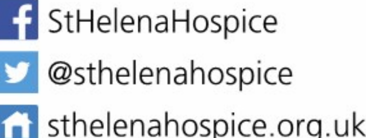
St Helena Hospice

Quality Account

2017 - 2018



Contents

Acknowledgements i
1.0 Statement on Quality 1
1.1 Statement from the Chief Executive Officer 1
1.2 Statement from Board of Trustees 1
2.0 Priorities for Improvement in 2018-19 2
2.1 Priority One: Reaching out based on need regardless of diagnosis or circumstances. 4
2.2 Priority Two: Empowering people to plan ahead, share their choices and achieve their wishes. 4
2.3 Priority Three: Providing excellent personalised care to more people in hospice beds and in the home 4
2.4 Helping life go on in the face of dying, death, and bereavement. 4
2.5 Priorities for Improvement from 2017-18 5
2.5.1 2017-18 Priority One: Embedding our New Model of Care 5
2.5.2 2017-18 Priority Two: Crisis Response 10
2.6 Mandatory Statements Relating to the Quality of the NHS Service Provided 11
2.6.1 Review of Services 11
2.6.2 Funding of Services 11
2.6.3 Clinical Audits 11
2.6.4 Participation in Research 14
2.6.5 Use of the CQUIN Payment Framework 14
2.7 Clinical Governance Structure 15
3.0 Review of Quality Performance 16
3.1 Overall Referrals to St Helena 16
3.2 Inpatient Services 16
3.3 Medical Team 16
3.4 Community Services 16
3.4.1 CNS Team 16
3.4.2 SinglePoint 17
3.5 My Care Choices Register 17
3.6 Mortality Review Group 18
3.7 Therapies & Wellbeing 18
3.7.1 Bereavement Service 18
3.7.2 Psychosocial Care 19
3.7.3 Complementary Therapy 19
3.7.4 Rehabilitation Service 20
3.7.5 Safeguarding 20
3.8 Chaplaincy 21
3.9 Education and Training 22
3.10 Quality of the Environment 22

3.11 Volunteering at St Helena 23
3.12 Quality Markers 24
3.12.1 VTE Assessments 24
3.12.2 Tissue Viability 24
3.12.3 Falls 24
3.12.4 Medicines Management 25
3.12.5 Catheter Acquired Urinary Tract Infections 25
3.13 Risk and Incident 25
3.14 Information Governance 28
3.15 Mandatory Training 28
3.16 Duty of Candour 28
3.17 Complaints/Feedback 28
3.17.1 Complaints 28
3.17.2 Service User Group Survey 32
3.17.3 Unsolicited Comments 33
3.17.4 iWantGreatCare 35
3.18 What Others Say 36
3.18.1 2017 CQC Inspection Report 36
3.18.2 IG Toolkit 36
3.18.3 Response by Healthwatch 37
3.18.4 Statement by St Helena User Group 37
3.19 Contacting St Helena 38

Throughout this Quality Account, we have included excerpts from patients' feedback on our service, gathered either from their cards and letters or via iWantGreatCare (see Page 33 for details). In all cases, it is anonymised and reproduced with only minor edits for length and clarity. We highlight it like this:

Working as a team. Everyone went the extra mile to make you comfortable and made you feel as an individual whether it be pain relief, cup of tea or going to the toilet.

They talked and listen keeping you informed.

Staff are wonderful.

Acknowledgements

Thank you to the following St Helena Hospice staff who contributed to this Quality Account. Thanks also to Stephen Lamb and Jenna Rhind-O'Neill at iWantGreatCare.

Name	Role
Ken Aldred	Chair, Service User Group and Trustee
Chris Aylott	Clinical Nurse Manager, Community
Nicola Button	Business Manager
Karen Causton	Head of IPU
Karen Chumbley	Clinical Director
Claire Dalling	Clinical Secretariat Manager
Kathryn Davies	Head of Community Services
Heidi Downs	Falls Lead
Sarah Hay	Clinical Audit Facilitator
Susan Hollock	Graphic Designer
Mark Jarman-Howe	Chief Executive Officer
Wendy Marcon	Volunteer Team Leader
Sarah May	IT Training and Reporting Administrator
Kevin McGill	Head of Estates and Facilities
Gill Moore	Chaplain
Kath Oakley	Lead Consultant
Jacquie Pamphilon	Learning & Development Officer
Liz Ritson	Occupational Therapy Clinical Rehab Team Manager
Frances Rowe	SinglePoint Lead
Laura Shukla	Head of Therapies and Wellbeing
Cherie Smith	Psychosocial Manager Adult Children & Families and Bereavement Service Manager
Kirsty Smith	Tissue Viability Lead
Jo Tonkin	Director, Patient and Family Services
David Traynier	Quality Lead
Peter Vergo	Chair of the Board of Trustees
Caroline Vince	Lecturer/Practice Educator
Sara Warnes	Infection Prevention & Control Lead

We were all reluctant and a little dubious about ....staying at a Hospice. Our ignorance gave way to preconceived ideas of a depressing, sterile facility full of dying people that would smell of bleach and over cooked cabbage. The reality could not have been further from our assumptions.

St Helena Hospice is the most uplifting and inviting environment you could ever hope to be a patient in. Firstly the building itself which is far from clinical, such beautiful surroundings and homely furnishings make all who stay or visit feel at home. State of the art facilities, home cooked, real food and an army of staff that can only be described as nothing short of heroic.

It is impossible to relay to you what this meant to us and what an amazing gift you gave to us. We effectively lived at the Hospice for those few days. The last night we spent with [our loved one] we laughed with him and cried but most importantly all four of us were holding his hands as he took his last breath.

When we alerted the nurses to [his] passing they once again surpassed any job description, they held us, comforted us and took such beautiful care of our loved one. The nurses continued to talk to [him] as if he would answer back any minute. They washed him, brushed his hair and placed a flower at his side. For the care and compassion they showed they will always have our deepest and most profound gratitude.

Hospice values

Respect
Always considering others

Working together
Finding strength in teamwork

Passionate about hospice care
Caring in all that we do and provide

Appreciation for all
A thank you matters

Valuing conversation
Taking the time to be excellent communicators

StHelenaHospice
@sthelenahospice
sthelenahospice.org.uk

Figure 1 Our hospice values

1.0 Statement on Quality

1.1 Statement from the Chief Executive Officer

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 East 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).[1] We support families, including children, pre- and post-bereavement.

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.sthelenahospice.org.uk

Mark Jarman-Howe

Chief Executive

1.2 Statement from Board of Trustees

The Board of Trustees is committed to 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 uncompromising, high standard; not only our wonderful healthcare professionals but 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

[1] See Page 9 for more details.

2.0 Priorities for Improvement in 2018-19

In this Quality Account, we review our work in 2017-18 supporting patients and families, as well as progress achieving the objectives we set ourselves last year. We also look ahead to 2018-19 and discuss our priorities for the coming year. There are contributions from a number of our senior managers reflecting upon developments in their areas of operation. We also provide activity data to paint a picture of the work we do and the demands on our services. As the discussion here concerns the quality of our provision of direct clinical care for patients and families (and relevant support services), we do not discuss important but non-clinical aspects of St Helena, such as Human Resources, Fundraising, and Marketing.

These priorities for the coming year are informed by our strategy, which became operative in 2017 and will guide us until 2022. As part of this new strategy, we have set ourselves four new strategic objectives:

- 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 and in the home.
- Helping life go on in the face of dying, death, and bereavement.

How we work to achieve this

- The care we provide will be individualised and unique.
- We will continuously improve our services to ensure that they deliver quality, flexibility, and cost effectiveness.
- We will work and act in a way that makes a positive contribution to our local community.

In the following section, we lay out our priorities for the coming year. This is followed by a review and update on progress made toward our priorities from last year.

We have developed our priorities for improvement after consulting with those who provide services as well as considering the views of our service users. Each priority relates to Domains 2, 4 and 5 of the NHS's five Domains of Quality.

- Domain 1: Preventing people from dying prematurely.
- **Domain 2: Enhancing quality of life for people with long-term conditions.**
- Domain 3: Helping people to recover from episodes of ill health or following injury.
- **Domain 4: Ensuring that people have a positive experience of care.**
- **Domain 5: Treating and caring for people in a safe environment & protecting them from avoidable harm.**

We will also guide our work in light of the six Ambitions for Palliative and End of Life Care, which have been formulated by the National Palliative and End of Life Care Partnership (NPELCP).[2] These illustrated in Figure 2, overleaf.

[2] National Palliative and End of Life Care Partnership (2015), 'Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020,' available at http://endoflifecareambitions.org.uk/wp-content/uploads/2015/09/Ambitions-for-Palliative-and-End-of-Life-Care.pdf accessed 26/04/16

01

Each person is seen as an individual

I, and the people important to me, have opportunities to have honest, informed and timely conversations and to know that I might die soon. I am asked what matters most to me. Those who care for me know that and work with me to do what's possible.

02

Each person gets fair access to care

I live in a society where I get good end of life care regardless of who I am, where I live or the circumstances of my life.

03

Maximising comfort and wellbeing

My care is regularly reviewed and every effort is made for me to have the support, care and treatment that might be needed to help me to be as comfortable and as free from distress as possible.

04

Care is coordinated

I get the right help at the right time from the right people. I have a team around me who know my needs and my plans and work together to help me achieve them. I can always reach someone who will listen and respond at any time of the day or night.

05

All staff are prepared to care

Wherever I am, health and care staff bring empathy, skills and expertise and give me competent, confident and compassionate care.

06

Each community is prepared to help

I live in a community where everybody recognises that we all have a role to play in supporting each other in times of crisis and loss. People are ready, willing and confident to have conversations about living and dying well and to support each other in emotional and practical ways.

Figure 2 Ambitions for Palliative and End of Life Care

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

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 across our community with palliative care needs who also have heart failure or dementia, promoting increased access to the My Care Choices Register (MCCR) and hospice services.

We will work collaboratively with Macmillan to deliver the Safeharbour project with an outreach Clinical Nurse Specialist (CNS) and a team of volunteers to meet the palliative care needs of under-served groups such as the homeless and others living with deprivation.

Personal attention and relaxed but professional care from every member of the team, whether they were employed or volunteers. Such a great place to spend every precious moment with people that make you feel you matter. Could not ask for more.

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

We will launch the new version of the My Care Choices Register (MCCR) and work with our Health and Wellbeing 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 (GSF) to deliver education to care homes across our community to help their staff better identify people approaching the end of life to enable them to record their choices and for their care to be coordinated.

We will work with Colchester and Tendring Borough homes to improve access to the MCCR for those who live with chronic health conditions and / or frailty within their sheltered housing schemes. We will also deliver GSF teaching to domiciliary care agencies to improve access to the MCCR for people receiving domiciliary care.

Staff very friendly and professional. All staff doctors and nurses have/make time to listen to any problems.

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

We will develop a business case for a further four beds on the IPU 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.

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

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 cooperate 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.

2.5 Priorities for Improvement from 2017-18

What a pity the government can't spend more money on places like these. We certainly need these places, don't make it profitable organisation. Right number of beds here. Lovely place keep up the good work.

2.5.1 2017-18 Priority One: Embedding our New Model of Care

This Priority related to:

- Domain 2: Enhancing quality of life for people with long-term conditions.
- Domain 4: Ensuring that people have a positive experience of care.

What We Wanted to Achieve

No matter how valuable and valued hospice services are, SHH must not be complacent. If SHH is to continue to be an effective and respected leader in the local health and social care arena, we must be ready to respond to the rapidly-changing terrain of modern British health and social care.

The UK's shifting demographics means that we are living longer, with a range of complex needs and demands that challenge the traditional model of hospice care. We are likely to see more life-prolonging treatments in cancer care, more complex interventions to ameliorate a range of chronic morbidities, and a rise in the incidence of dementia. More people will be recognised as needing palliative care and so seek hospice care, but their needs are likely to be very different from those that are currently commonplace, demanding from hospices new skills and new models of care.

