't need to protect others from my grief. I am at the beginning of a long journey and she has given me the tools to help me through. For now my life has no meaning, that went when my husband died, but with Lorraine's help, I know that, with patience, something will give me purpose. She has helped me to re-discover my determination and resolve, she has made me believe in myself again and she pushed me out of a terrible, terrible place.
I can face my future now, I'm no longer frightened by my thoughts, my life is what I choose to make of it- it will be good!
Thank you Lorraine.
Absolutely no improvement is required :-).

| Incident Category/Type | Bereavement | Chaplaincy | Clinical Secretariat/ Reception | Community | Community CNS | Family Support | IPU | SinglePoint | Therapies and Wellbeing | Grand Total |
|---|---|---|---|---|---|---|---|---|---|---|
| Abuse | **0** | **0** | **0** | **0** | **1** | **0** | **1** | **0** | **0** | **2** |
| **Harassment** | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 |
| **Other** | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 |
| Accident | **1** | **0** | **0** | **4** | **0** | **2** | **93** | **0** | **3** | **103** |
| **Injury** | 0 | 0 | 0 | 3 | 0 | 0 | 4 | 0 | 1 | 8 |
| **Moving and Handling (load)** | 0 | 0 | 0 | 1 | 0 | 0 | 2 | 0 | 0 | 3 |
| **Moving and Handling (patient)** | 0 | 0 | 0 | 0 | 0 | 2 | 25 | 0 | 0 | 27 |
| **Other** | 1 | 0 | 0 | 0 | 0 | 0 | 5 | 0 | 0 | 6 |
| **Slip Trip or Fall (Non-patient)** | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 2 |
| **Slip Trip or Fall (Patient)** | 0 | 0 | 0 | 0 | 0 | 0 | 55 | 0 | 2 | 57 |
| Clinical Incident | **0** | **0** | **0** | **19** | **2** | **1** | **174** | **4** | **2** | **202** |
| **Clinical Admin Error** | 0 | 0 | 0 | 2 | 0 | 0 | 3 | 0 | 0 | 5 |
| **Clinical Complication** | 0 | 0 | 0 | 0 | 0 | 1 | 2 | 0 | 0 | 3 |
| **Delayed District Nurse Visit** | 0 | 0 | 0 | 3 | 0 | 0 | 0 | 0 | 0 | 3 |
| **Inadequate clinical care** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 2 |
| **Medical / Nursing Notes not available** | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 2 |
| **Medicines error** | 0 | 0 | 0 | 3 | 0 | 0 | 47 | 0 | 0 | 50 |
| **Other** | 0 | 0 | 0 | 8 | 2 | 0 | 14 | 2 | 1 | 27 |
| **Pressure Ulcer(s)** | 0 | 0 | 0 | 3 | 0 | 0 | 106 | 0 | 0 | 109 |
| **Unsafe Discharge** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 |
| Communication | **0** | **1** | **0** | **11** | **5** | **0** | **7** | **3** | **3** | **30** |
| **Malicious written communication** | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |

| Incident Category/Type | Bereavement | Chaplaincy | Clinical Secretariat/ Reception | Community | Community CNS | Family Support | IPU | SinglePoint | Therapies and Wellbeing | Grand Total |
|---|---|---|---|---|---|---|---|---|---|---|
| **Other** | 0 | 0 | 0 | 10 | 4 | 0 | 7 | 3 | 2 | 26 |
| **Rudeness/Poor Conduct** | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 2 |
| **Service user dissatisfied** | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 |
| Confidentiality/IG | **0** | **0** | **3** | **2** | **3** | **0** | **7** | **4** | **3** | **22** |
| **Confidentiality Breach** | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 |
| **Data Protection** | 0 | 0 | 3 | 1 | 2 | 0 | 5 | 3 | 2 | 16 |
| **Loss of employee information** | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| **Other** | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 1 | 1 | 4 |
| Environmental/ Facilities | **0** | **0** | **0** | **2** | **0** | **0** | **0** | **0** | **0** | **2** |
| **Other** | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 2 |
| Equipment / Device Failure | **0** | **0** | **1** | **0** | **0** | **0** | **2** | **0** | **0** | **3** |
| **Equipment Malfunction** | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 2 |
| **Other** | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Fire | **0** | **0** | **0** | **0** | **0** | **0** | **1** | **0** | **0** | **1** |
| Other | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 |
| Illness | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **1** | **1** |
| **Other** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 |
| Patient Bay/Room Closure | **0** | **0** | **0** | **0** | **0** | **0** | **1** | **0** | **0** | **1** |
| **Hygiene/Infection Risk** | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 |
| Safeguarding (Adults) | **2** | **0** | **0** | **0** | **0** | **0** | **1** | **0** | **0** | **3** |
| **Neglect** | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 |
| **Other** | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| Security (inc. Theft) | **0** | **0** | **0** | **0** | **1** | **0** | **2** | **0** | **0** | **3** |
| **Keys Missing** | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 |

| Incident Category/Type | Bereavement | Chaplaincy | Clinical Secretariat/ Reception | Community | Community CNS | Family Support | IPU | SinglePoint | Therapies and Wellbeing | Grand Total |
|---|---|---|---|---|---|---|---|---|---|---|
| **Other** | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 |
| **Theft / Damage of Patient Property** | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 |
| Vehicle Incident | **0** | **0** | **0** | **0** | **0** | **0** | **1** | **0** | **0** | **1** |
| **Other** | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 |
| Welfare concern (staff) | **0** | **0** | **0** | **2** | **1** | **0** | **0** | **0** | **0** | **3** |
| | 0 | 0 | 0 | 2 | 1 | 0 | 0 | 0 | 0 | 3 |
| Grand Total | **3** | **1** | **4** | **40** | **13** | **3** | **290** | **11** | **12** | **377** |

*Table 3 PFS Incidents 2018-19*

## 3.14 Information Governance

In the past couple of years, St Helena has been focused on improving its information governance, both in preparation for the introduction of the General Data Protection Regulation and afterward.

In April 2018, we appointed a Data Protection Officer, who now holds a Certified Information Privacy Professional/Europe qualification. The DPO is supervising a programme of improvements across St Helena, as part of his wider remit as Head of Quality & Compliance.

All IG incidents are logged on our incident system and a regular report on all related matters is submitted to our Senior Management Team.

Our Records Management Group supervises all matters involving IG in our Patient and Family Services directorate.

In March, we submitted our first self-assessment for the new Data Security and Privacy Toolkit. For details, see Page 54.

## 3.15 Mandatory Training

The implementation of scheduling and more robust monitoring has helped us to maintain compliance figures above the required thresholds for the last quarter of 2018-19. We are monitoring eLearning and face to face mandatory training, including safeguarding, BLS, and manual handling.

We have rolled out an internal prospectus to allow staff easier access to book onto training courses, and we have encouraged staff to use the prospectus to support their annual appraisal.

## 3.16 Duty of Candour

The Duty of Candour was established under Regulation 20 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014 and requires providers to be open and transparent with people who use our services. It also sets out some specific requirements we must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, truthful information, and an apology. St Helena introduced a Duty of Candour policy during 2016-17 and this approach, along with the Being Open principles, is also incorporated into our incident and complaints policies and training. Duty of Candour is also a mandatory section of our incident reporting form, ensuring that all staff reporting an incident must address the issue and report what they have told the patient or carer. This also allows us to audit compliance, if necessary.

## 3.17 Complaints/Feedback

### 3.17.1 Complaints

St Helena receives thousands of referrals every year and we are very proud of our 'Outstanding' Care Quality Commission (CQC) rating (see Page 51). Nevertheless, in a very small number of cases, things do sometimes go wrong. During 2018-19, we closed fourteen complaints. We treat each complaint as an opportunity to learn and improve and these complaints are summarised, below.

