Quality Account 2020/21

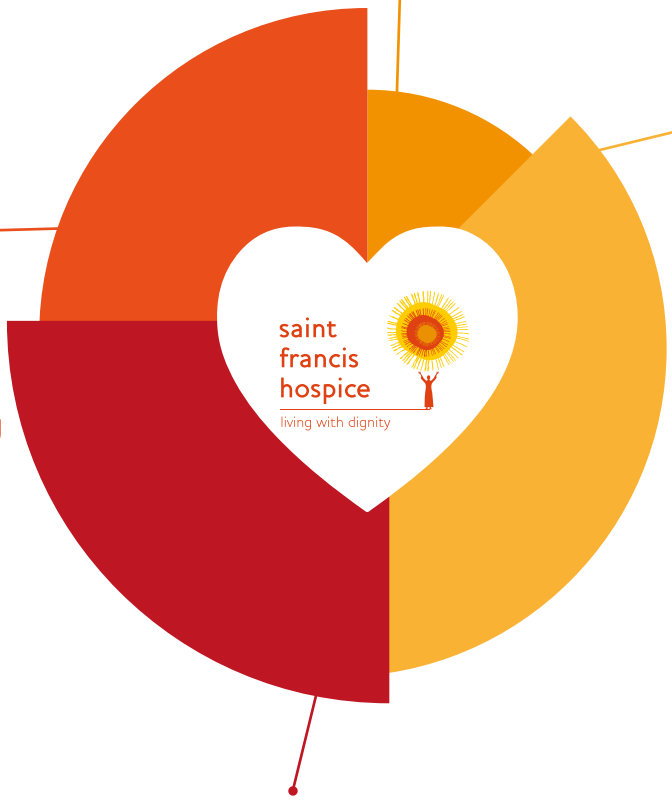
saint francis hospice
living with dignity

Registered Charity No. 275913

2020/2021 Innovations

The last twelve months have turned out to be the most innovative period in our history. Our entire service was impacted by the global pandemic, requiring innovative solutions to brand new challenges in order to maintain services while prioritising safety for all.

- Working Safely protocols
- Gold command established for business continuity – now Transitional Integrated Governance
- PPE for staff, volunteers and visitors
- New and adapted service models to avoid service disruption
- Vaccinations for all hospice staff and volunteers
- Safe family visits to Saint Francis Hospice ward enabled throughout lockdowns



- Qualified Hospice at Home nurses trained to be able to complete verification of death
- Widening access to homeless people
- Covid-specific bereavement counselling
- Care home in-reach to help avoid unnecessary hospitalisation/advise and support best care

- Use of virtual technology across the services to aid individual and carer contacts
- Working off site implemented
- Use of Teams and Zoom for communication and virtual meetings
- Partnership working with Mutual Aid with BHRUT and PAH
- Improved relationships with local hospices - working together as a united force to ensure equality in service provision

- Increased care provision via community teams
- Increased throughput in IPU – with 10 year high of people cared for by the IPU in this last year
- Still meeting grant funding requirements through service adaptations
- Virtual exercise classes
- Creative therapy packs for patients at home

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PART 1
INTRODUCTION

About Us

Our Approach

As an independent charity and one of the largest adult hospices in the UK, Saint Francis Hospice has a vital role to play in the local community. We have a committed team of specialist consultants, doctors, and nurses who work alongside other health and social care professionals across our catchment area to provide comprehensive care for all who need it. These qualified and compassionate people provide care and support to individuals with a life-limiting illness, as well as to their carers, families and loved ones.

We serve the growing and diverse populations of Havering, Brentwood, Redbridge, West Essex and Barking and Dagenham. With only 28% of our funding provided by the government, we need to raise £8.28 million in voluntary donations this year to continue to offer our services, without charge, to those who need them. Every donation is essential to us, and we value every one of our supporters immensely: individuals, schools, faith groups, local organisations, trusts and foundations and businesses, as well as large corporations. We are grateful to our team of some 780 skilled and committed volunteers who help us across the organisation — keeping costs down and adding huge value to the hospice.

Our Vision

A world where everyone gets the right palliative and end of life support and care for them and their loved ones.

Our Values

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

Supportive: We listen to people and value peoples' experiences and use them to give the personal support that is right for everyone.

Compassionate: We are kind and provide a caring and compassionate environment for everyone. We put people at the heart of our actions and words and support people's choices and decisions, helping them feel safe, secure and valued.

Inclusive and Respectful: We are open and transparent and value each person's individuality. We respect everyone and value diversity. We believe our different experiences and knowledge make us stronger. Together we achieve more.

Professional: We are experienced in what we do as a hospice and as a charity. We encourage everyone to give of their best, in providing the appropriate care and expertise to those who need us and support us.

Always Learning: We are open and outward looking, always ready to adapt and change, looking for better ways of doing things, by learning from each other and from the ever changing world around us.

Chief Executive Officer Statement

I am delighted to share our 20/21 Quality Account and to communicate more about our work, focusing on the improvements and developments we have made since the last report.

The Quality Account provides an overview of the vital work we are doing for our communities - providing care to local people, their friends and families, where and when they need it most. Each year I am proud that we develop further and provide more services and care, often in different ways than the year before. This has been especially true this year.

The 2019/20 Quality Account, published in June 2020, prioritised the following projects:

- Clinically assisted nutrition and hydration
- Co-ordinate My Care
- Move & groove exercise and lymphedema
- Embedding ultrasound scanning into clinical practice
- Reporting and follow up of pressure ulcers
- To create a visibly inclusive service for all
- Corneal donation

We could not have imagined the circumstances in which we would work on these priorities, but significant progress has been made in each area, despite the pandemic (see Part 2).

We are now, incredibly, more than a year on from the first lockdown and in the greatest crisis in a generation. Changes were made at breakneck speed at the Hospice in order to accommodate what we thought would be a short term situation. As time went on, we realised we would be living with the implications of Covid for some time, and life at the Hospice has gradually settled into a new normal.

Throughout, the safety of patients, families, staff and volunteers has been paramount, coupled with a determination to continue to care for people facing the end of their lives in the midst of national chaos.

We had to adapt all our services and it is testimony to the professionalism and commitment of staff and volunteers throughout the organisation that people have been able to access, in some form, all we would normally offer.