At the same time, the UK is moving to a more outcomes-based approach and SHH will need to adopt both health and social care outcome measures as a way of ensuring that people are getting what they need from us. It will also ensure we are ready to access any statutory funds through health and social care using an outcomes-based approach.

We have identified four key areas of performance:

1. *Ensuring good outcomes within an integrated care landscape.*
2. *Ensuring fairness in the light of changes to commissioning models.*
3. *Ensuring choice in the light of changes in epidemiology and demography.*
4. *Ensuring provider sustainability in the light of competition and private sector interest.*

Although SHH has always had criteria for referral based on recognised Specialist Palliative Care definitions, we've never worked to a structured model of care. The aim, therefore, is to develop an integrated health and social care model, adopting the principles from Essex County Council's Good Lives approach and outcomes for social care and embedding the Outcome Assessment and Complexity Collaborative (OACC) Suite of Measures (recognised by NHS England) across Patient and Family Services.

The overarching premise and philosophy of the new model is the recognition by all staff and volunteers that patients and families are the experts. We certainly have knowledge, skills and expertise to help support patients and families but we need to be prepared to accept that we are NOT the experts when it comes to the lives of the people we meet.

The purpose of developing a new model will be to bring clarity to the work we do, provide a clear structure and process for caseload holders to work within, to move away from a paternalistic, clinical model and to

introduce an enabling and empowering approach for patients and families to live their lives and to ensure greater access for patients and families in need of our support.

It will mean an adjustment in our culture and traditional thinking, as well as a total review of our referral, assessment and key-working policies and procedures. Our staff will need, in the first instance, to be able to look to themselves to change and adapt, while challenging each other in any ongoing misconceptions around adapting to and changing within the new philosophy of care. This new model will enable our services to be aligned equally with both health and social care models, commissioning and approaches to care.

A project group has been set up, so that all associated policies and procedures can be developed, training and education needs identified, and the model embedded within our teams as seamlessly as possible. We will also need to ensure our communication around the new model is clear to all stakeholders.

St Helena Hospice model of care

Figure 3 Model of Care (Original Version)

What We Have Achieved

We introduced our new Model of Care (MoC) in April 2017, in order that we could continue to fulfil our purpose statement of 'Helping local people with incurable illness live well and die with dignity and choice,' even in the face of rising demand.

It is the UK's shifting demographic profile that is creating this rising demand; we are living longer, with a range of complex needs and demands that challenge the basis upon which hospice care traditionally has been provided. More people are being recognised as needing palliative care and we know that the future will bring more life-prolonging treatments in cancer care, more complex interventions to improve a range of chronic morbidities, and a rise in the incidence of dementia. More people are seeking hospice care, but their needs are changing, demanding from hospices new skills and new ways of working.

The new Model was launched on the premise that we needed to change our assumption that people need hospice services on an ongoing basis or that all patients needed us. We saw a need to focus our attention on delivering a service that enabled people to help themselves when they needed to; and to provide ongoing care only when and if required. This very closely follows Essex County Council's 'Good Lives Approach' for social care, where the emphasis is on patients' and families' assets and strengths rather than deficits and process.[3] The intention behind Good Lives is to work with the patient to co-produce a system of support, including supporting networks of friends and relatives, to enable them to be safe, well, and happy within their own homes. This approach incorporates the 'Three conversations' model to needs assessment and care planning focusing primarily on people's strengths and community assets.[4]

Conversation One

What do you want to do? What can we connect you to?

This revolves around looking for ways to maximise people's existing support networks; for example, their families, friends, neighbours, and GPs; as well as hospital teams and district Nurses.

Conversation Two

What needs to change to make you safe? How do we help to make that happen?

What resources do we have at our disposal to support you? How can we pull them together in an 'emergency plan' and stay with you to make sure it works?

This conversation focuses on sourcing alternative or additional support services; for example, voluntary and community groups.

Conversation Three

What does a good life look like? How can we help you use your resources to support your chosen life? Who do you want to be involved in good support planning?

This conversation covers providing hospice support to the patient, usually following a model of six sessions of care. We 'stick like glue' to the patient to ensure we identify their needs and problems at the outset and have met these by the end of the six sessions.

The overarching aim of this three-conversation model, therefore, is to enable, equip, and empower people by maximising their existing support network and sourcing alternative support from other agencies. This has been delivered through a six-session care model that supports patients and their families to identify key issues, plan the appropriate interventions, and reach goals by the end of the sessions.

The new Model of Care has been a huge cultural shift for some members of the St Helena multidisciplinary Team and, while it fits with our broader strategy and direction of travel, it has created some tension within teams and for some individual members of staff. After nine months of working in this new way, it was important that we review the new model to see if it had in fact helped us to achieve our strategic priorities without damaging patient care and experience. Reassuringly, we are meeting the needs of more people and continuing to provide a high-quality service; however, there have been some issues

[3] For details, see https://www.livingwellessex.org/vision/cross-cutting-initiatives/good-lives-approach/good-lives-model/

[4] For details. See https://www.scie.org.uk/future-of-care/asset-based-places/case-studies/three-conversations

that have arisen that have made it harder for patients to navigate to the right person in our teams. On occasion, we have created barriers that have meant that our service is not led by each individual person's needs. As a result, we have made some recommendations for slight adjustments to the model to resolve these issues:

- Through the Multidisciplinary Team (MDT) teaching programme, clinical teams will re-visit the Good Lives/ Three Conversations approach to further develop their knowledge and experience of promoting of independence.
- The six-session model should be seen as a flexible guide rather than a rigid requirement; thereby enabling professionals to make a joint decision with patients as to whether more or fewer sessions (or a different frequency of visits) is required.
- The method of patients making contact with the team member who managed their spell of care will be reviewed by clinical teams urgently. A contact card outlining such for patients and carers will be provided to reduce the number of unnecessary calls coming through directly to CNSs, Allied Health Professionals (AHPs) or Doctors. Emergency and other calls will instead be channelled through SinglePoint.
- Patients who are referred to the CNSs will be managed on an active or maintenance caseload allowing CNSs to continue to lightly monitor a small number of patients beyond six sessions.
- The MDT will be able to make direct referrals to team members on the basis of clinical need without a further triage system
- Productivity and activity will be monitored quarterly, to ensure that caseload management does not deteriorate.
- Clearer written communication is required to GPs and hospital teams regarding the level of assessment undertaken and the level of intervention planned.

The revised model is demonstrated in Figure 4 on page 9, below. We will continue to monitor our progress.

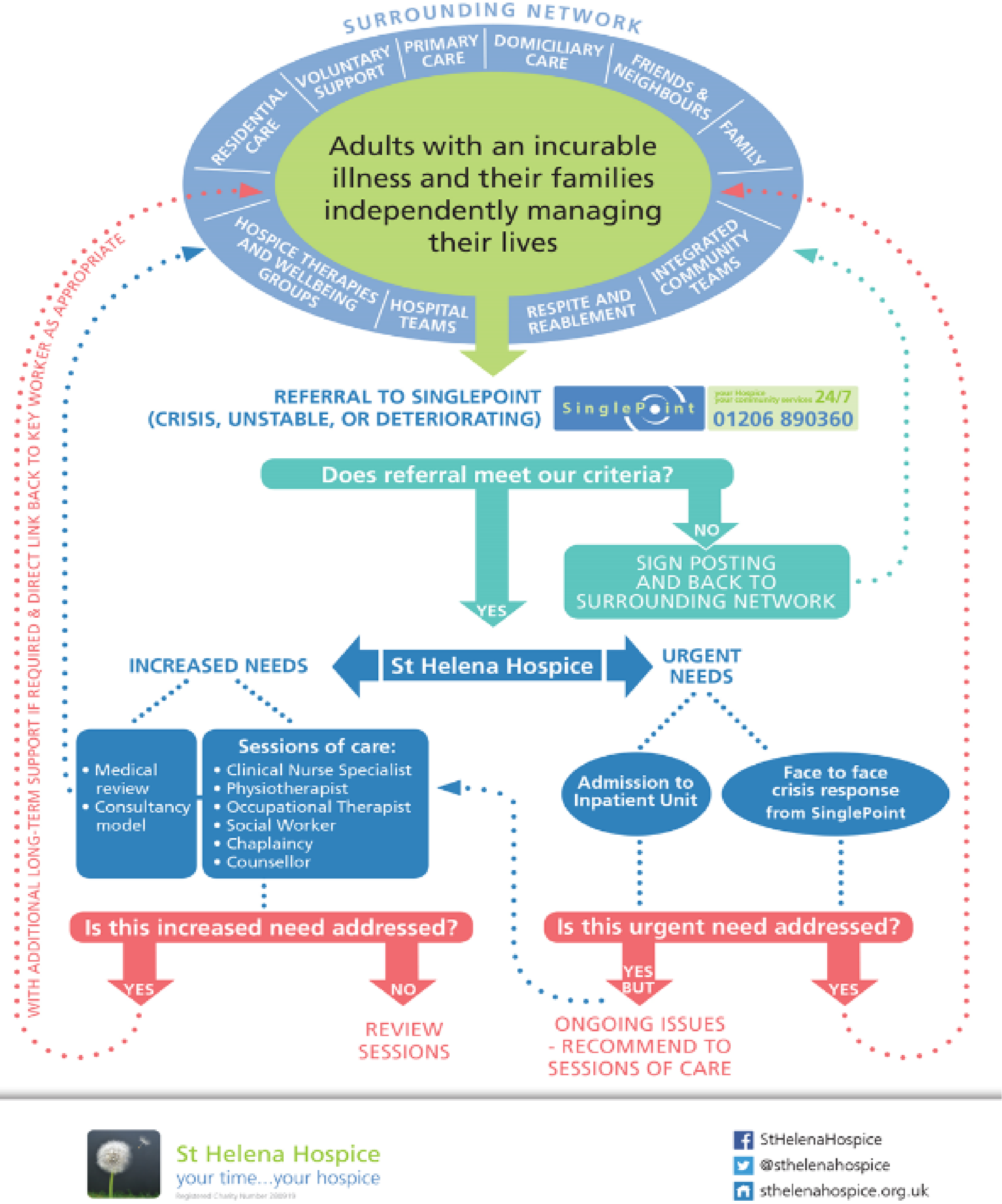


Figure 4 Model of Care (revised version)

You are always treated with respect confidence and moods are always lifted by the group and look forward to meeting. Nobody is forced to impart information if they don't want to.

2.5.2 2017-18 Priority Two: Crisis Response

This Priority relates to:

- Domain 2: Enhancing quality of life for people with long-term conditions.
- Domain 4: Ensuring that people have a positive experience of care.

What We Wanted to Achieve

A key factor in ensuring that the SHH model is effective lies in ensuring that robust systems are in place to help patients and families at moments of crisis. 'Crisis' is defined as

"…a perception or experience of an event or situation as an intolerable difficulty that exceeds the person's current resources and coping mechanisms."5

Possible causes of crisis in palliative care include:

Physical

- *Symptoms (e.g. severe pain, dyspnoea, terminal secretions).*
- *Palliative care emergencies (e.g. haemorrhage, superior vena cava obstruction, spinal cord compression, hypercalcaemia).*
- *Practical problems (e.g. care/ equipment/ medication/ managing practicalities of elimination, nutrition).*
- *Uncertainty about disease stage; i.e. whether or not the cause is reversible.*

Social

- *Social isolation/ family dynamic issues/ carer exhaustion.*
- *Care provision.*

Psychological

- *Anxiety and fear - patient and family/ terminal agitation.*
- *Fear of loss and abandonment.*

Spiritual

- *Speed of decline - inadequate preparation and planning.*
- *Helplessness/hopelessness in difficult situation or loss of faith.*

SinglePoint receives phone calls 24/7, 365 days of the year, some of them from patients and families who are experiencing a situation that is becoming overwhelming. A survey of the clinical literature on crisis suggests that successful response depends upon the following:

a) *Establishing a therapeutic relationship.*
b) *Clearly defining the problem.*
c) *Exploring the feelings associated with the problem.*
d) *Reviewing previous attempts to resolve the crisis.*
e) *Exploring alternatives and developing an action plan.*

SinglePoint is staffed largely by Registered Nurses (RNs) with a smaller number of Clinical Nurse Specialists (CNSs). Our response in a crisis will employ the most appropriate professional available in the timeliest way.