**1.** A relative complained that they had not been informed of a patient's fall.

A Root Cause Analysis of the incident revealed that the Next of Kin had been informed but the complainant did not respond to further communication, so the complaint was closed.

During the investigation, some gaps in our Falls Assessment Tool became known, concerning the need for equipment such as bedrails. As a result, while the fall was unavoidable and there were no lapses in clinical care, we decided to amend the form.

**2.** The husband of one of our community patients complained that the process for accessing personal care visits had not been fully explained to him, that care from St Helena Home Care (SHHC) had been lacking, and that SHHC's communication regarding his wife's distress and pain was not reported or acted on.

Our investigation found that the complainant had not been given adequate information about the SinglePoint Team or the arrangements for care, by either the nurses who visited or the hospital staff at the point of discharge. Also, there appeared to have been a delay in applying for NHS Continuing Health Care Fast Track funding, which would have allowed the agency that was commissioned to deliver care to have started sooner.

We sent an apology to the complainant, acknowledging our failings, and explaining some of the specific learning around the incident.

**3.** We were contacted by someone who had self-referred to our Bereavement Service but had had a poor experience doing so. They complained that our staff had sounded as if they 'did not want to know,' showed no apparent empathy, and failed to contact them again following the initial waiting list letter.

Our investigation found clear failings with the tone and content of our communication in this instance, for which we apologised. The Head of

the Service gave renewed guidance to the bereavement administrators and counsellors who are involved with taking and triaging referrals about the personal manner and communication style expected when speaking with bereaved people. This will be monitored in order to ensure that it is effective.

**4.** Two daughters of a patient who died at home under our care complained that we had not given them enough practical help and guidance, particularly around signposting their mother's rapid deterioration. They also said that, although they were told by one of our staff that they could 'ring any time' to receive specialist advice and support, this had not been their experience; for instance, when SinglePoint had, on one occasion, instead advised them to call the 111 service. They also complained that our staff had not been clear about their mother's condition, had not properly addressed the specific causes of her pain, and that a staff member had been too focused on provided emotional rather than practical support.

Our investigation found that there had been communication problems, including our failure to give a clear and realistic picture of what support was available in the community from statutory care providers. We also found that the staff member who had advised the complainants to call 111 should have made the call.

As a result of the complaint, the Head of Service reiterated to the SinglePoint Team that they must make onward calls unless a patient or family member insists otherwise. The CNS Team was also been instructed to explain where their role fits in with other services and be clearer about the role of SinglePoint. We communicated all of this to the complainants in a letter of apology.

**5.** The Daughter of a patient complained about the care her mother had received between December 2016 and May 2017. In particular, she expressed dissatisfaction that two of our Clinical Nurse Specialists (CNSs) had not kept to appointments, that one had been slow to return calls, and that other care had been delayed.

Another concern was that one of the CNSs had been inexperienced and had given inappropriate advice. The complainant further complained that she had been given no support or guidance about caring for her mother and that she had been told that her mother was not ill enough for admission. Finally, the complainant expressed dissatisfaction with the local healthcare system in general.

Our investigation found that one of the CNSs involved had deferred an inappropriately high number of appointments and had provided a level of service that fell short of our expectations. This CNS has since left us. In the case of a second CNS, while inexperienced and clearly unable to provide the assurance and confidence the complainant required, they were found to have been diligent and professional throughout. We also found that the patient had not met the criteria for an IPU admission and that their documented preferred place of care was home. Nevertheless, we apologised if these criteria had not been explained clearly enough.

Our Director of Care sent the complainant a letter explaining our findings, providing a documented timeline of care given, and apologising for any distress or unhappiness the complainant felt.

**6.** A lady complained to us that treatment had extended her mother's life contrary to her mother's wishes. She further complained about the discharge planning for her mother; expressing her view that discussions had begun two soon after admission and that her CNS did not make clear that if her mother's condition stabilised other care options would be discussed. The daughter also complained that she had not been advised of the likely consequences of her mother being prescribed Dexamethasone or given the opportunity to refuse it, and that treatment options around her mother's diagnosis of hypercalcaemia had also not been discussed.