Income generation has been particularly challenging during the extended periods of lockdown, and we have worked hard to make savings across the Hospice to compensate for reduced income at a time of increased referrals. We rely on IT more than we could have ever imagined before March 2020, and we will need to make significant investment to support home working and virtual service delivery.

Looking to the future, we will take forward learning from this extraordinary period to develop our service offerings, and to further widen access to hard to reach parts of our diverse community. We are proud to have weathered the storm thus far, and look forward with confidence to continuing to provide care to all who need it in our changing world.

Pam Court
CEO

Statement of Assurance from the Board

On behalf of the Board of Trustees, I am delighted to present the Saint Francis Hospice Quality Account for 2020/21. I am pleased to see the progress made over the last year, particularly towards our improvement priorities.

The Board has a role to play in monitoring and maintaining the clinical and corporate governance of the Hospice, fulfilled by attending quarterly governance committees: Clinical, Corporate and Finance, Audit & Investment Governance. These committees receive reports about the work that is done, in order to maintain, develop and improve the high quality services provided by our Hospice. This year, in extraordinary circumstances, these committees have met virtually.

Our visits to Hospice departments took place via Teams, in order to maintain vital communication with the workforce. We have had a steep learning curve over the last year, to ensure that no one who needed us was left behind as we moved swiftly into the virtual world. The entire Hospice workforce has pulled together to serve our community while keeping everyone safe. No easy task!

The wellbeing of staff and volunteers has been a priority and we put measures in place to help everyone cope with increased demands during an uncertain and stressful time, including bereavement groups, mental health counselling and contact with furloughed staff.

During this exceptional year, we received increased funds from the Government, for which we are very grateful, and which have to some extent filled the financial gap created by cancelled events, closure of our retail shops and multiple lockdowns.

People in our local community did everything they could to help – from sending meals for Inpatient Unit staff to providing PPE in order to keep the ward open and everyone safe. We received donations from Trusts, corporates and individuals who contributed to ensure our services remained

available to people who needed them. I am grateful for this amazing show of generosity.

Our priorities for 20/21 reflected our commitment to developing care provision to fulfil the needs of those we serve, particularly important when everything was changing fast. All data available on the quality of care provided has been reviewed.

Hospice care goes far beyond what people might think, and this year's challenges have caused us to develop new ways of communicating and caring for our local population. I am proud that throughout the pandemic, we were able to find a safe way for families to visit their loved ones on our Inpatient Unit.

I would like to thank everyone in the Saint Francis Hospice family for the extraordinary effort and commitment shown over the last twelve months, putting others first while working in challenging conditions. It has been a year we will never forget.

Peter Crutchett
Chairman, Board of Trustees

PART 2

REPORTING ON OUR PRIORITIES

The Quality Account gives us an opportunity to appraise and report on the progress we have made on the priorities identified in last year's publication, and in this section we do exactly that. All improvement priorities – under the headings of Patient Safety, Clinical Effectiveness, and Patient Experience were chosen for their direct impact against the quality of care that patients and families receive from the staff employed by, and services provided by, Saint Francis Hospice.

Priority 1: Patient safety projects

1.1 Clinically Assisted Nutrition and Hydration:

Authors: Isabel Richmond and Dr Pia Amsler

Our guidelines on this area required updating following learning from a national report on the importance of support of nutrition and hydration at end of life, newly available national guidance and an internal audit on our current (2019/20) practice and documentation.

This Quality Improvement Project was predominantly about embedding better discussions and their documentation but could ultimately lead to a far wider reaching service development (review of clinical staff's competencies of intravenous fluid administration in particular) if we are to truly individualise our care and support in the provision of nutrition and hydration in the last days and weeks of life.

The following actions were taken:

1. The guidelines have now been rewritten, emphasising a clear and structured approach as suggested by the British Medical Association in conjunction with the General Medical Council. It has been approved by the SFH Ethics Interest Group.

2. The organisation has started to establish how to implement an individualised approach of fluid management in the last days of life. This will include, for some carefully selected patients, an active decision to offer hydration. For this to be possible, existing nursing staff needs to develop IV competencies and newly appointed staff with pre-existing competencies gained elsewhere need to be empowered to maintain those iv competencies.

3. The paper based documentation of the end of life care framework has been changed to an electronic version which is accessible on icare. It is now mandatory to comment on aspects of hydration and nutrition in the last days of life. This way we can ensure that all conversations with the family (and patients where possible), are fully documented.

How will the progress be monitored and reported?

1. Annual nurse appraisal and personal development records of trained nursing staff
2. Repeat of the initial audit after implementation of the electronic End of Life Framework (EOLF). This could be done by one of the GP trainees in Autumn 2021
3. Feedback from bereaved families – this still needs to formally established

Goals for 2021/2022

1. Maintain IV competencies and clinical skills update days for staff joining SFH with IV and cannulation skills.
2. Develop competencies and training for current nursing staff to be able to acquire these skills
3. Introduce the above into existing nursing professional portfolios
4. Audit of electronic End of Life Care Framework (suggest Autumn 2021 by one of the August GP trainees)
5. Gain regular feedback from bereaved families, with specific emphasis on our handling and communication of hydration and nutrition at EOL

Progress

- The policy was approved by the Ethics Interest Group and was ratified in the summer of 2020.
- Electronic End of Life Care Framework is now established. Daily consideration of nutrition and hydration needs is part of this and is now part of this documentation.
- The timeframe for some of the goals need to be modified in light of Covid 19. (please see below)

Work outstanding

1. Consider how to obtain feedback from bereaved families about nutrition and hydration at end of life. This could be incorporated into an existing SFH survey for bereaved families
2. Developing IV competencies and training for ALL trained nursing staff. This is planned for the second half of the year 2021 as it may require staff to gain experience in other areas requiring possible partnership with NELFT and BHRUT. In current times this is not possible due to Covid 19. It is hoped that the Practice Development Nurse post will be appointed in the next few months. This post will be pivotal in progressing this goal.

1.2 Co-ordinate My Care

Authors: Dr Corinna Midgley and Diane Drain, Advance Care Planning SIG lead

Our aim: to support, champion and lead the development of use of Coordinate My Care (CMC), a London-wide electronic palliative care coordination system which has only recently come to outer east London. CMC prompts discussion and documentation of key diagnoses, treatment options and escalation plans, preferences for care and what to do in a crisis. The CMC record is then accessible by GPs, paramedics and urgent care responders, district nurses, hospitals and specialist palliative care so when called to a crisis the attending team can help, mindful of the clinical situation, special wishes, preferred place for care and death and best management of symptom control, without conveyance to hospital, if hospital is not wanted.