[5] Richard K. James, Burl E. Gilliland (2001) (4th ed.) "Crisis Intervention Strategies", Brooks/Cole Thomson Learning, p. 3.

What We Have Achieved

SinglePoint is committed to responding to crisis situations by using Registered Nurses (RNs) and Clinical Nurse Specialists (CNSs), who are also prescribers, to provide face-to-face visits in a timely manner. The Team continues to work closely with other community services to provide patients with a prompt response to a change in healthcare needs.

> *The professional staff and volunteers are all so caring and seem to have all their time for you and nobody else.*

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

2.6.1 Review of Services

During 2017-18, 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, 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, Cancer Group, Fatigue, Relax and Move, and Walking.

2.6.2 Funding of Services

St Helena is an independent charity, which during 2017-18 provided its services largely free of charge to the end user. Our income from the NHS in 2017-18 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.

> *I felt that I could say anything I wanted and they listened, where as friends listen to a degree but not the same way and felt she always gave me an answer. I hear her voice in my head sometimes when I'm having a bad day and I think of what she told me.*
>
> *It's just so nice to think that someone cares and will listen, and it didn't matter how upset I got.*

2.6.3 Clinical Audits

2.6.3.1 National Audits

During 2017-18, no national clinical audits and no National Confidential Enquiries covered NHS services that St Helena provides.

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 2017-18, we updated our Clinical Audit Policy and Procedure to include enhanced data protection guidelines. Most notably, we also recruited a Clinical Audit Facilitator who, while still only new in post, has already helped us improve the number of audits carried out and the support available to staff.

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

Controlled Drugs Accountable Officer Self-Assessment

This was a yearly audit completed by the Controlled Drug Accountable Officer (CDAO), the Head of Inpatient Services. The audit highlighted the need for risk assessment to be undertaken to understand the risk of undertaking CD stock check only once a day. A subsequent assessment showed this risk to be low, therefore no further action was required

Unknown Diagnosis Audit

In 2016-17, 7% of referrals to the hospice had an unknown diagnosis on reporting. This audit investigated why there was a significant rate of unknown diagnosis and suggested methods to improve record-keeping.

The following reasons were found for an uncoded primary diagnosis:

1. Free text entry rather than diagnostic code 26%
2. Patient not seen / died before being seen 28%
3. Patient declined referral 6%
4. Referral declined as out of area 14%
5. A bereavement referral incorrectly coded as a patient 14%
6. Diagnosis present, unknown reason for recording error 4%
7. Home care or Complementary Therapies only 6%

Management of Controlled Drugs

The purpose of this audit was to ensure that St Helena continues to meet the legislative requirements surrounding the use and storage of Controlled Drugs (CDs), including the Misuse of Drugs Regulations (amended 2007), The Health Act (2006), and the Controlled Drugs (Supervision of Management and Use) Regulations 2006. It is an annual audit of our policies and procedures relating to the ordering, storage, recording, prescribing, administration, and destruction of CDs such as morphine, and was carried out by the St Helena Controlled Drug Accountable Officer (CDAO). We used the Hospice UK audit tool, which consists of six modules. Our compliance is given in brackets.

1. Adequacy of Premises/Security (100%).
2. Procurement (100%).
3. Examination of stock held (100%).
4. CD Register, Records and Audit (100%).
5. Prescribing of Controlled Drugs (100%).
6. Administration of CDs (95.2% - We were non-compliant with one question).

Management of General Medicines

As an organisation we have agreed that an audit of this type examining our policies and procedures will be undertaken yearly to ensure that St Helena continues to meet the legislative requirements surrounding the use and storage of non-controlled medicines. We used the Hospice UK General Medicines audit tool, which consists of seven modules. Our compliance is given in brackets.

1. Standard Operating Procedures (SOPs) (100%).
2. Purchasing and Supply of Stock Medicines (100%).
3. Storage and Destruction of Medicines (100%).
4. Prescribing of Medicines (100%).
5. Administration of Medicines (100%).
6. Patients' own Medicines (100%).
7. Non-Medical Prescribers (100%).

Spirituality Needs Assessment on IPU

This audit was commissioned to ascertain how well this element of care is being delivered and evidenced on our IPU. Spiritual care is an integral part of holistic care; however, it has previously been labelled the 'poor relation' of clinical care.

15 patient records were randomly selected from admissions during November 2017. The audit found that, while spiritual care is being given, the documentation and evidence for this is sporadic and recorded in disparate locations within the record. This audit recommended further staff training, a mandatory spiritual care plan, and the development of a spiritual care policy and procedure (see Page 21 for more detail).

Impact of the New Model of Care on the Medical Caseload

The new Model of Care was introduced across the directorate earlier this year. This audit was to investigate whether the Medical Team was compliant with the new Model and if it had impacted on referrals to the Team or the profile of patients seen.

The Medical Team had undergone a number of personnel changes but a comparison of our capacity during July 2016 and July 2017 showed it had not significantly changed. For each month, the Team has approximately twenty contacts available each week.

1st class treatment all along the line and big thank you. I'm about again and able to look after myself. Thank you all

Dry Mouth Audit

Dry mouth and painful mouth are common oral problems in palliative care. They may result from poor oral intake, drug treatments, local irradiation, oral tumours, or chemotherapy.

Oral symptoms may significantly affect the person's quality of life, causing eating, drinking, and communication problems, and oral discomfort and pain.

Simple saliva stimulation measures to treat dry mouth were recommended, such as cold unsweetened drinks, ice cubes, smearing petroleum jelly on the lips, and sugar-free chewing gum or sweets. However, patients may also need drug treatment to alleviate their symptoms. The internal standard is that all patients reporting sore or dry mouth should receive an intervention like Glandosane spray, Biotene gel, Fluconazole or Nystatin to alleviate this.

The purpose of this audit was to look at the drug management of dry mouth symptoms and check how well we are managing this. Data was collected between March-May 2017 using IPOS (Integrated Palliative Care Outcome Scale) data and SystmOne records from all inpatient admissions during this time. Patients included were those that had at least 2 IPOS scoring for dry mouth on admission and at subsequent review.

The results found that 60% of the included patients had improved with proper oral care, indicating that we are reasonably good at managing dry mouth symptoms. However, the results also showed that not all patients had an initial IPOS assessment on admission and/or the recommended follow up, meaning that those patients were excluded from the study and this contributed to the small sample group.

The auditors therefore recommended that IPOS be included as standard in all inpatient care plans on admission as well as followed up as recommended by OACC (Outcome Assessment and Complexity Collaborative). Treatment recommendations were also made on the findings from this audit.

Prescribing accuracy audit

This re-audit was carried out following the previous audit in January 2017.

The original audit was carried out in October 2015, following concerns raised by both the Medical and inpatient Nursing Teams regarding the accuracy of prescriptions and the correct completion of drug charts with respect to administration of records on the inpatient unit (IPU). A number of errors had been reported to the Risk and Incident Group and a decision had been made by the Medicines Management Group to look urgently at the issue.

The previous re-audit in January 2017 had shown a rise in the number of prescribing errors (none of which resulted in any patient harm), but a fall in the number of administration errors to very low levels. The recommendation at this time was re-audit in six months.

The audit was carried out via an unannounced spot check of drug charts on the IPU. Findings from this audit have shown a rise in the number of prescribing errors (none of which resulted in any patient harm) and a further fall in the number of administration errors, to 0.8% of drug charts checked.

We are hoping to introduce electronic prescribing to the IPU in the autumn of 2018 and this should eliminate entirely a number of the more trivial clerical errors, for example correct notation of allergies on every page of the record.

Recommendations following this re-audit include emailing the Medical Team to remind them of the importance of correct documentation on the prescription charts (particularly with regard to allergies), and that when a new drug is prescribed they ensure it is dated correctly.

Rapid response visits performed by the SinglePoint Team

This audit was carried out in order to accurately quantify the time spent carrying out ‘rapid response’ visits by the SinglePoint Team, who requested them, and how much time staff spent following each visit liaising with other healthcare professionals, ordering equipment, and requesting care.

Each SinglePoint Community Nurse Specialist (CNS) and Registered Nurse (RN) logged their activity on an audit tool (designed by the Quality Lead) during November 2017-January 2018 and the data was then combined and analysed.

The results showed that, overall, the majority of rapid response visits were requested by the shift co-ordinator, as opposed to the Referrals Team.

The data illustrated that, while visits, and the travel they required, took up the most time overall, the most time-consuming single activity was writing up visit notes onto our electronic patient record, SystmOne. All other administrative tasks (combined) undertaken following a visit do not take the time that the writing-up of notes does.

2.6.4 Participation in Research

There were no appropriate national, ethically approved research studies in palliative and End of Life care in which we could participate during this period.

2.6.5 Use of the CQUIN Payment Framework

St Helena income in 2017-18 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because we do not use any of the NHS National Standard Contracts.

I was surprised at the speed you made contact.

I was surprised at the advice and support that you quickly advised me.

I am surprised at the wealth of support services you provide.

I know I am in the early stages of my cancer demise but you provided the information that has left me relaxed about my future.

2.7 Clinical Governance Structure

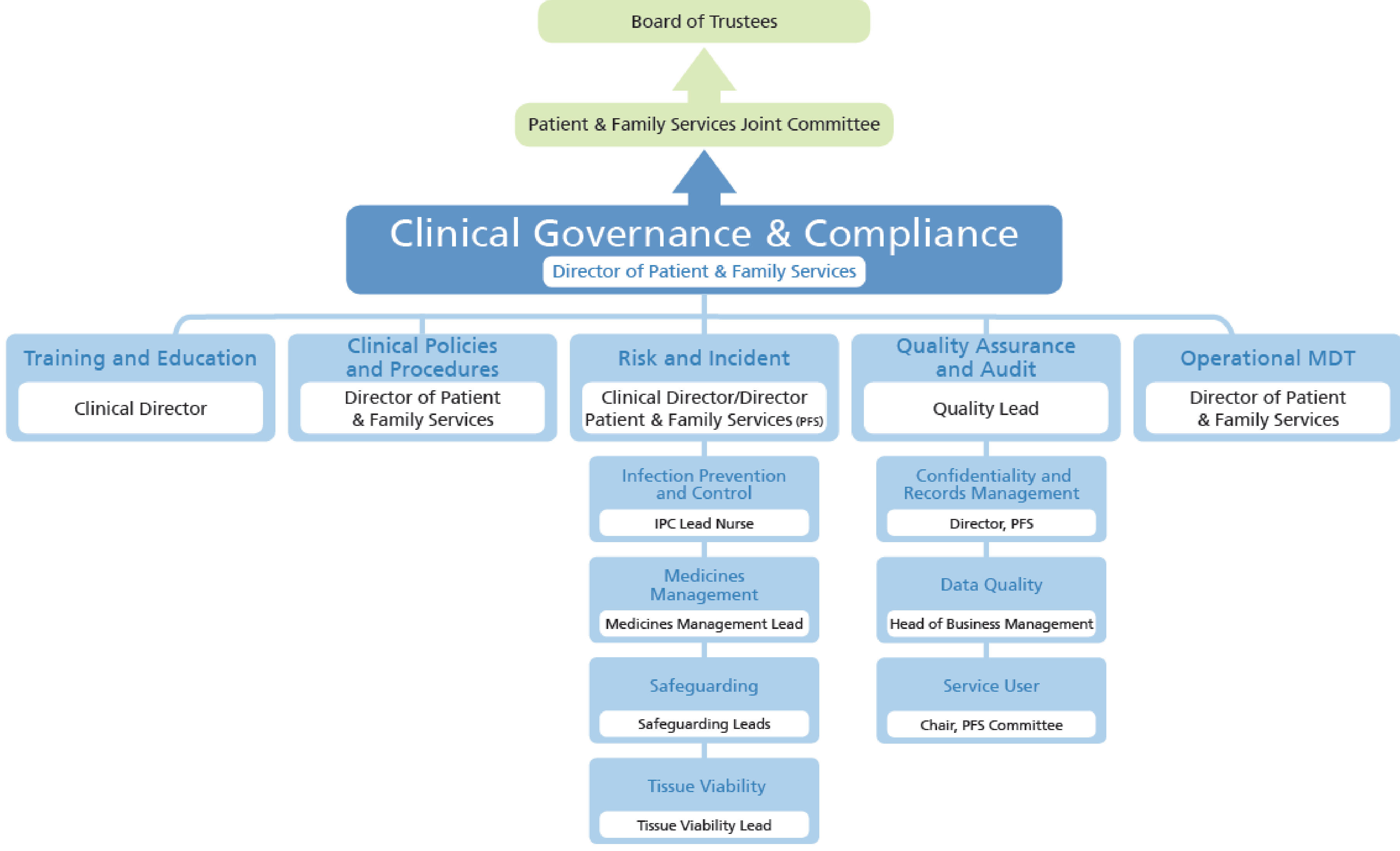


Figure 5 Clinical Governance Groups, April 2018

3.0 Review of Quality Performance

The item that stands out most is that you are human and are treated as such. Your comments count and fears are dealt with in a very calm manner which in turn makes you feel of value. Keep up the good and very valued work