Our investigation found that our communication around discharge planning, the possibility of treatment lengthening life expectancy, and the effects of Dexamethasone had indeed been poor and, as a result, we made amendments to our Admissions & Discharges Policy and Admissions Template to improve this. Our Clinical Director sent a letter of apology to the complainant, acknowledging what had gone wrong and the distress it had caused, and outlining the action we had taken.

**7.** We received a minor complaint from a patient concerning noise outside their room caused by domestic staff. We sent a communication to our IPU Nursing Team, reminding them of the need to be as quiet as practicable when outside patient rooms.

**8.** This was raised as a concern, but we chose to treat it as a complaint. Patients at one of our Friendship groups complained when we had to cancel a session. The cancellation was forced on us by a lack of staff that day with enough manual handling and Basic Life Support (BLS) training.

As a result, we have amended our Resuscitation Policy so that more staff will have BLS training. We will also ensure that Family Support staff receive manual handling training.

**9.** We received a complaint from the Cheviot nursing home, concerning what they saw as our unsatisfactory discharge of a patient back into their care. The substance of their complaint was that we had not prescribed appropriate medications and had given inadequate advice via telephone.

Our investigation found that the prescribing by one of our junior doctors had been inadequate, that our communication had been unclear, and that we did not prescribe anticipatory medications because we believed, incorrectly, that the patient was not actively deteriorating but was stable. We also found that some of the information we gave during discharge was out of date.

As a result of the incident, we gave teaching to the junior doctors around checking paperwork and *pro re nata*[12] prescribing. We also contacted the family of the patient and invited them to come to a meeting so that we could explain the circumstances of the incident.

**10.** A patient's husband raised a concern with us (which we raised to a complaint) that, despite contacting SinglePoint on several occasions to ask for help and advice, and despite being promised a home visit; no one was able to attend. The family also

[12] Medication intended to be given as and when required.

complained that, on the day of the patient's death, they were promised someone would attend; however, the patient died before this happened. Our investigation found that our failures to attend resulted from nothing other than demand on our services and that, while regrettable, nobody was at fault.

We wrote to the complainant to express our regret for the situation, explain the pressures upon our team, and discuss the fundraising efforts we were undertaking to increase staffing.

**11.** The relative of a patient raised concerns about the conduct of one of our Family Support Team, asserting that she had shown poor conduct and had acted against the best interests of his mother.

We wrote to the complainant, to express our sympathy that our care did not meet his personal expectations at a very difficult time for him and his family. However, we were unable to uphold the complaint, as we could find no evidence of poor or inappropriate conduct; finding that the staff member in question had behaved appropriately, professionally, and in his mother's best interests throughout.

We noted the complainant's wish that his mother's care be handled by someone else.

**12.** The friend of a patient complained to us, raising four issues. The first of these was that our staff should have recognised, and communicated, that a patient was dying sooner than they did. The second was that we had not given her enough information about what to expect in the final hours of her friend's life. A third complaint was that we did not sufficiently control the patient's 'distress, disorientation and delirium,' while their fourth concern was that, while she had been assured that the patient was on the waiting list to come into IPU, this was not the case.

On review, we were not able to uphold any of the four components to this complaint. On the first point, we found that our CNS had correctly interpreted the patient's symptoms to conclude that, while they were deteriorating, they were not imminently dying. A few days later, then this changed, our CNS had communicated this to the complainant, but we believe that she was, understandably, not receptive to hearing it. On the second point, our CNS did document giving guidance to the complainant on end of life symptoms.

On the third point, we concluded that we had controlled the patient's symptoms when aware of them; however, we could not reasonably have been expected to address symptoms reported to us after the fact (in this case over night) but we did respond to them as soon as was feasible. On the final point, while our CNS had raised an IPU admission as a possibility, this never progressed to concrete discussion of a referral. We regret that the complainant misunderstood this.