Progress:

- Our medical, Hospice at Home and Clinical Nurse Specialist (CNS) teams have gained confidence in exploring Advance Care Planning and initiating and updating CMC records. We have progressed our understanding of what urgent care providers find a helpful record in a crisis, through working with London Ambulance, paramedics, our local hospitals and other partners in care. We have now run sessions for our therapy and our family support teams, and most recently the Royal Marsden hospital (who devised the CMC record) has come to Saint Francis Hospice to share CMC with OrangeLine staff and volunteers.
- 'My CMC': We now have a much better understanding of the value of people initiating their own records. Our OrangeLine, therapies and community facing teams are confident to discuss the value of a CMC record with their clients and to support people to create their own 'My CMC' record.
- We have completed two audits on CMC. One focussed on content (quality) of the record, the other on outcomes such as: Were wishes realised? Were health crises made more manageable by the existence of the record? Was preferred place for care achieved? Was preferred place of death achieved? Was unnecessary hospitalisation avoided? These audits were presented in house, and to specialist teams in North East London.
- We have had hugely valuable discussions with our urgent care responder colleagues, which have helped us to understand what they need to know, towards creating and updating records that help them support in a crisis.
- We have created Webinars and other teaching, which we have shared and delivered to GPs, paramedic colleagues and care home staff amongst others. Talking about CMC, learning about its impact in a crisis, sharing stories of the difference a good record has made has made a tangible difference to the number of records being created, the quality of the records and the viewings by our Urgent Care colleagues.

Work Outstanding:

We need to continue to work with and champion CMC locally; we have seen it make such a positive difference to outcomes. We will work to build our confidence in and the use of My CMC. Our Inpatient staff are the group least familiar with CMC and we will work to change that in the coming year. We wish that we could access, see and contribute to the Essex system, System One, for our Brentwood residents, and we are discussing this with our Commissioners at St Luke's Hospice and our partners in care across Mid-South Essex.

1.3 Move and Groove Exercise and Lymphoedema Support

Authors: Kathryn Owens & Tracie Brennan

Support Groups in palliative care are aimed at providing a 'safe haven' for patients to receive advice, support, symptom management and care. Patient safety is always a priority and monitored carefully throughout their attendance, both for symptom control and wellbeing.

Introduction

The Therapies Team provide support, advice, care and symptom management for many people both in their homes in the community and onsite at the Hospice. This provision of care must always have the patient's safety at the forefront, ensuring that their physical and mental health is safely provided for. A person's ability to maintain a safe, active and independent life can be affected by many things. Reduced mobility and movement due to physical diagnosis and mental health will directly affect a person's independence and safety.

Move and Groove Exercise Programme

With the aim to increase physical strength and movement safely, the Therapies Team set up a 'Move and Groove' exercise group programme which was delivered by our Therapies assistants, guided and monitored by our Physiotherapists.

Aims

- Patients needing to improve general strength
- Improve confidence and self-esteem
- To improve independence and ability to carry out activities of daily living safely

Target Client Group

- Patients with reduced general strength and activity level that has a significant impact on their day to day living and a wish to improve this to better manage independently and safely
- Able to engage in and attend a session for up to one hour

Group structure

- Warm up and session of gentle sitting and standing movements guided by a Therapies Assistant
- Session of relaxation

Referral Process

- To be seen by clinical member of SFH initially – to confirm they are physically safe to attend and if they are on any medication that could cause problems or side effects if exercising
- Must be in mild to moderate health to be able to attend and to be mobile
- Referral to be completed. Must include current mobility, whether transport is required and if on oxygen they need to have their own concentrator.

Outcome

These groups took place until March 2020 then due to the concerns to keep our patients safe as a priority during the Covid 19 pandemic and to comply with Working Safely Government guidelines, a review took place, resulting in some changes in the way these services could be provided.

As numbers within a limited space were reduced or not possible during this restricted time the decision was made to see patients individually in an outpatient situation. The team were also instrumental in providing individually prescriptive Physiotherapy plans to achieve at home with telephone or video call support. People were also signposted to videos provided on our website for

basic movement and seated exercise sessions.

Conclusion

These small groups and individual sessions were a valuable source of motivation and education to increase the attendees' independence and level of activity ensuring continued safe mobility.

Patient comments

I find these exercise sessions so rewarding, it gets me out and I feels so much better afterwards. I love the company at the exercise sessions. Its great fun and it motivates me to exercise at home

Lymphoedema Wellness Management Virtual Sessions

A support group programme was set up by our Complementary Therapy Team to increase independence and safe self-management of Lymphoedema for those living with this condition,

Aims:

- To provide education around Lymphoedema; causes, effects and management strategies
- To provide peer support through the use of a group medium
- To improve the individual's ability to self-manage
- To improve the individual's ability to manage activities of daily living safely and effectively as a result.

Target Client Group

- Patients diagnosed with secondary lymphoedema which has significant impact on their day to day living and who wish to improve their understanding of the condition and how to better manage it safely
- Need to be able to engage in and attend a session for up to one hour
- Need to have access to an online platform

Group Structure

- Small group introduction covering general advice and education around lymphoedema delivered by the Complementary Therapy team
- Follow up: patients will receive a telephone call to see whether they are satisfied or require personalised follow up 1:1 sessions
- 1:1 session for specific advice

Referral Process

- To be seen by clinical member of SFH initially – to confirm they are physically safe to attend and if they are on any medication that could cause problems or side effects if exercising
- Must be in mild to moderate health to be able to attend and to be mobile
- Referral to be completed. Must include current mobility, whether transport is required and if on oxygen they need to have their own concentrator.

Outcome

With the Covid 19 pandemic restrictions in place, this service became a virtual support group. This group offered small groups the ability to meet and discuss any subjects relevant to Lymphoedema and then follow up with one to one sessions led by our Complementary Therapy team. Provision was also made for those without technological access to be supported by telephone and some individual appointments.

Conclusion

Although access has been restricted for some, the availability of this resource for those with lymphoedema has been important in keeping this client group safely active and knowledgeable about how to continue this independently.