3.1 Overall Referrals to St Helena

Quarter	No. of referrals in 2017-18
1	1793
2	1755
3	1989
4	1905
Total	7442

Figure 6 Overall referrals

3.2 Inpatient Services

St Helena's Inpatient Unit (IPU) is located at our Myland Hall site in Colchester. In the IPU, patients and families have access to our Doctors, our Rehabilitation Team, Complementary Therapies, our Counsellors, our support workers, and our Chaplaincy Team. The IPU provides specialist care and support for up to 16 patients in two four-bedded bays and a number of single rooms with en-suite facilities. We can also provide some limited accommodation for patients' families.

We admit people to IPU for a number of reasons. It might be to remedy physical symptoms such as pain or nausea and then, with the help of the Community Team, to help them return home as soon as possible. We might also admit to provide emotional or spiritual support or it may be because the person has stated that the IPU is their preferred place to receive End of Life care.

We opened our 16th bed in December 2017, which was commissioned by North East Essex Clinical Commissioning Group as part of their Winter Resilience Project. We've used this bed to care for patients transferred to us by Colchester General Hospital's Palliative Care Team. We are currently applying for funding to keep this 16th bed open and we're also working across the Hospice to increase our bed capacity to 20.

3.3 Medical Team

The Medical Team has expanded and, since August 2017, two junior Doctors at a time have worked on the IPU, in four-month rotations. This has given the Team greater flexibility for dealing with patient admissions and provided these Doctors with excellent training in End of Life care, which they can take to future positions.

Four GPs have enjoyed the opportunity of a fixed-term placement within the Medical Team. These were designed to allow them to learn more about palliative care and two of these GPs are currently completing qualifications in this area. This collaboration has allowed joint working with primary care, promoting palliative care in the community.

We have also worked with the Essex Partnership University NHS Foundation Trust[6] to bring palliative care expertise to the wards for people with advanced dementia. People living with dementia have traditionally received less palliative care than those without and this project helps us begin to remedy this inequality.

This year, a member of the Medical Team has taken a lead in palliative care for people who are living with heart failure. We have worked with Anglian Community Enterprise (ACE) to identify people with heart failure who may benefit from palliative care and we are starting to see the numbers referrals rise.

3.4 Community Services

The Community Services Team has undergone a number of changes this year and has adjusted in size in order to meet demand. The Head of Community Services role has been frozen while, beginning in May 2018, the current holder takes up a Nurse Consultant role. The current Clinical Nurse Specialists Lead and the SinglePoint Lead now manage their teams with support from the Director of Patient and Family Services.

3.4.1 CNS Team

The Clinical Nurse Specialist (CNS) Team now works to the Model of Care and, as a result, they are more responsive to new referrals and have

[6] EPUT provide community health, mental health and learning disability services for approximately 2.5 million people throughout Bedfordshire, Essex, Suffolk, and Luton.

more manageable caseloads. We have also created two new developmental CNS posts, based in Colchester.

The CNS Team has continued to provide 'Dealing with Dying' workshops to help prepare carers and families for the reality of dying at home. CNSs have also begun to undertake training modules in non-medical prescribing to equip them to be prescribing Nurses. This has focussed on those serving the Tendring area initially, but we intend to give all the CNSs the same opportunity in time.

3.4.2 SinglePoint

During the past year, the SinglePoint Service has focused on consolidating its considerable development and growth during previous years. The Service handled a reduced volume of calls during 2017-18 and, although this resulted partly from an internal redistribution of workload, we will re-publicise SinglePoint during 2018-19.

While continuing to provide the 24hr telephone triage service, the Team will also make more face-to-face rapid response visits. This has been made possible by the introduction of Clinical Nurse Specialists to the SinglePoint Team, who are also able to prescribe.

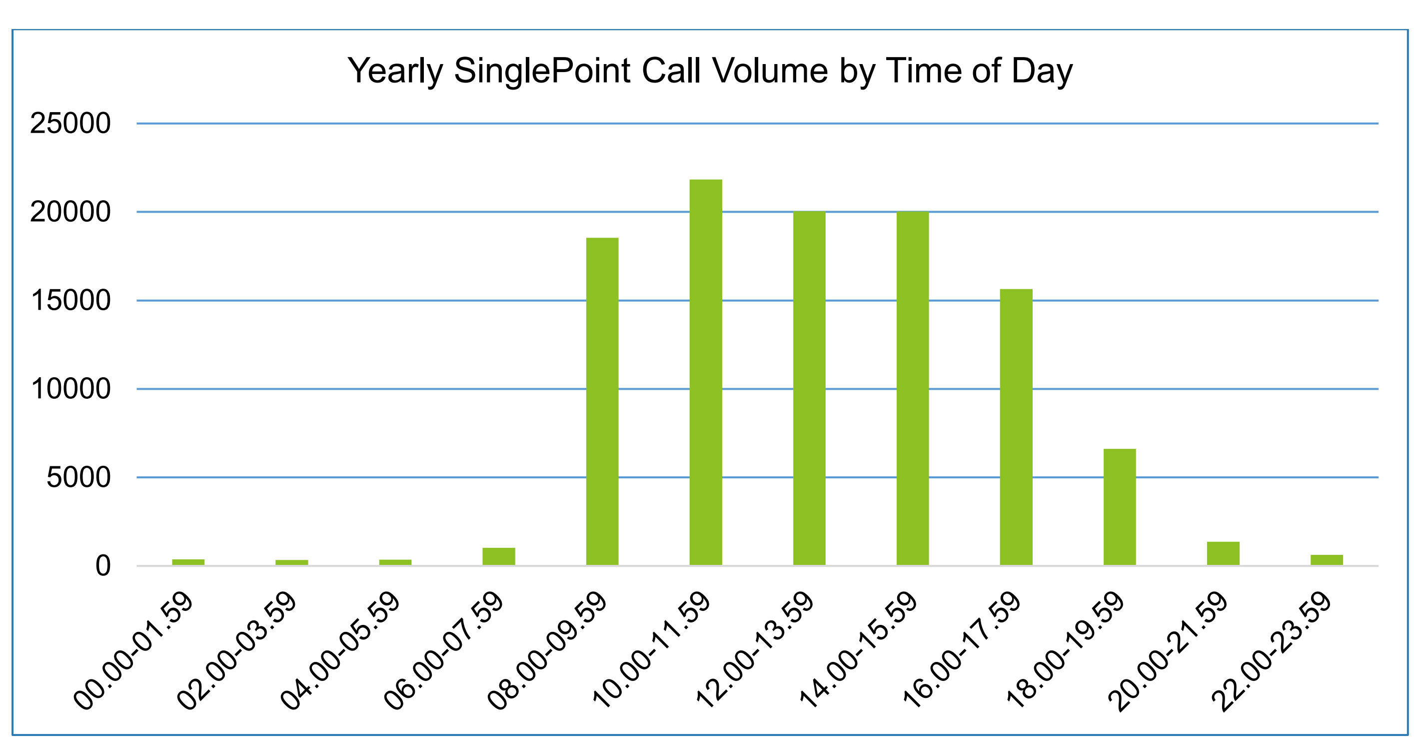


Figure 7 SinglePoint Calls 2017-18

3.5 My Care Choices Register

The My Care Choices Register (MCCR) is a secure database that holds details of people's End of Life care preferences. These will include the care that they would like to receive, the location in which they would prefer to receive it (e.g. their own home, hospital, or hospice), and any cultural or religious wishes. The Register can only be accessed by healthcare staff responsible for a person's care. The MCCR also holds key information about the patient's diagnosis, their condition, and the medical treatment they are receiving. Healthcare staff can access the MCCR at any hour of the day or night, so patients can be confident that everyone looking after them knows exactly what care is required.

Use of the MCCR increased in 2017-18. In March 2018, over 2400 people thought to be in the last year of their lives had an entry, with a discussion about Preferred Place of Care (PPC) documented in 84% of cases. Most people wish to be cared for in their usual place of residence at the end of their lives. Locally, 44% of people die in hospital but for people on the MCCR, this falls to 20%. This demonstrates that care planning with the person

and their family promotes them dying in their PPC.

We have worked with care homes, Colchester General Hospital, the Ambulance Service, and Anglian Community Enterprise (ACE) to publicise the Register.

3.6 Mortality Review Group

The Mortality Review Group meets monthly to discuss cases of people who have died in hospital where this was not their Preferred Place of Death (PPD). Our work with Colchester General Hospital's Palliative Care Team provides valuable insight into what might have prevented the terminal admission. Work has been completed on a new format for the reporting tool, which should help streamline our reporting, and we will use this from April 2018 for all hospice-known patient deaths.

3.7 Therapies & Wellbeing

The Therapies and Wellbeing (T&W) directorate comprises four individually managed teams: Occupational Therapy, Physiotherapy, Psychosocial care, and Complementary Therapies. The Macmillan Counselling Service, which had been based with us, is now managed by Colchester General Hospital. The T&W teams are staffed by qualified therapists, Counsellors, Social Workers, specialist Nurses, and a team of dedicated volunteers.

We continue to accept referrals into the services from a variety of sources, both internally and externally, and the T&W teams all operate throughout the hospice: delivering care in groups and individually at our Joan Tomkins and Tendring Centres, as well as in IPU and patients' homes. They continue to support patients and carers through a variety of approaches, using feedback to provide an ever-evolving timetable of care and support. This constant evolution aids the T&W teams' ongoing efforts to deliver individualised, person-centred care that is driven by the patient or carer.

Our staff also educate students training in various related disciplines, both through lectures at the University of Essex and to those on clinical placements.

3.7.1 Bereavement Service

The national bereavement service, Cruse, closed locally a year ago and, as a result, referrals from the community have increased noticeably. Many referrals are now more complex; resulting from particularly traumatic causes of death, such as murder, suicide, and infant death, which all have a significant impact on the bereaved.

We have set up a full time Duty Desk, staffed by qualified Counsellors who thoroughly triage both internal and external referrals to ascertain the level of intervention people need. Level 1 intervention is one-to-one support provided by a bereavement volunteer. Level 2 is either one-to-one support or group support provided by a Family Support Worker, student Counsellor or an experienced bereavement volunteer (with some additional training). Level 3 intervention is either one-to-one counselling, couple or family counselling or group therapy.

Like other clinical services across St Helena, the Bereavement Service has reviewed the number of sessions we provide to people and we now offer either six or twelve sessions, in line with the new Model of Care. We anticipate that this will help with the increase in referrals.

We currently have a 2-3 month waiting list for Level 1 and 2 bereavement support. To address this need, we are in the process of giving five days' training to an additional 15 bereavement volunteers who will join our existing team of 29. We continue to provide training opportunities to student Counsellors, of whom we currently have two.