> The love, concern and genuine warmth that I received from your bereavement group Counsellor is incomparable.

**13.** The wife of a patient who died on IPU in the early hours of the morning complained that we had not informed her because we had not taken her mobile telephone number. While we did have her landline, she

would not hear this at night. As a result, she was unable to come to IPU as soon after the patient's death as she would have wished.

We upheld this complaint, as we found that our staff had not properly taken the wife's contact details. Our Director of Care sent a communication to relevant staff about this and we apologised to the complainant.

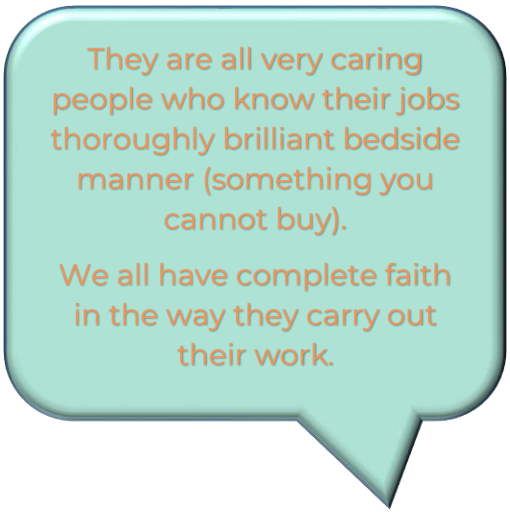
**14.** A relative was concerned that we had not accepted a referral to our IPU because we felt the patient was not sufficiently ill and that a member of our SinglePoint Team had been obstructive and unhelpful.

We partially upheld this complaint. The patient was not admitted as his symptoms were due to a chronic musculoskeletal complaint. The Medical Team judged that the chronic pain service was a more appropriate service to manage this. We explained in our letter to the complainant that, at this time there was a waiting list for IPU beds and that we can only offer beds for the management of pain and symptom control for complex end of life care.

We also found that, while the information our SinglePoint nurse was trying to provide was accurate, when challenged she did become defensive. The nurse in question and her line manager listened to this call and reflected on how the nurse might change her practice in the future. We also conveyed the nurse's apology and acknowledged that her response did not provide the support and reassurance that were needed at a difficult time

### 3.17.2 Patient Listening Day

It has been St Helena's custom, for several years, for our Service User Group (SUG) to carry out an annual satisfaction survey of recent patients and carers. Unfortunately, in recent years we have seen the response rate slowly drop, perhaps in reaction to the increased number of satisfaction surveys people are invited to complete in their day to day dealings with shops, utilities, healthcare providers, and the like.




Considering the reduced response rate, in 2018 the Chair of the SUG decided to try a new approach: A Patient Listening Day where we would invite a group of recent former patients and their carers to attend a focus group-like session. Unfortunately, our attempt to do this in February 2019 did not draw enough interest. However, at time of writing, another attempt is planned for June and the response has been more encouraging. We will report on this in next year's Quality Account.

### 3.17.3 Unsolicited Comments

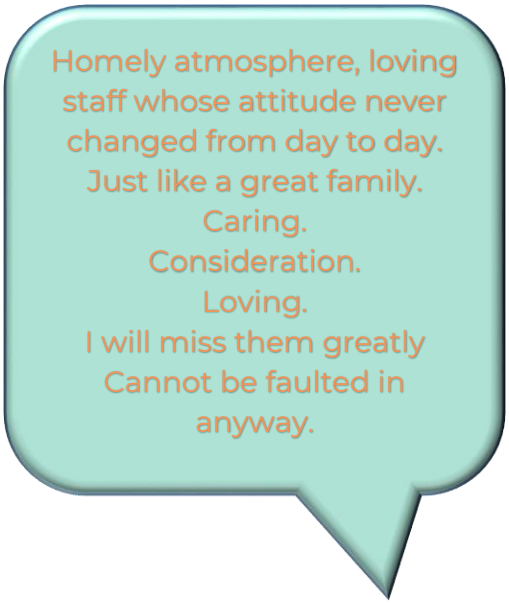
St Helena receives many cards, letters, gifts, and donations each year, which is always very heartening for staff. Following the introduction of iWantGreatCare (see Page 49), we ceased qualitative analysis of the comments we receive in cards and letters. We did this because such unsolicited communications are usually an expression of gratitude only. We do still record these comments; however, and several of them feature throughout this Quality Account.