Patient comments

Thank you for great care management and treatment of my left arm. It has made an immeasurable difference to my life how I have missed my visits during lockdown. It makes such a difference to my arm and myself

Priority 2: Clinical Effectiveness Projects

2.1 Embedding UltraSound Scanning into clinical practice:

A project to equip our medical and nursing staff with USS competencies for bladder and abdominal ascites assessment.

Authors: Jo Eastman, Diane Drain and Tahnee Kemp

The organisation currently has the services of a volunteer Sonographer twice a week. The assessment of urinary retention and the volume of abdominal ascites have been highlighted as areas that would benefit from more frequent assessment being available within the organisation.

Bladder scanning enables appropriate catheterisation to be carried out and the assessment of abdominal ascites allows drainage to be carried out at the Hospice, thus avoiding a disruptive hospital transfer. Both of these procedures can support patients' symptom management, aiding comfort. A National Framework for Local Action (2015-2020) identifies six Ambitions for Palliative and End of Life Care, with ambition three identifying 'Maximum comfort and wellbeing'.

What did we want to achieve?

A recognised cohort of trained, competent and confident staff that can perform bladder scans and assessment of abdominal ascites in a timely manner on appropriate patients. This will include staff from the newly formed Continence Service Improvement Group

Summary of Actions

- A certified training programme that is time protected for medical staff and nursing staff. This can include Healthcare Assistants
- A one hour face to face classroom session led by our volunteer Sonographer. This would cover basic ultrasound physics, technique, and pitfalls that might be encountered in practice.
- A one hour practical classroom based assessment with competencies that will be signed off by our volunteer Sonographer.
- An observed practical assessment with a patient. A learner can request more than one practical patient assessment until confidence is achieved.
- Ongoing support via image review with our volunteer Sonographer.

How will the progress be monitored and reported?

- Identification of staff to be part of the Continence Service Improvement Group
- Registers of trained staff
- Student feedback
- 3 yearly competence review
- Audit of training and scanning
- Feedback from the Service Improvement Group to the Clinical Effectiveness Group
- Feedback from the Clinical Effectiveness Group to Clinical Governance.

Achievements so far

- 5 staff members have been identified and have now reformed the Continence Service Improvement Group.
- 3 group members have had 1 hour classroom based teaching and 1 hour practical assessment.
- Register of staff who have been trained
- Step by step guidance has been written
- Student feedback from the training session.

Going forward

- Further training sessions to be organised
- Audit identifying the effectiveness of early identification of a full bladder on the comfort of patients

2.2 Reporting and follow up of pressure ulcers

Introduction

Pressure ulcers are caused when an area of skin and the tissues below are damaged as a result of being placed under pressure sufficient to impair blood supply. All patients are potentially at risk of developing a pressure ulcer. However, they are more likely to occur in people who are seriously ill, have a neurological condition, impaired mobility, impaired nutrition, poor posture, or a deformity. Also, the use of equipment such as seating or beds, which are not specifically designed to provide pressure relief, can cause pressure ulcers. NICE (2014)

Standard

Hospice UK (April 2016) advocates that patients who are at risk of the development of pressure ulcers or those with an existing pressure ulcer are managed in line with national guidelines. Hospice UK also supports that the Hospice complies with required reporting framework by the Care Quality Commission (CQC) and Clinical Commissioning Groups (CCGs).

The incidences of pressure ulcers are reported whether they developed during care provided by us, or were present on admission to the service. They are reported with an accurate assessment of the degree of harm, in alignment with the reporting requirements of the Hospice UK Clinical Benchmarking Team, in line with the National Health Service Improvement (NHSi) guidance on pressure ulcers: revised definition and measurement (June 2018). As an organisation, it is imperative that where pressure ulcers have been reported, we must ensure that investigation and learning is achieved and disseminated where appropriate.

Summary of actions

An in-depth review of systems and processes was undertaken on the Inpatient Unit following an investigation into the incidence of a pressure ulcer. While we were assured that policies and systems were in place, some processes required review. From this, it was identified that how the pressure ulcer reporting is followed up and the learning shared, could be achieved in a more effective and timely manner.

Actions

The Hospice has a well-established Wound Management Service Improvement Group. The lead of this group has been given access to added protected administrative time with the aim to review the process of pressure ulcer incident reporting. This has included the review of assessment documents, auditing compliance to the adherence of completing appropriate documentation, providing teaching, assisting and supporting the reporting of pressure ulcers, active involvement with the investigation of pressure ulcer incidents, and ensure learning from incidents is disseminated appropriately.

The lead ensured that the Wound Management Service Improvement Group were kept informed of the progress of the project as were the Practice Development Team, Ward Manager and Head of Nursing, Quality and Assurance - Registered Manager. Where appropriate, the information was fed into the relevant management groups.

Authors: Michaela Sen: Head of Nursing, Quality and Assurance

Priority 3: Patient Experience Projects.

3.1 To create a visibly inclusive service for all

Author Bridget Moss

We know that access to palliative care can be patchy and LGBT people face significant barriers to getting such care when they need it.

We know from studies that older LGBT people fear that health and social care professionals may be indifferent or even hostile towards sexual or gender identity. The end of life is a time of vulnerability for the person and their family and professionals may unwittingly cause lasting damage if insensitive towards a person's key relationships. As the population ages, the need for high quality palliative and end of life care increases. It is vital to meet the expectations of LGBT people for person centred care that acknowledges and supports those that are important to them.

Identified Goal: To create a solid and visible inclusive service for all. This will involve staff and volunteers across the organisation; the initial focus will be Lesbian, Gay, Bisexual and Trans (LGBT) people. It is recognised that this abbreviation covers a diverse group of people with very different experiences and needs. The focus of the group will widen during 2021, as highlighted below.