Unfortunately, we also have a 2-3 month waiting list for Level 3 bereavement counselling, which is currently provided by Counsellors employed by the hospice (plus six sessional Counsellors), one art therapist and one music therapist. Sessional workers are self-employed and are allocated referrals as and when funding permits, depending on the waiting list.

We have reviewed the STARS young family bereavement programme and, as a result, we've changed the format from an annual residential weekend to three activity days with monthly follow-up sessions. This means we can offer more bereaved families an opportunity to attend.

We have identified the need for a Bereavement Friendship group in the Halstead area and specialist peer groups for people whose adult child has died or those bereaved by suicide. We are unable to provide these services at present

because of limited resources but, with the increasing demand on the Service, we have proposed the need for additional staff, such as a Counsellor and a Family Support Worker. We are currently exploring various grant opportunities.

> *To all the wonderful Doctors, Nurses and everyone who works at St Helena Hospice.*
>
> *Words cannot express how grateful we are for the excellent care you gave to our brave sister…You all made [her] feel safe and cared for in the last weeks of her life.*
>
> *From the bottom of our hearts we thank you so very very much. Also for the kindness you all showed to us her family. Thank you so much*

3.7.2 Psychosocial Care

The Psychosocial Team continues to work across Inpatient Services, Community, and the Therapies and Wellbeing Service. Staffing within the Psychosocial Team consists of Counsellors, Social Workers, assistant Social Workers, Family Support Workers, and volunteers.

Assessment and intervention is family-focussed, which ensures the needs of the whole family, including the patient, are addressed. The Team provides a wide range of support; from one-to-one, couple and family counselling, and family support to prepare children for a parental death, to social work to provide advice and support with planning for dependants and assisting with arranging complex care packages.

We offer a range of therapeutic groups to patients and family members. These include the Friendship Group, for patients to specifically focus on their psychosocial issues such as fears, worries and frustration, alongside family relationships, housing and financial concerns. We work closely with the Chaplaincy Team to facilitate the Art Group, which focusses on addressing the psychosocial and spiritual aspects of patient care through creative activity. The unique Side by Side Group, aimed at couples, has been running for a year and, following feedback, we will be moving this evening group to a daytime slot. The Group enables couples in similar situations to talk with each other about difficult topics. We continue to facilitate the Carers Group as and when the need arises.

To improve the continuity of care for patients and families within the IPU, we now have one Social Worker and one Family Support Worker covering the Unit, Monday to Friday. Figure 8 is an example of the positive feedback we have received.

This year, we reviewed the Hospice Neighbours project, and, because of limited funding, we decided to close the service in its current format. We will reconsider reopening a remodelled version of the service at some point in the future.

3.7.3 Complementary Therapy

Dear All,
My family and I would like to convey our most sincere thanks for the love and attention you gave Michael [illegible] during his time spent in the hospice and for moving all 6 of us, plus Michael, into one room was to us something special.
With grateful thanks and best wishes to you all
[Names redacted]

Figure 8 'Thank you' card

Complementary Therapies (CT) are provided by dedicated and skilled qualified complementary therapists, beauty therapists, and hairdressers, led by a qualified CT Manager. The Team also manages volunteer chiropodists and the owners of our Pets as Therapy (PAT) dogs who both support day centre activities.

The therapies provided are massage, Indian head massage, aromatherapy massage, inhalers and diffusers, reflexology, reiki, and shiatsu, as well as nail and hair care. Referrals to our Service are made from IPU, Rehab, Psychosocial, Bereavement, CNS, SinglePoint and we also

accept self-referrals. The support we offer is also available to staff and volunteers.

The Service is offered in day centre groups, such as the Friendship Group and the Supporting Togetherness, Empowering Positivity (STEP) Group, which is led by the Rehab Team. Individual appointments are booked according to the Model of Care with regular reviews of progress.

During 2017-18 we received referrals to treat 391 patients or their families. We provided 1,812 individual treatment sessions, plus support therapies for our staff and volunteers.

The table below shows a further breakdown of this information.

Place treatment given	Number of treatments
IPU	464
Community	167
Tendring Centre	159
Referrals 1-1 and JT groups	1022
Total	**1812**

Figure 9 CT activity

We have hosted several Look Good, Feel Better (LGFB) workshops for selected patients and these have been very well received. We are now working with the national LGFB charity to roll out their new programme by building a team of LGFB-trained volunteers who can provide this valuable service across all areas of St Helena.

3.7.4 Rehabilitation Service

The Rehabilitation Service is staffed by Occupational Therapists, Physiotherapists, Registered Nurses (RNs), Rehabilitation Assistants, and Assistant Nurses (ANs). They work across the Therapies and Wellbeing Service, the IPU, 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 Therapies and Wellbeing Service; for example, STEP, FAB (Fatigue and Breathlessness) and Breathe Happy (a specialist service for respiratory based conditions). These groups operate from both the Joan Tomkins and Tendring Centres. This year, we have expanded the number of groups that are run at the Tendring Centre to include Relax & Sing and Gentle Yoga.

We also offer specialist breathlessness and fatigue management through clinics, support groups, and home visits. We continue to offer the very successful Macmillan 'Helping Overcome Problems Effectively' (HOPE) programme to our patients and have recently introduced a gym/exercise open session operating out of our Rehab Therapy room on the IPU.

The Rehab Team have also been involved in delivering lectures to Occupational Therapy and Physiotherapy students at the University of Essex this year.

To all at St Helenas. Thank you so much for caring for .... In his final days - he was so peaceful in the surroundings of his own private space and of the personal care that he received during his entire stay at St Helenas. The family cannot express in words their gratitude for the care he received from everyone whilst there.

3.7.5 Safeguarding

This year, we appointed dual Safeguarding Leads for Adults and Children and we also have a part-time Social Worker who will shortly be coming into post as lead for safeguarding for people with learning disabilities and mental health problems. Unfortunately, last year a lack of funds meant we were unable to recruit an additional Social Worker and have had to put that post on hold.

The Safeguarding Team are currently looking at Prevent, which is a strand of the Government's 'Contest' counterterrorism strategy with the stated aim of preventing and detecting radicalisation.[7] The lead Social Workers are attending Prevent training and will be updating our safeguarding training to include it. The Education Team are also looking at adding an additional eLearning package for all clinical staff.

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

[7] The other parts of the Government's 'Contest' counter-terrorism strategy is Prepare, Protect, and Pursue.

templates, staff can record a Mental Capacity Assessment and Best Interests Decision within SystmOne. The Essex Children Safeguarding Board has amended its referral process, and this has been updated on SystmOne with all clinical staff advised 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 also designed a safeguarding leaflet for all volunteers who have face to face contact with patients, to ensure they know what to do if they have concerns about an adult or child.

We still use the Safeguarding eLearning for all staff as well as face-to-face training. This face-to-face training is jointly delivered with a member of the Medical Team and now includes The Mental Capacity Act. This training supplements the eLearning.

We have also recently updated the way that clinical staff report pressure ulcers. The Adult Safeguard Board now requests that all pressure areas grade three and above are recorded as safeguarding concerns and a SETSAF[8] form sent to the Local Authority. The policy has been amended to incorporate the Southend Essex and Thurrock Adult Safeguarding Guidelines (October 2017).

This year, St Helena Social Workers have been 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 involves 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).

Hospice Social Workers continue to attend safeguarding training, GP forums, and safeguarding forums to ensure they are up to date with legislation and policy. This information is shared within the organisation.

3.8 Chaplaincy

The Chaplaincy Team leads on spiritual care within the hospice and raising the 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.

We have recently reviewed the Chaplaincy Service in order to ensure that it continues to meet the needs of the current model of specialist care St Helena provides. The number of referrals has noticeably increased, particularly in the community and so we've needed to make changes to ensure we meet people's needs. Also, many referrals are now more complex and spiritually diverse in both the community and IPU. Therefore, the Team now have more defined roles. The Lead Chaplain, as well as leading across the organisation in spiritual care, now provides support to patients, families, staff, and volunteers on the IPU, to non-clinical teams, and to Therapies and Wellbeing services in Colchester. The part-time Chaplain provides support to patients, families, staff, and volunteers in the community and to Therapies and Wellbeing services in the Tendring Centre. This Chaplain also supervises our team of volunteer Pastoral Assistants, who visit patients and families in the community who require a lower level of support.

During the past year, we have produced a Spiritual Care policy, implementing a training programme on spiritual awareness for staff and volunteers, re-named and re-dedicated the Chapel, and completed audits of spirituality assessment and provision of spiritual care. Ongoing work has included the Summer Reflections and Tree of Memories memorial services, bereavement support (including conducting funerals) and encouraging self-care for staff and providing them with ongoing support. The Chaplaincy Service continues to grow and develop throughout St Helena, allowing us to meet the holistic needs of the people for whom we care.

In addition to providing ongoing informal pastoral support to staff, we've introduced 'Chat with the Chaplain' sessions to help staff take responsibility for their self-care by dropping in and coming to talk in a non-supervisory but confidential place to

[8] Southend and Thurrock Safeguarding Alert Form

unload, explore, and reflect on anything that is burdening them. This year, this has included supporting staff and volunteers after the recent deaths of two staff members.

> *We were so grateful for all the support given to myself and the family of the late [Name]. The support from the callhandlers to the nurses allowed us to care and keep Dad comfortable at our home. It was a priviledge to have Dad here amongst his family in his last weeks but it was the patience and understanding shown by the Singlepoint team that made this sad day by wonderful experiance that all of us have been able to take happy memories from thank you from all the family.*

3.9 Education and Training

St Helena currently has an established Education and Research Centre, providing a range of teaching and learning opportunities relating to End of Life and palliative care. The subjects we teach and our approach to learning are underpinned, often explicitly, by the '6 Cs' of Compassion in Practice: care, compassion, competence, communication, courage, and commitment. Our courses include symptom control, psychosocial issues, and communication skills. A great deal of our teaching, medicines management for instance, is skills-based. We also offer bespoke education to nursing homes, care homes, and care agencies. This can include topics such as Verification of Expected Death, and Syringe Pump Management; as well as core skills for managing people at the end of their life. These enable staff outside of the hospice to offer a more comprehensive service to palliative patients.

The Education Team also co-ordinate and deliver teaching to Hospice staff and help to keep all staff aware of new national policies and international developments that might influence practice. All staff are supported by the services of a committed librarian, a team of volunteers and a well-equipped library. Our teaching is founded on a strong evidence-base, so we can equip our staff to deliver the highest quality palliative and End of Life care.

3.10 Quality of the Environment

In 2017, the Senior Management Team agreed the five-year Estates Strategy and approved the capital investment necessary to meet its objectives. As a result, hospice sites have benefitted from the following improvements:

- Refurbishment of the Joan Tomkins Centre.
- Refurbishment of the Rehab Team offices.
- Relocation of the SinglePoint call centre to a substantially upgraded facility.
- Refurbishment of the multi-faith chapel.
- Replacement of the fire alarm infrastructure with a modern, addressable[9] system.
- Renovation of the inpatient garden terrace.
- Relocation of the library to a refurbished facility.
- Relocation of the Records Office to a refurbished facility.
- Creation of a new side room for patients on IPU.
- Creation of a new Therapies Room on IPU.

The Estates Strategy also identifies a further extensive capital programme, which includes a number of key refurbishment projects for 2019. We are currently working out costings for these with contractors. In the meantime, we have a rolling programme to upgrade IPU lighting to an LED system, which will improve the quality and reach of light for patients, visitors, and staff.

The in-house Catering Team has successfully retained its five-star food hygiene rating for all three kitchen facilities. All food continues to be cooked on-site from scratch and we source many ingredients locally. The Catering Team has also introduced theme days throughout the year to celebrate food from different cultures.

We are continuing to use technology to improve our processes. For instance, the Domestic and Catering teams are now using the Helpdesk system to pick up issues that are reported, log

[9] An addressable system allows one to pinpoint the precise location of the fire alarm used and so to locate the fire more quickly.

new work requests as a result of audits, and to receive catering requests. This allows the teams to process requests efficiently and with audit trails. In addition, the Maintenance Team are currently reviewing the use of the Sentinel system to record planned maintenance works.