### 3.17.4 iWantGreatCare

We have been using iWantGreatCare (iWGC) to manage user feedback since January 2016. The system is much like 'TripAdvisor', which is used in the hospitality sector. Patients and families from across all our services are invite to complete paper questionnaires, which are then sent to iWGC to be scanned and collated. Alternatively, feedback can be left on the iWGC website.

The feedback is analysed using the iWGC management interface and reports are presented to our monthly Quality Assurance and Audit Group (QAAG). These detailed reports include a breakdown of the figures for the organisation, and by service. They also include the free text comments received. In November 2018, we separated services so that each team could see their own feedback and included child feedback for bereavement and family support. Our current iWGC services are Bereavement, Bereavement Children, Community CNS, Complementary Therapies, Family Support, Family Support Children, Inpatient Unit, Rehab Team, and SinglePoint Virtual Ward.

QAAG looks for themes and trends and responds as appropriate to any negative feedback. These monthly reports allow us to react more quickly to what our constituency is telling us, thereby making us a more responsive organisation. Moreover, because the website is hosted externally, we can assure transparency. While the system has safeguards in place to protect against mischievous or vexatious comments, we cannot censor or suppress genuine and legitimate criticism (although we can respond to it on the website). To view all our comments on the iWGC website, please visit https://www.iwantgreatcare.org/hospitals/st-helena-hospice