Actions Taken

- Involvement in Romford Virtual Pride June 2020
- Organisational survey completed by 235 staff; the findings of this were subsequently presented to the organisation at the CEO Forum
- Virtual training delivered by Bridget Moss, Head of Education and Chair, across Sept-November to 94 staff. This included making a pledge to improve practice, with an example, and a badge to symbolise additional training and skills
- Ensuring, where possible, that all staff had equal access to computer stations for virtual learning through reorganisation of the education space
- Integrating this work into the wider work of the HR management Group
- Keeping contacts with external colleagues for research and funding opportunities (although not a priority during COVID19 times)
- A newly formed Diversity & Inclusion sub-group has been established and met for the first time in December 2020. The group agreed that it should have a proactive role and a wide remit which covered religion, spirituality, age, disability, sex, race, marriage and civil partnership, pregnancy and maternity and sexual orientation. The group also has membership which links into the LGBTQ+ Service Improvement Group, work which is taking place on homelessness, and improving access and uptake of service for Black, Asian and Minority Ethnic (BAME) groups.

Work outstanding

- Continuing contact with London Hospices Network, with particular attention on participating on London Pride 2021 if the event is safe, and sustaining the work contacts and potential for joint working
- Recognising LGBT History month (February 2021) and marking this in the organisation in a number of ways, including education sessions and building on previous learning
- Learning from published research and guidance, for example the Royal College of Nursing publication Fair Care for Trans and Non-Binary People, updated November 2020, and incorporating this in learning events
- It has emerged, from the work so far, that this activity continues to play an important part of being a culturally sensitive organisation

3.2 Corneal Donation

Author Diane Drain

What is Corneal Donation?

How can we enable people who would like to donate their corneas to do so. To share that wish, so that we are aware and can support them in their choice.

Corneas are the clear tissue like window covering the front of the eye. They control and focus the entry of light into the eye and accounts for between 65-75% of the eye's total focusing power.

How was this priority identified?

Corneal transplants can restore sight, but there is a national shortage of corneas in this country. At present we buy corneas from other countries to cope with this shortage and there continues to be a long waiting list for recipients.
A recent change in CQC inspection standards for Hospices (2018), highlighted the need to honour patient's wishes for organ and tissue donation at end of life.

These discussions are often neglected which means patient's wishes are not always honoured and the opportunity to donate their corneas may be missed.

What do we want to achieve?

To improve corneal donation rates within Saint Francis Hospice.
All patients who wish to donate their corneas have an opportunity to do so.
Sustainability of corneal donation, whilst consistently taking patient wishes into account.
For all staff at Saint Francis Hospice to be aware that this is a service we provide.

How will this priority be achieved?

This will be achieved by developing a Quality Improvement Project across the Inpatient Unit and Community Services. Establishing a Service Improvement group for corneal donation
Liaising with our Local Hospital Development Nurse Practitioner from NHS Blood/Transplant, for support, advice and guidance. Multidisciplinary meetings to ensue all Hospice staff are aware of the project. Obtain baseline data on staff knowledge and awareness of corneal donation.

Develop a process with guidelines that can be used by all staff. Arrange specialist training in collaboration with NHSBT for all staff on the process of corneal donation, including how and when to facilitate conversations with patients and their loved ones, how will the decision be documented on iCare, how to contact NHSBT and how all relevant staff are aware of the patients decision. Write the corneal donation policy.

How will the progress be monitored and reported?

Daily reports emailed to the Service Improvement Group to ensure that there is an accurate record of patients being asked about their corneal donation wishes and their wishes being honoured.
Monthly reports from NHSBT confirming our corneal donation activity.

Yearly audits

Bi-monthly Service Improvement Group meetings
Feedback from patient loved ones.

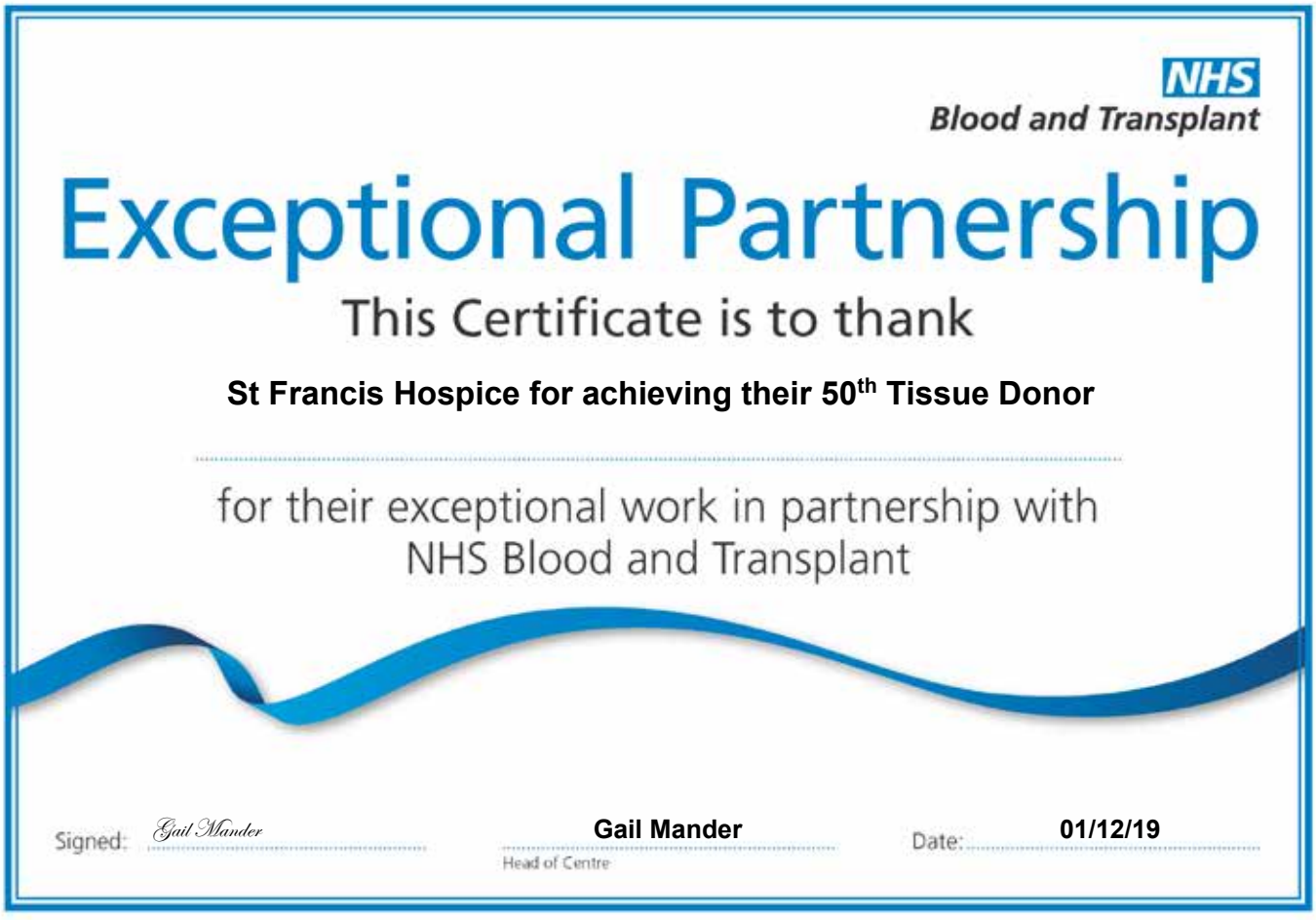
Achievements so far

From November 2018- December 2019 we established the process for corneal donation at Saint Francis Hospice.