The professionalisation of the Estates Team continues apace, with the Catering Manager, Domestic Manager, Maintenance Manager, and Health & Safety and Support Services Manager all successfully completing Institute of Leadership and Management (ILM) qualifications over the course of 2017-18. Our Health and Safety and Support Services Manager is also currently undertaking an 18-month National Vocational Qualification (NVQ) Diploma in Health & Safety.

The Health and Safety Team continue to chair the quarterly Health and Safety and Wellbeing Committee meetings, as well as the monthly clinical and non-clinical health and safety meetings. The Team also deliver health and safety induction training, refresher training, and lone working workshops to several other directorates.

The senior managers have recently undertaken a training workshop on Business Continuity and we have written a new draft policy, procedure, and Business Continuity Plan. The scope of this project has been extensive, with the learning cascading to all departments to ensure that a responsive and joined-up approach to business interruption can be delivered when needed.

The Estates Team are participating in the NHS Patient Led Assessment of the Care Environment (PLACE) for the second consecutive year. The feedback from the first assessment was collated and reported to the Senior Management Team and a number of areas were refurbished as a consequence. The organisation is also trialling dementia-friendly signage and a number of other dementia-friendly initiatives to help make the environment more accessible.

After listening to patient feedback concerning the no smoking policy, we decided to build a smoking shelter near the entrance to the main site. The chief benefit of this is that it provides patients with better protection from vehicles and shelter during inclement weather. The shelter is now in place and is available to patients only.

To all the nurses who cared for my husband, [Name], day and night, I just wanted to say thank you all, everyone of you, for all the kindness and compassion you showed him, I shall be enternally grateful. As for myself, you kept my spirits up through the last few days, nothing was too much trouble-something I shall never forget. My son [Name] joins me as well in saying "thank you"

3.11 Volunteering at St Helena

Volunteers at St Helena continue to be an integral and valued part of the organisation who bring a great range of skills, interests, and individual experience to support our patients and their families. We continue to benefit from the support of over 1,000 dedicated volunteers who cover more than 50 roles, supporting 17 different departments.

The Volunteer Services Team have been working with line managers to embed new, simplified processes to deal more speedily with volunteer applications. We receive these daily and, following a focussed recruitment campaign during February this year, recruited 33 new volunteers in just one month. Recruitment is ongoing, with the Volunteer Services Team out and about in the local community to engage with the general public to promote the benefits of volunteering.

With the General Data Protection Regulation (GDPR) coming into force in May this year, we have contacted all volunteers on our HR database to ensure we have their consent to contact them about Hospice matters beyond their volunteering role. The response to this has been excellent and has resulted in ensuring that both the volunteer database and the Marketing and Communications database are up-to-date.

We launched a new newsletter for volunteers in January, 2018. The first newsletter invited volunteers to suggest a title for the publication and, following a suggestion from one of our volunteer receptionists, it is now known as 'Volunteer Voice'. The newsletter contains news and information relevant to volunteers and has been positively received. Alongside the newsletter, we launched a Facebook page, creating another platform for volunteers to engage with each other and share news and

updates. Volunteers have really taken to this and it's working well. With the newsletter and the Facebook page, we are delighted that communication to volunteers has improved greatly and more volunteers than ever are attending induction days and being kept informed.

The annual 'Thank You' Day for Volunteers will take place on 2nd October, 2018 at the Weston Homes Community Stadium. This new venue will allow us to accommodate more volunteers than ever before. Once again, volunteers will receive Long Service Awards at this special day. St Helena is exceptional in that we have several volunteers who have remained with us for more than 30 years.

Plans for 2018-19 include training for staff who manage volunteers along with a new written guide. Classroom sessions are already in place to help those volunteers who find the mandatory online training difficult, which ensures we remain compliant. The Volunteer Services Team continues to work with both volunteers and their line managers to ensure all our volunteers receive the best experience throughout their volunteering time, from beginning to end.

3.12 Quality Markers

3.12.1 VTE Assessments

Venous thromboembolism (VTE) is a significant risk to people admitted to hospice. Each person admitted to our IPU should undergo a risk assessment for thromboembolism and have a discussion with the Medical Team about whether they wish to have a daily injection to help prevent it during their admission.

Over 90% of people admitted to IPU during 2017-18 had such a risk assessment documented in their clinical record. We are working hard to achieve 100% in this area and have seen the rate of assessment increase over the course of the year.

Quarter	No. of VTE Required Admissions	No. of VTE Assessments Completed	Compliance (%)
1	74	72	97.3%
2	77	76	98.7%
3	95	91	95.8%
4	71	65	91.5%
Total	317	304	95.9%

Figure 10 VTE Compliance

3.12.2 Tissue Viability

Although pressure ulcers are an inevitable occurrence when dealing routinely with patients who are near the end of their lives and have weakened skin, we decided that all pressure ulcers, regardless of origin or severity, would be recorded as incidents on our Sentinel system. We did this to improve the consistency and depth of our reporting and analysis.

All pressure ulcers are reported to the 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 this year, we have appointed a new Tissue Viability Lead and completed work on a new Tissue Viability policy. We are also planning to revise the SystmOne care plan to make documentation clearer and more efficient. The frequency of audit will also be increased from yearly to quarterly.

For pressure ulcer figures during 2017-18, see Table 1 on Page 27.

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.'[10]

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

[10] 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.

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 or not a falls plan had been created and correctly followed and all reasonable precautions put in place. On the basis of 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.

St Helena also reports its falls figures to Hospice UK. Comparing our performance on falls with other providers is challenging because the causes of falls are complex and not necessarily related to the aggregate health of the patients (the 'casemix'). For example, a ward comprising several very sick people who are bed-bound will very likely report fewer falls than a ward of people who are suffering advanced dementia but are ambulatory.[11]

This year, we have purchased new equipment, including sensor mats, cushions, and mattresses, which links to our Call Aid System. These devices sound alarms and trigger staff pagers whenever patients stand on them or gets off a chair or cushion. We've also added new lighting to aid patients and staff. We are hopeful these will help reduce patient falls on the IPU.

The caring is excellent, you are not just a number but a person.

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 will be adopting the NHS Controlled Drug error coding scheme and introducing electronic prescribing.

For the numbers of reported medicines errors, see Table 1 on Page 27.

3.12.5 Catheter Acquired Urinary Tract Infections

During 2017-18, two patients acquired catheter infections and nine were admitted with them. The poor health of the patients we admit to IPU – who often have a number of separate conditions and weakened immunities – means it is obviously not feasible to eliminate entirely the risk of an infection resulting from a necessary catheterisation. We do strive, however, to reduce this risk to the absolute minimum.

3.13 Risk and Incident

Our Risk and Incident Group (RIG) meets fortnightly and is chaired by either the Director of Patient and Family Services 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

[11] As the National Patient Safety Agency commented in 2007 (speaking of NHS acute hospitals) 'Where trusts have very low numbers of falls, this is likely to indicate that there are data quality or reporting problems, and so the average figure is likely to be an underestimate. High reporters may have particularly vulnerable patients because of the age profile of their community or because they provide specialist care to patients more vulnerable to falls, or the rates may reflect conscientious reporting,' NPSA (2007) "Slips, trips and falls in hospital," p.13, available at http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=61390&. Accessed on 18/04/2016.

does not tell you how safe they are and should not be used to make isolated judgements about the safety of care.' [12] 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.[13] This way, we can build a more accurate picture of adverse events within the organisation.

During the year, we have begun the process of bringing a dedicated complaints module into use in our Sentinel system and we plan to roll this out to all areas over the coming months. We have also held Root Cause Analysis and investigation training for managers.

In Table 1 on Page 27, we present a breakdown of incidents affecting our Patient and Family Services directorate, which were closed during 2017-18.

[12] NHS England (2015) "Serious Incident Framework," p. 11

[13] North East Essex Clinical Commissioning Group (2015) "Incident Reporting & Management Policy/v2.3/May 2015" p. 10.

Incident Type	Clinical Secretariat/Reception	Community	Inpatient Services	Therapies and Wellbeing	Grand Total
Abuse of staff	0	2	1	1	4
Accident	1	5	77	7	90
Injury	0	1	4	2	7
Moving and Handling (patient)	0	2	2	2	6
Other	0	2	0	0	2
Patient Falls	1	0	70	3	74
Slip Trip or Fall (Non-patient)	0	0	1	0	1
Clinical Incident	0	16	114	5	135
Clinical Complication	0	3	1	3	7
Medical / Nursing Notes not available	0	0	1	0	1
Medicines error	0	7	47	0	54
Other	0	6	4	2	12
Pressure Ulcers	0	0	59	0	59
Unsafe Discharge	0	0	2	0	2
Communication	2	22	12	16	52
Other	2	20	10	14	46
Rudeness/Poor Conduct	0	2	2	2	6
Confidentiality/IG	4	2	2	0	8
Environmental	0	0	1	1	2
Equipment / Device Failure	0	1	0	0	1
Illness	0	0	1	1	2
Safeguarding (Adults)	0	1	1	1	3
Security (inc. Theft)	0	1	2	0	3
Grand Total	**7**	**50**	**211**	**32**	**300**

Table 1 PFS Incidents 2017-1

3.14 Information Governance

Our Records Management Group continues to meet regularly. The incoming Director of Patient and Family Services received Caldicott Guardian training and the Quality Lead has attended a number of conferences and courses concerning IG and was recently appointed Data Protection Officer.

Since July 2017, we have been working to make our processes compliant with the General Data Protection Regulation and the new Data Protection Act, both of which came into force in May 2018.

3.15 Mandatory Training

Our compliance figures increased slightly toward the end of the year and we are putting measures into place to ensure that we maintain an acceptable level of compliance for all of our mandatory training.

We are now using Eventbrite as a booking system for our education programme, and this allows us to run reports that capture all attendees and the training they complete. We will trial this for the coming quarter, in place of our HR system, iTrent, to see if this is adequate to meet our education and training requirements.

Manual handling training is in place for the coming year for all staff who need it. We have engaged a Neuro Physiotherapist and have trained some in-house trainers to fulfil our requirements across the hospice.

We now have a Clinical Education Lead who will facilitate clinical training. New training will include dementia care.

By September, there will be four members of staff completing apprenticeships under the government training levy scheme.

We will be taking part in Project Echo later in the year, which will involve streaming live training out to Care Homes.

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.

Just to be able to talk about my loved one, the good and the bad and not be judged. To cry openly without family members seeing and being upset themselves. My therapist was a lovely lady who listened to me first and foremost. Thank you for a wonderful service.

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 36). Nevertheless, in a very small number of cases, things do sometimes go wrong. During 2017-18, we closed a total of eleven complaints. We treat each complaint as an opportunity to learn and improve and these complaints are summarised, below.

1) The wife of a patient felt that she had not been properly supported in the final days of her husband’s life and that he had been removed from a CNS caseload inappropriately. The complainant also felt that her own experience as a palliative care Nurse had possibly led our staff to think that she would need less support and continuity of care.

Our investigation found that the complainant had not been supported adequately with End of Life care planning, such as anticipatory medication and resuscitation forms, which had not been available in a timely way. This exacerbated the distress of an already painful situation. While this was not the sole responsibility of St Helena, it was the case that someone should have taken the overall lead. Overall, we were not responsive enough at a time of need, and communication between different St Helena teams was inadequate.

Our Risk and Incident Group reviewed the development of this case on three occasions and judged that this was an unfortunate incident that happened during the transition to the new Model of Care. With new processes in place, we do not anticipate that a similar set of circumstances will arise again.

Our Head of Community had several contacts with the complainant and wrote to apologise and offer bereavement support.

2) A complainant found that our Inpatient Team had not met her or her husband's requirements; specifically, that staff had said he did not have palliative needs and that we had handled his discharge insensitively. She also complained about the discharge from our Community Team and the care she and her husband had received from a specific CNS.