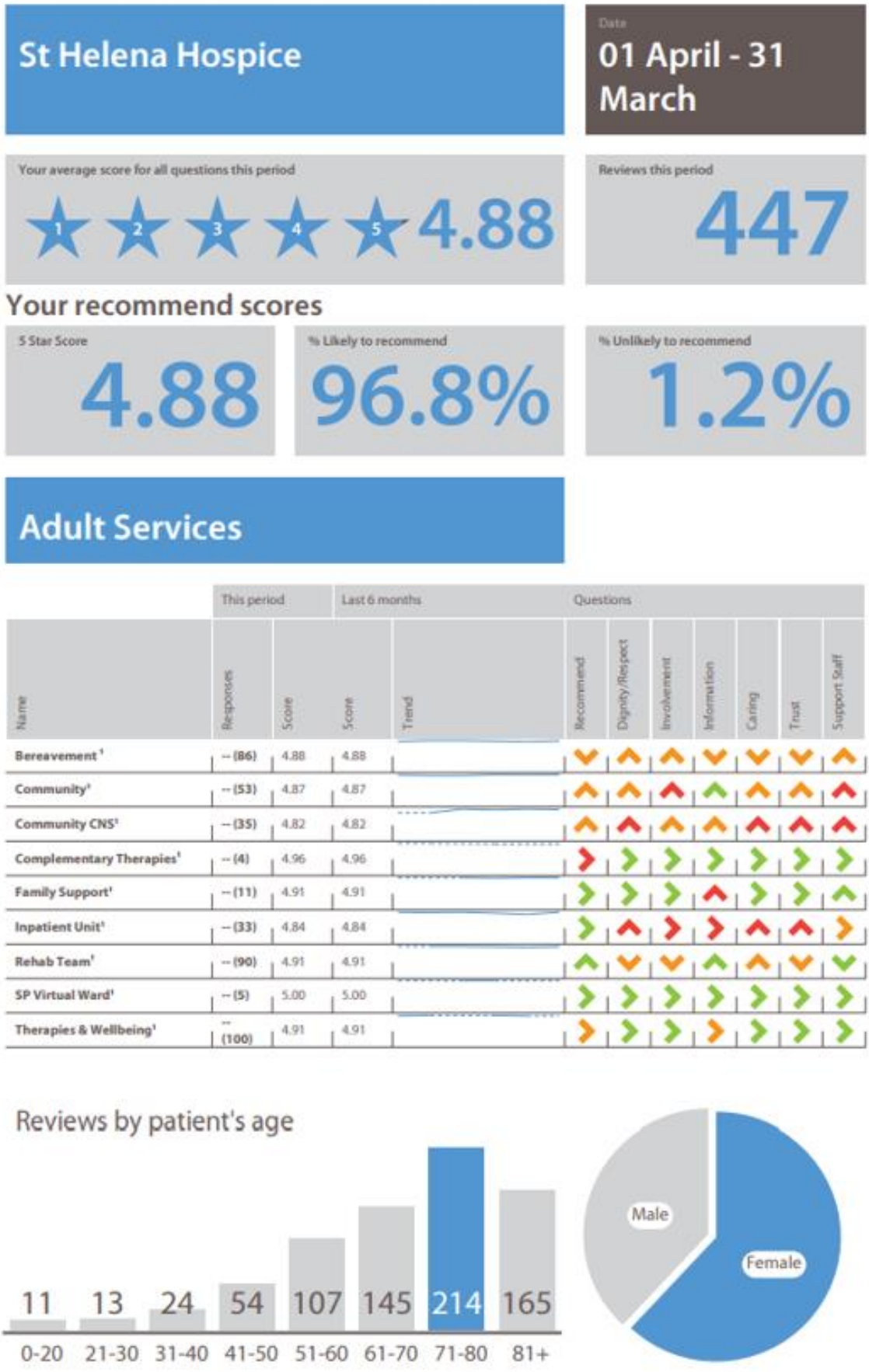



*Figure 5 2018-19 IWGC data, courtesy iWantGreatCare*

### 3.17.5 Freedom to Speak Up Guardian

Every NHS trust must have a Freedom to Speak Up (FtSU) Guardian to give independent support and advice to staff who want to raise concerns. St Helena has decided to adopt this policy as well and we have appointed our Staff Development Officer to the position.

Our Guardian will offer:

- Support and advice for staff who speak up or are supporting a colleague who is speaking up.
- Feedback on investigations and the conclusions.
- Immediate action if patient safety is compromised.

## 3.18 What Others Say

### 3.18.1 2017 CQC Inspection Report

St Helena is registered with the Care Quality Commission to provide the following regulated activities:

- Personal Care
- Treatment of disease, disorder or injury

St Helena is required to meet the Essential Standards of Quality and Safety. The Essential Standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. The CQC regulate us against these standards.

Our most recent evaluation by the CQC was in November 2016, when we underwent a two-day unannounced inspection. This was then followed up in February 2017 with another two days during which the CQC spoke to a number of people who use our services.

We were subsequently rated 'Outstanding' –the highest rating that the CQC can give. The full report is available from the CQC website using the link below. In summary, the inspectors found that 'People received excellent care based on best practice from experienced staff with the knowledge, skills and competencies to support their complex health needs' and that our service has,

"a strong person centred approach. People's dignity was supported and staff treated people with respect at all times. Staff were exceptional at helping people to express their views. People and their families who received care, treatment and support from St Helena could not speak highly enough about the staff who supported them. People who were challenged in coming to terms with a life limiting illness or a terminal diagnosis told us repeatedly that they were enabled to manage their condition and their emotional wellbeing because of the excellent care and support received from various departments within SHH. Staff were exceptionally kind, caring and compassionate. People we spoke with were only too pleased to share their stories of compassionate appropriate care, treatment and support."