In December 2019 this was recognised by NHSBT and we were awarded an Exceptional Partnership award for 50 donations being made.
In November 2019 we had an abstract accepted for Hospice UK National Conference titled 'Implementation of a Pathway to Improve Rates of Corneal Donation within a Hospice setting: A Quality Improvement Programme'. We were also invited to display a poster at the conference.
In January 2020 we submitted our project to the BMJ Awards, but was unsuccessful this time
In March 2021 we proudly had our 100th corneal donation, this is an amazing achievement by all the team involved at Saint Francis Hospice.

Going forward

Continue to ensure all our patients who wish to donate their corneas have an opportunity to do so.
Continue to work closely with our community teams, ensuring patients we care for in the community are also offered the chance to donate if they wish too.



PART 3

PRIORITIES FOR IMPROVEMENT

We're proud of the services we provide at Saint Francis Hospice but we know that there are always things that could work better. The delivery of high quality care is at the heart of what we do, for our patients, staff, volunteers and trustees, and to make our care even better, we prioritise key areas of development each year.

This section highlights the main quality improvement projects we will be focusing on in 2021/22.

Priority 1: Patient Safety
1. Occupational Therapy and Physiotherapy: a new model of care

There are many aspects of care that can be provided by Occupational and Physiotherapy services beyond the basic mobility and equipment provision.

How was this identified as a priority?

To ensure that all patients admitted to the Inpatient Unit (IPU) received an equitable high standard of rehabilitative care during their stay a review of the current model and referral procedure was taken.

At review patients were:

- Referred by any member of the Multi-Disciplinary Team (MDT)
- A representative from the Therapies team attended daily handover meetings and twice weekly MDT ward meetings.

This system relied on the MDT's awareness of what services could be provided by the Therapies teams. This resulted in the main focus of referral to be on discharge planning and general mobility.

How will this be achieved?

With the aim to provide a more holistic and thorough service for people during their stay on the IPU, the Therapies teams propose:

- Daily attendance by Occupational and Physiotherapists at daily ward handovers and twice weekly MDT
- Referral of all new admissions to the Inpatient Unit to Occupational and Physiotherapy teams
- Patients to be seen within three working days of admission

This will allow the teams to identify people that would benefit from rehabilitation or symptom management support, to provide a more holistic service during their stay. It would also enable the teams to be involved early on in discharge planning so that all necessary equipment and support can be provided in a timely manner.

How will the progress be monitored and reported?

Three month pilot to be reviewed by the Therapies teams and the Ward Manager.

During the three months, further monitoring would take place as follows:

- Regular discussion with the inpatient MDTs for feedback
- Simple real time feedback from patients' experiences on discharge
- Review of IPOS scoring & outcomes
- Review of iCare statistics

Priority 2: Clinical Effectivness
2. Widening Access to People with Dementia

How was this identified as a priority?

The hospice has noted increasing number of referrals of people with dementia (PwD), both to IPU and to the community team. Saint Francis Hospice has no dedicated strategy or clinical pathways on how best to approach the current and expected influx.

Goals we are setting

As part of the widening access group and in conjunction with key players in the Havering community and hospital dementia services, we

- Are auditing the kind of input our Community team are currently offering to PwD;
- Will support and empower our colleagues in the memory clinic and primary care to progress with advance care planning and the use of Coordinate My Care records;
- Will develop a referral pathway for colleagues in primary and secondary care for PwD into Specialist Palliative care;
- Will develop a business plan to support PwD and their carers in our day services, taking a multi-professional and multi-organisational approach, based on the Havering Strategy. This model will need to be adjusted as the Covid related restrictions are easing;
- Will continue our collaboration with the Havering Dementia Action Alliance;
- Seek representation on the Dementia Partnership Board meetings (Commissioning level) to improve their understanding of what the hospice can offer beyond Hospice at Home in last days of life;

How will the progress be monitored and reported?

In parts, we have already achieved the set objectives. Future spot audits and reviews

- will assess an increased referral rate of people with a primary diagnosis of dementia;
- will see beginnings of "Your Day, Your way" as day services open again;
- will see education and collaborative working with key players in the community and hospital;
- will see more CMC records and Advance care plans for PwD throughout Havering;
- will see the Havering Strategy be adjusted to include the holistic hospice support before the end of life is reached.

All of the above will be reported through the appropriate Governance channels and shared with the Senior Management Team.