Our investigation found that we handled the discharge insensitively and should have allowed the complainant to have a longer respite break. This problem was worsened by the patient's advanced dementia, which we are not equipped to deal with long term.

The experience on IPU was unduly stressful for the patient and we did not meet his special needs appropriately. We also found that there should have been a face to face meeting to explain the patient's removal from the CNS's caseload. Overall, our communication was inadequate. This was all set out in a letter of apology to the complainant.

3) We received a complaint expressing disappointment with our communication and the response of two SinglePoint CNSs regarding an admission to IPU. The complainant was unhappy that we did not admit their loved one with the reason given being that, as they were already in a care home, this would not be a priority. SinglePoint had also failed to respond to a call within our two-hour target and had not been able to provide a visit (contacting the patient's GP instead).

Our investigation found that our staff had incorrectly assumed that an admission was unnecessary and that we had missed other care needs, including depression, which we had not been informed about in the original referral. Consequently, we also missed an opportunity to refer the patient to psychological services.

As a result of this incident, our Referrals Team were asked to ensure that they fully explore any psychological factors affecting patients. Separately, we have also recently augmented our SinglePoint staffing to increase its capacity to make visits. The complainant was apprised of all this in a letter.

4) A family complained that we had moved their relative from a private room to our men's bay without their knowledge and that this had caused them distress when they arrived to find the previous room being cleared. They also asserted that they should have been consulted and that the move had distressed the patient.

Our investigation found that the patient had been moved for legitimate reasons of capacity and that this had been done with the patient's consent. We also found that staffing (Reception and Nurses' Station) and scheduling issues had meant that we had not contacted the family on time and that nobody had been on-hand to explain the move when the family arrived. The family declined the opportunity to make a formal complaint, but we chose to treat it as one.

5) The husband of a community patient complained to us that our SinglePoint Service had been unable to give consistent help with his wife's incontinence. He also said that they had been told that the 'clean up' service we provided had been stopped.

Following an investigation, we established that our SinglePoint Team had made every effort to provide assistance on each occasion they received a request, including on one occasion when their help had been declined.

Our Head of Community wrote to the complainant to express regret at any distress caused but also to make clear that it had never been in SinglePoint's remit to provide continence care and that no 'clean up' service had ever existed. Regrettably, any such help given can be given only when resources permit. The Head of Community made clear that she would be happy to visit the complainant in person at any point during the coming months.

6) A complainant contacted us regarding the death of her mother. She felt that she had been reassured that someone would be with her mother when she died but that this had not happened. The complainant also stated that she

had been declined CNS support after her mother's period of care had been ended. She also complained that care had been poorly coordinated between SinglePoint and the District Nurses, that out of hours access to medicines had been difficult, and that she had not been properly prepared for the practicalities of her mother's death.

An investigation by our Head of Community found that further CNS care would have been outside our remit, as the patient's needs were not complex. It also found that SinglePoint had done everything within their power to coordinate inter-agency care but that they were not responsible for the (in)actions of external organisations.

In her letter to the complainant, our Head of Community expressed regret that a member of staff could not be present with her mother at all times but pointed out that there are insufficient resources for this kind of one to one care. The Head of Community also agreed that if medicine supplies had been allowed to run low this would have been unacceptable and apologised if SinglePoint had contributed to this. Finally, the Head of Community expressed regret that the complainant had felt she had had a poor experience and offered her a referral to our Bereavement Service.

7) A complainant raised two issues with us concerning the death of her husband. The first was that her requests for information from a CNS about what she should do once her husband had died had not been heard properly and that, instead, she had been told to contact SinglePoint who would assist with everything. Secondly, when the complainant's husband had died, the family called SinglePoint who then relayed the request for assistance to the deceased's GP. For the complainant, this fell short of their expectation that they would receive 'help every step of the way'.

The consequence of these occurrences was that the patient's wife and daughter felt very unprepared and frightened, as well as disappointed with the service they received.

Our investigation found that the underlying cause of the problem was a CNS's eagerness to give unwarranted reassurance about what to expect, which was compounded by them failing to request a GP visit even though the death was predicted. This meant that SinglePoint were unable to verify the patient's death as he had not seen a GP for over 14 days. Had this visit occurred, the issue for the family would have been averted.

We identified the following areas requiring remedial action:

- The need to provide realistic preparation for patients' families on what to do after a death, especially when they ask more than once for this information.
- The need to ensure that the role of SinglePoint is carefully explained, so that patients and families are not given false expectations.

A letter of apology was sent with an offer of bereavement counselling.

8) The daughter of a patient who died with us in 2017 year contacted us to express disappointment at the care her mother had received. The specifics of the complaint were:

- A lack of practical care provision: no respite care, no carer, 'the service from the hospice was very limited and didn't support the needs of the family'.
- A failure to control her mother's pain and symptoms.
- A lack of compassion shown by SinglePoint.
- Anger at the CNS visiting her mother in Cheviots nursing home when the daughter felt the CNS had badly let her down.

Our investigation found that pain control had been appropriate but noted that the patient had declined pain control on one salient occasion. On reviewing the call logs, it was determined that staff had been compassionate but that the communication of factual information, while well meant, might have been received as tactless. On the CNS visit to the Cheviots nursing home, it was noted that the complainant had welcomed the prospect of this visit when it had first been raised. Finally, in our letter to the complainant, we expressed regret that they had felt unsupported, but we explained that personal care is not something we have the resources to provide.

We expressed sorrow for the complainant's distress and informed her of the improved communications training that we are providing to our CNS and RN staff.

9) A relative complained that she had been advised that CNS support would be available to deal with her mother's needs. When the referral was triaged, however, it was deemed non-urgent and, because the original CNS handling the case was on leave, their stand-in did not visit. The complainant also felt under-supported by our SinglePoint Service. This resulted in poor symptom control and emotional support for the patient and their loss of faith in St Helena.

Our investigation found that SinglePoint had failed to recognise that the patient was dying and to send out the SinglePoint CNS Team to visit in a timely way. Some elementary communication issues were evident: not listening carefully and a defensive stance when it came to resource allocation.

As a result of this complaint, we have taken several steps to minimise the risk of this situation arising again.

- The CNS Lead has reinforced to staff that any patient referred to a CNS on annual leave should receive a call from the CNS 'buddy' to explain this.
- Any calls to SinglePoint during which the caller expresses frustration that they are not being heard or are unhappy with the service being offered should be escalated to a manager or SinglePoint CNS at the earliest opportunity.
- SinglePoint RNs will receive additional communication training.
- There will be monthly call reviews for the SinglePoint Team to allow them to reflect upon their communication style. This is being aided by a new online system for call auditing.
- We are in the process of implementing the use of a telephone 'checklist tool' in SinglePoint to ensure that advice and support given is consistent and that the right person is sent to help at the right time
- We have reviewed SinglePoint staffing over key days such as Bank Holidays, weekends, and during events.

Our full response was sent by letter to the complainant.

10) The wife of a patient who had died with us raised a number of concerns, including:

- That she had not been sufficiently involved in decision-making about her husband's care.
- That she was not sufficiently informed about what was happening because she did not know what questions to ask.
- That news of the patient's short prognosis was not communicated in a sufficiently sensitive or supportive way and that it came as a surprise.
- That information about certain aspects of nutrition and treatment had not been communicated well and that the complainant was informed incorrectly that it would have been impossible for her husband to return home.
- That the behaviour of a particular Nurse had fallen short of expectations.

Our Director of Patient and Family Services met with the complainant. Our investigation found that we had not always communicated with the patient and his wife or involved both in decision-making as effectively as we could have done. Some of these communication problems stemmed from short-staffing caused by sickness. We also found that a referral to family support had not been followed up when it should have been. We found that the husband had expressed a preference to spend his final days in the hospice and that the wife should not have been told going home would be impossible.

We apologised to the complainant and issued communications to staff about where we failed, so that similar circumstances can be avoided in the future. We also addressed with the Nurse in question the specifics of the complaint against her and she was invited to reflect on the incident with her manager.

Our full response was sent by letter to the complainant.

11) We closed one complaint during the quarter, which concerned our failure to refer a relative of a recently-deceased patient to our Bereavement Service. The complainant was upset, as they felt that we had broken our promise to them.

This problem arose because the patient had been taken off the SinglePoint caseload before the follow-up for the relative had been made. As a result of this complaint, we have implemented a new process to ensure that, when a patient dies,

they are not removed from the caseload until a follow-up phone call or visit has taken place.

The complainant received a letter of apology, an explanation of what went wrong, and details of the steps we will take to prevent the problem happening again.

3.17.2 Service User Group Survey

In November 2017, the Service User Group (SUG) conducted its annual survey of users (patients, families, and carers). As with previous years, questionnaires were constructed for patients who had received care on IPU, in the community, or who had used Therapies and Wellbeing services.

Although the response rate (23.2%) was down markedly on last year, the results showed high levels of satisfaction. As can be seen, St Helena scores extremely highly on dignity and respect for service users (98.0%) and a clear majority (63.1%) rate their experience with St Helena as 'excellent' (although this is down on the previous year's 72%).

Figure 11 SUG Survey privacy & dignity

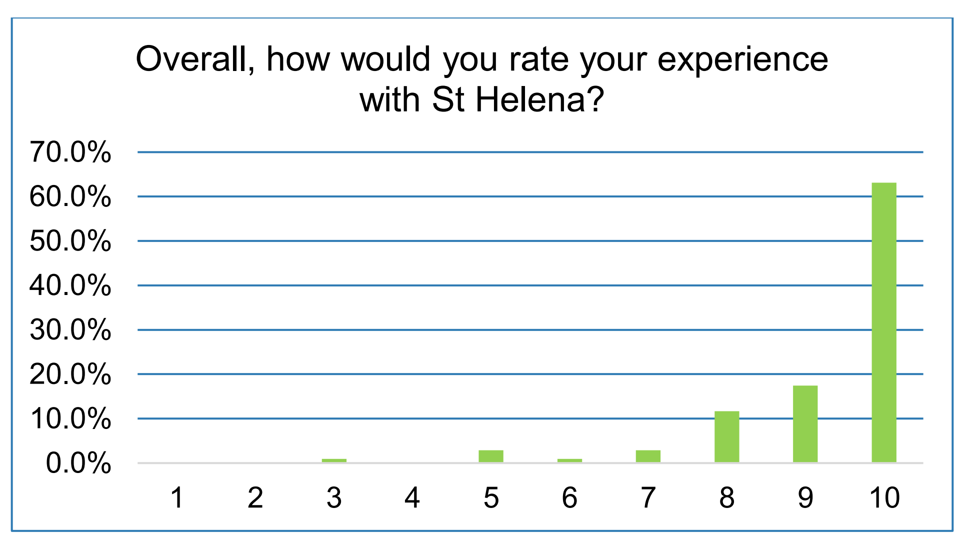


Figure 12 SUG Survey overall score

Summary of Results

Community

The general picture was of high satisfaction with the Service. For instance, approximately 60% of respondents rated SinglePoint 10 out of 10 for both the time it took for their calls to be answered and the quality of the help provided (Qs 1b(i) and 1b(ii)). With one exception, nobody scored SinglePoint less than 8/10.

On communication issues, such as staff introducing themselves, explaining about the Service, and explaining what they were doing (Qs 3-5), Community also scored well. For Q7, there was a single report of staff 'sometimes' speaking in front of a patient as if they were not there. Respondents also confirmed that they and their families or carers were involved in decisions about their care as much as they wanted (Qs 11 and 12).

Overall satisfaction was high, with all respondents reporting that they had 'always' been treated with respect and dignity (Q16) and 80% giving their experience 9 or 10 out of 10 (Q17).

Inpatient Services

As one might expect, the majority of respondents (28/33) had come in for a planned admission rather than End of Life care. The vast majority of respondents felt that they had been admitted to IPU at the appropriate time although just under 10% felt it had been too soon.

IPU staff scored well on communication issues, such as introducing themselves, being accessible, explaining what they were doing, and giving understandable answers to questions. Regrettably, respondents did recall some occasions when staff had spoken about them as if they weren't in the room or had given insufficient or contradictory information.