*Figure 6 CQC 2017 assessment*

Link: [http://www.cqc.org.uk/location/1-116828568](http://www.cqc.org.uk/location/1-116828568)

You gave him dignity, comfort and respect and enabled me, as the main carer, to have time out to recharge my batteries.
I'm particularly grateful to the love, care, kindness and support shown by our specialist nurse, Emma Mazerolle throughout my husband's illness and especially in his final days. Without her emotional support, knowledge and expertise in symptom control I would not have been able to cope during the difficult times. I will never forget all she did for us. She went above and beyond the call of duty. She is a great asset to the hospice.

Not a thing could be improved. I had such a marvelous care. I couldn't ask for better care. I always thought hospice was somewhere you come to die but its far from the case. I wish everyone here the best Christmas they could ever have. I have been so happy with everything they do for you. And wish them all the best for the future and everything.

### 3.18.2 Statement by Healthwatch

Healthwatch Essex is an independent organisation that works to provide a voice for the people of Essex in helping to shape and improve local health and social care. We believe that health and social care organisations should use people's lived experience to improve services. Understanding what it is like for the patient, the service user and the carer to access services should be at the heart of transforming the NHS and social care as it meets the challenges ahead of it.

We recognise that Quality Accounts are an important way for local NHS services to report on their performance by measuring patient safety, the effectiveness of treatments that patients receive and patient experience of care. They present a useful opportunity for Healthwatch to provide a critical, but constructive, perspective on the quality of services, and we will comment where we believe we have evidence – grounded in people's voice and lived experience – that is relevant to the quality of services delivered by St Helena Hospice. In this case, we have limited feedback about services provided by the Hospice, and so offer only the following comments on the St Helena Hospice Quality Account.

- HWE is encouraged to see such an impressive quality account and the continued use of the hospice 'Our Values' approach.
- HWE is very impressed by the commitment of the hospice to its patients, carers, family members', volunteers, staff and the community it serves.
- HWE is encouraged by the development of the new priorities which continue to support and deliver last year's priorities around reaching out, empowerment, more excellent personalised care at home and support services around death and bereavement.
- HW Essex recognises the lead role St Helena is playing around the new whole system approach to health & social care in North East Essex. The role around the Alliance and areas of growth which support the wider Health & Social care infrastructure.
- HW Essex supports the creation of End of Life champions to work alongside the primary care hubs which will lead to great access to community care, support and information.
- HW Essex recognises that progress has been made across a few work pathways that have yet to achieve the desired outcome. HW Essex would support the hospice in its continued effort to deliver these future outcomes.
- HW Essex is encouraged by the range of Lived Experience being shared by patients, carers and family members.
- Finally, HWE recognises the value placed on the volunteers and the opportunities available to them to play a strong role in the life of the hospice.

Listening to the voice and lived experience of patients, service users, carers, and the wider community, is a vital component of providing good quality care and by

working hard to evidence that lived experience we hope we can continue to support the encouraging work of St Helena Hospice.

*Dr David Sollis*
*Chief Executive Officer, Healthwatch Essex*
*25th June 2019*


### 3.18.3 Statement by St Helena User Group

The St Helena Service User Group (SUG) comprises volunteers who have had some experience of the hospice services, either directly or indirectly. We use that experience to assist the professional clinical teams to develop quality services that are focussed on the patients and families' needs. As such, we congratulate the Hospice staff on their incredible work in bringing excellent end of life care to more people while also improving the quality of that care. We fully endorse the content of this report.

### 3.18.4 Data Security & Privacy Toolkit

During 2018-19, NHS Digital replaced the Information Governance (IG) Toolkit with a new self-certification scheme called the Data Security and Privacy Toolkit. St Helena published its first self-assessment under this new scheme on 29th March. We provided 70/70 mandatory evidence items and confirmed 30/38 assertions. As such, we are deemed to have met the required standards.

## 3.19 Contacting St Helena

If you wish to give feedback or comment on this Quality Account, please contact:

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**Chief Executive Officer**

**St Helena Hospice**

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