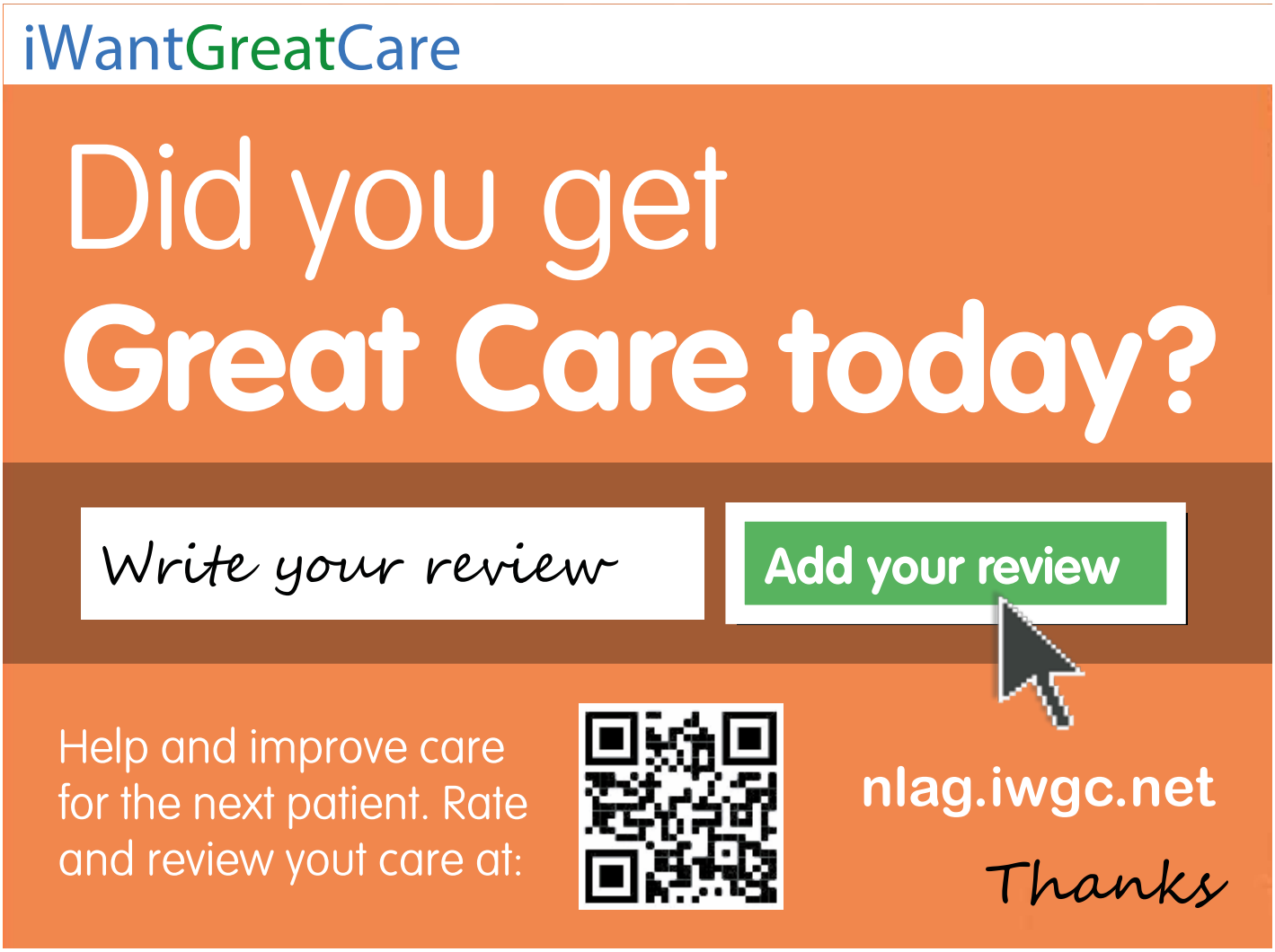
Author Dr Pia Amsler
Consultant in Palliative Care

On behalf of the Widening Access Group for dementia, April 2021

Priority 3: Patient Experience

3.1 Individual experience feedback

Authors: Brigid Hardy, Jan Scott, Tracie Brennan



How was this identified as a priority?

Our Individual Experience Management Group has identified that the number of completed user feedback surveys has decreased over the past 12 months. Our survey forms encourage feedback from people to provide meaningful, totally honest and independent reviews on the services they have received. Feedback also allows people to say 'thank you'. We then use this feedback to assist with improving services – and as a quality indicator of what we are doing well and how we can improve even further in the future.

What are the goals you are setting for yourself?

To receive independent and transparent feedback we aim to provide a monitoring and feedback system that is simple to use, and which gives people a choice of options on how they would like to respond. This can be via our website, by using a simple app, in person, on site or by telephone.

How will the progress be monitored and reported?

Our aim is to invest in the iWantGreatCare system. This system is used successfully by many NHS and hospice care providers and will provide people with easier feedback options. This in turn will provide us with quantitative and qualitative feedback. This will give us a real insight, with data, that provides us with the opportunity to ensure continuous improvement of all the services we offer, highlighting a better quality of life to those we support.

3.2 Sleep well Initiative – IPU Priority

Authors: Jo Noguera, Kathryn Owens, Corinna Midgley

How was this identified as a priority?

We aim to provide a calm and restful environment on our Inpatient Unit but we know from some feedback to the ward that we do not always achieve this. In particular night sleep as an inpatient can be difficult, for environmental, also individual reasons. Identified environmental factors include bright lighting and noise. Barking Havering and Redbridge University Trust (BHRUT) hospitals identified similar challenges, leading to BHRUT running a 'sleeping well' project last year. We felt the goal of sleeping well was a great one, so have committed to our own 'sleep well' project.

What are the goals you are setting for yourself?

To support our inpatients to each get the best night's sleep they can.
We will identify causes of disturbed sleep, looking to rectify what environmental factors where possible.

- How was your (people on the ward) sleep last night/this week?
- What sort of things stop you (them) sleeping well?
- What sort of things help you (them) to sleep well?
- What in the ward environment (if anything) disturbed you (them)?

Our therapies team will incorporate sleep questions into their assessments, feed back any environmental issues or symptom /psychological challenges to the ward team at handover, and work on relaxation and sleep promotion techniques with people who are finding sleep hard.

They will look at the possible role of 'sleeping well' packs, either tailored for individuals or generic for use by anyone who needs them (e.g. packs with eye mask, pillow blends). Such packs will require funding so if pursued, a source will need to be identified.
The team will evaluate the impact of sleep investment, by tracking sleep satisfaction and the current Integrated Palliative Care Outcome Scale (IPOS) questionnaire (used at discharge) will be adapted to include a question on sleep.

How will the progress be monitored and reported?

Via ward handover/Multi Disciplinary Team meetings, where feedback will be received from our therapies team about individuals on the ward, and from IPOS feedback as people are discharged, which will be collated and reviewed by the therapies team and the wider ward team, together, monthly.
The project will give formal feedback to the Clinical Governance Committee at 9 months.

3.3 Widening Access Group Project for People Experiencing Homelessness

Authors: Ann Dalgliesh and Isabel Richmond

How was it identified as a priority?