Patients being kept awake at night by noise from hospice staff remains a problem, with 5 patients (16%) reporting that this had happened.

General cleanliness and the quality and choice of food continue to score well, although it is disappointing that two patients recalled not always getting enough help to eat their meals.

Overall satisfaction was high, with all respondents reporting that they had 'always' been treated with respect and dignity and 80% giving their experience 9 or 10 out of 10.

Therapies and Wellbeing

Staff generally scored well on communication, although a third of respondents reported that they were only 'mostly' able to talk to staff as easily as they would have liked. It is also disappointing that, while staff were reported as being 'always' respectful by over 90% of respondents, one person did recall that staff were not respectful of their home and possessions.

Almost 90% of respondents reported that they and their families had been involved in decisions about their care to the extent they wanted but three people would have wanted more involvement.

Respondents rated the SinglePoint Service highly, with a clear majority awarding it 9 or 10 out of 10. Most respondents did not have hospice food but, of those who did, 80% thought it 'good' or 'very good'. More disappointingly, 5 people reported not having been given a choice of food and not being offered a drink often enough.

10% of respondents didn't think there was enough variety of therapy groups and several kindly offered suggestions of what they would like to see.

90% of respondents felt that they and their families had benefitted from Therapies and Wellbeing services. Overall satisfaction was high, with 90% of respondents reporting that they had 'always' been treated with respect and dignity and 80% giving their experience 9 or 10 out of 10.

3.17.3 Unsolicited Comments

St Helena receives a large number of cards, letters, gifts, and donations each year, which is always very heartening for staff. Following the introduction of iWantGreatCare (see Page 35), we ceased qualitative analysis of the comments we receive in cards and letters. We did this because such unsolicited communications are almost always an expression of gratitude only. We do still record these comments; however, and a number of them feature throughout this Quality Account. The chart below shows the number of communications, broken down by receiving service.

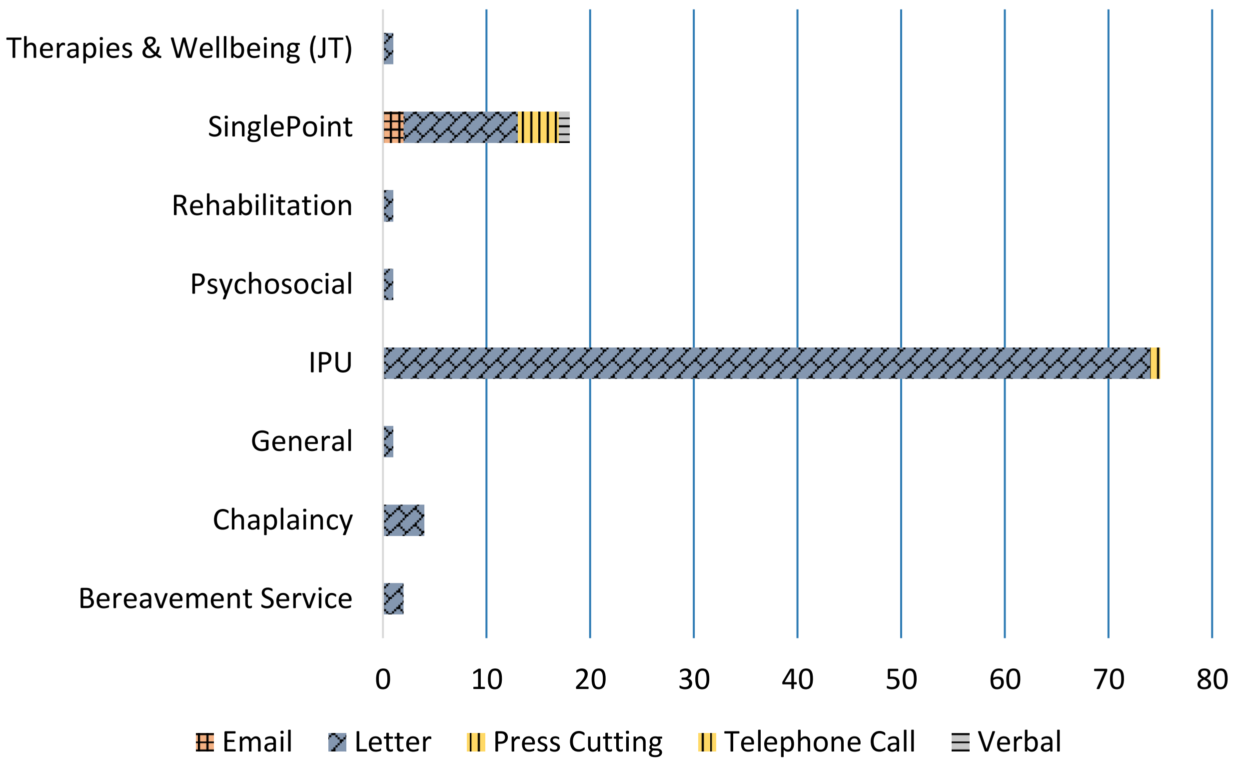


Figure 13 Unsolicited comments 2017-18

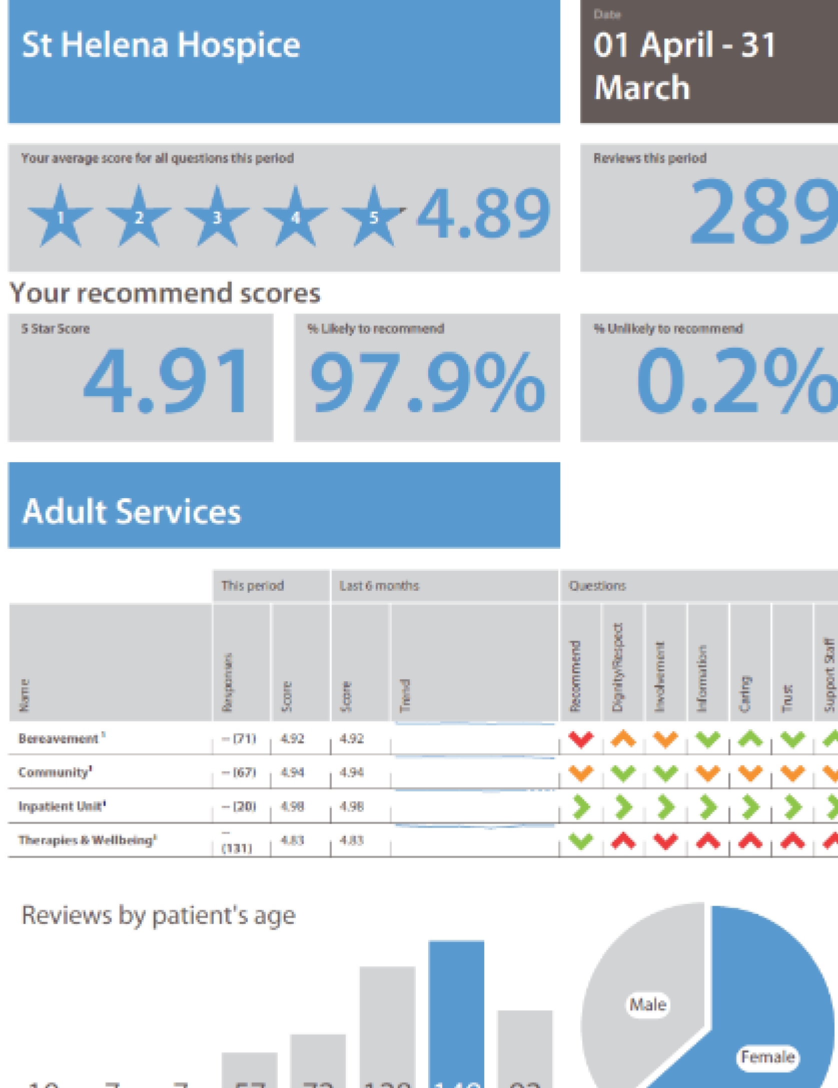
To everyone at the Hospice. We just are so grateful to everyone who looked after my beautiful Mum and wife in her last 3 days it has been a very hard journey for us all but to know she was happy and pain free was wonderful. My mum's last words to me were when I told her she was in the Hospice on the day she got admitted she said "oh how lovely". i will never forget it - Dad and me will cherish her last days knowing she was comfortable and clean and had the care she deserved. thank you all so very much

3.17.4 iWantGreatCare

We have been using iWantGreatCare to manage service user feedback since. The system is much like ‘Trip Advisor’, which is used in the hospitality sector. Services users across all of our services are now invited to complete paper forms, which are then sent to iWGC to be scanned and collated. Alternatively, patients and families can visit the iWantGreatCare website and leave feedback for us there.

The resulting feedback is analysed using the iWGC management interface and reports presented to our monthly Quality Assurance and Audit Group (QAAG) for review. These detailed reports include a breakdown of the figures for the organisation as a whole and by four designated services: Inpatient Services, Therapies and Wellbeing, Community, and the Bereavement Service. These reports also include the free text comments received. Data for 2017-18 is presented in Figure 14, opposite.

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 are able to 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 iWantGreatCare website, please visit https://www.iwantgreatcare.org/hospitals/st-helena-hospice



Data collected and analysed by iWantGreatCare. ©

Figure 14 iWGC returns

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.

In November 2016, 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 are delighted to report that we have been 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."

Overall rating for this service	Outstanding ☆
Is the service safe?	Good ●
Is the service effective?	Good ●
Is the service caring?	Outstanding ☆
Is the service responsive?	Outstanding ☆
Is the service well-led?	Good ●

Figure 15 CQC 2017 assessment

Link: http://www.cqc.org.uk/location/1-116828568

3.18.2 IG Toolkit

St Helena's Information Governance Assessment Report overall score for 2017-18 was 66% and was graded Satisfactory.

Clinical Coding Error Rate

St Helena was not subject to the Payment by Results clinical coding audit during 2017-18 by the Audit Commission.

3.18.3 Response 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 received quality of 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.
- 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 new areas of growth and support the wide Health & Social care infrastructure.
- HWE recognises the ambition of the hospice around the endo of life /palliative care work and the introduction of the 6 ambitions.
- HWE recognises the investment of the Hospice in its environment and continued development and refurbishment of the site.
- 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

29th June 2018

3.18.4 Statement by St Helena User Group

The only criteria for membership of the Service User Group (SUG) is some experience of hospice services, either personally or as a carer/family member or friend. At present, about 12 people regularly attend the monthly meetings. The Group uses its collective experiences to help guide the development of patient services, particularly focusing on services' impact on, and the way they're explained to, service users.

This year, the SUG's Annual Survey had a disappointing response rate (see Page 32), which we suspect may be due to survey overload brought on by being presented with a survey after every purchase and interaction during each normal day. A survey combined with a stressful healthcare situation may be just too much, and alternatives will be explored at a meeting of relevant individuals in July.

The SUG was pleased to be able to assist with the PLACE audit again this year (see Page 22). As always, the Group continue to be impressed by the comprehensive and speedy attention to any issues raised.

St Helena's CEO and Senior Management Team take care to keep the SUG fully apprised of new developments and plans and take account of the comments and views expressed. The Group is aware that this is a time of significant change and tries to offer a constructive reflection on how to minimise the impact on service users.

The Group would again wish to commend the staff and management on the excellent standard of care provided during 2017-18, as evidenced by this report.

Ken Aldred

Chair, St Helena Hospice Service User Group

June 2018

3.19 Contacting St Helena

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

Mark Jarman-Howe, Chief Executive Officer

St Helena Hospice

Barncroft Close

Colchester

CO4 9JU

Tel. 01206 931450

Email: mjarmanhowe@sthelenahospice.org.uk

www.sthelenahospice.org.uk

Follow us:

@StHelenaHospice

https://en-gb.facebook.com/StHelenaHospice/

sthelenahospice.org.uk
Telephone: 01206 845566

St Helena Hospice is a company limited by guarantee.
Registered in England and Wales Number 01511841.
Registered Charity Number 280919.
Registered Office: Myland Hall, Barncroft Close,
Colchester, CO4 9JU.