Through the Widening Access Group (WAG) and through visits to the Salvation Army drop in. From 2017 to 2019 only 3 people experiencing homelessness were referred to SFH for palliative care. Deterioration can be difficult to predict, people who are homeless are frequently poorly engaged with the healthcare system and support workers rarely come from a healthcare background. These factors lead to an inequity of care and services which are not joined up. The WAG successfully applied for Masonic funding via Hospice UK for an 18 month project to address this. Initially for the first 9 months we will focus in Havering then expand into Barking and Dagenham and Redbridge.

What are the goals?

To develop relationships with the local homeless community in order to facilitate better access to palliative and end of life care at SFH. This will be achieved by working collaboratively with the wider multi-disciplinary team through:

- Implementation of the new SFH referral guidelines
- Education programme for internal and external front line workers
- Raising awareness for SFH staff
- Attendance at multidisciplinary case meetings
- Joining community of practice meetings
- Presence at drop in centres
- Attendance at borough homelessness forums

Ann Dalgliesh (Senior Staff Nurse, Hospice at Home) has been seconded one day per week to lead this project forward supported by the WAG.

How will the progress be monitored and reported?

- Reporting to Hospice UK using the progress summary of activities log
- Data collection on i-care
- Educational data collection
- As a regular agenda item on the WAG

3.4 Widening access to hospice services for people of black, Asian and other minority ethnic background

How was this identified as a priority?

When two of our doctors reviewed existing ethnicity data at Saint Francis Hospice over the last few years, it was evident that the Hospice was receiving significantly fewer referrals for care and support of people from black, Asian and minority ethnic (BAME) groups than would be expected, given the population we serve. We were concerned to understand why. If we could identify barriers to access, what could we do to break them down, to ensure access to and greater uptake of our services?

Goals we are setting:

1. To ensure continued active, regular review of SFH ethnicity data, and comparison against our local population Census data, so that ongoing low uptake of services by BAME groups is flagged for exploration.
2. To ensure that referrers know that there is under-referring of people from black, Asian and minority ethnic groups into our services so that they can contribute to identification of and breakdown of any barriers to referral.
3. To ensure SFH staff, and volunteers (including the Board) are aware of low referrals of people with a BAME background, so that they can also contribute.
4. To develop links into our faith communities via our pastoral care team, to listen and to learn from their understanding of and experience of hospice care.
5. To conduct a research project with SFH's BAME service users to gain insight into their experience of SFH care.
6. To identify whether and what resources are needed to prevent widening of the gap between those in need that we do see and those that we do not see.
7. To develop and implement organisational key performance indicators that monitor and support this work.

How will the progress be monitored and reported?

Progress will be monitored via the Clinical Governance Group as a standing quarterly report item, and by annual review of ethnicity data, with an annual action plan.

3.5 Keyring Keepsake – IPU Priority

- **How was this identified as a priority?**

We adopted the project from the concept of 'Ashes to Glass' during the Covid19 pandemic when it was difficult for families to visit their loved ones on the Inpatient Unit. Safety restrictions and Government guidelines meant that not all family members were able to visit and spend the time with their family members. One of the nurses came forward with the concept due to the increase in uptake of personalised mementos of loved ones such as 'Ashes to Glass' whereby a deceased person's ashes are incorporated into a piece of jewellery, at cost to the family. We adapted this into a cost effective alternative to a person's ashes yet just as unique - their fingerprint.

- **What are the goals you are setting yourself?**

We aim to offer each family member of anyone who dies on the Inpatient Unit a key ring with their loved one's fingerprint. On the reverse of the keyring is a poem linked to the concept. The keyring is placed in a small orange bag and presented to the family.

We present the family with a leaflet outlining the concept of the keyring and there is an option for a voluntary donation, so that the project could be self-funding and possibly to provide additional fundraising for the Hospice.

- **How will the progress be monitored and reported?**

An audit form will be set inside the keyring storage box to record:

- The number of families offered a keyring
- How many decline the offer
- How many accept the offer
- How many keyrings are provided
- Value and number of any donations received

The fundraising directorate will allocate a separate coding for donations received from the keyring keepsakes as a form of monitoring. Additionally, feedback from families will be recorded.

PART 4

PARTICIPATION IN CLINICAL AUDITS

Clinical and Service Audits Programme

Clinical audit is high on our priority list although we are unable to participate in NHS-led national clinical audits and national confidential enquiries, due to being a voluntary sector organisation. We understand that if we want our services to continue to offer the best clinical practice, and to grow in quality to better support people with an increasingly more complex range of life-limiting conditions, we need to continuously assess our practice against the best standards possible.

Our annual audit programme is dynamic and broad, and is managed by Michaela Sen, Head of Nursing, Quality and Assurance and Diane Drain, Practise and Quality Improvement Lead.

Audit activity is reported:

- Monthly at the Quality and Care Directorate team meeting
- Bi-monthly at Clinical Audit Group
- Bi-annually to the Clinical Effectiveness Group
- Annually to the Clinical Governance Committee.

1. Annual Audit Programme

Each year, we run an ongoing programme of audit activity, both in-house generated and against nationally recognised excellence standards which have been researched and developed by Hospice UK (national charity for hospice care in the UK). Hospice UK provides audit tools which enable us to benchmark our specialist palliative care services against the best standards of excellence for a large range of health, safety and care delivery principles.

Annual audit programme

Number	Name
01	Hospice UK - Infection Prevention - Inpatient Unit (IPU)
02	Hospice UK - Infection Prevention - Pemberton Place
03	Hospice UK - Pre-Bereavement
04	Hospice UK – Self-Assessment; Accountable Officer
08	Hospice UK - Admission Telephone CNS
10	Hospice UK - General Medicines
11	Hospice UK - Controlled Drugs
12	SFH in house - Resuscitation Policy Audit
14	Hospice UK - Nutrition & Hydration
15	Hospice UK - Pain Management
16	Hospice UK - Bereavement Support
17	Hospice UK - Medical Gases
18	Hospice UK - Safety Matrix Benchmarking tool
19	SFH in house – SCCS Standards
20	Patient Led Assessment of the Care Environment (PLACE)

2. Short Observational Framework Inspection (SOFIs)

Short observational audits are undertaken on an annual basis, unless concerns are identified. SOFIs are particularly useful for evidencing compliance against Care Quality Commission (CQC) key lines of enquiry. They are also beneficial in evidencing gaps not sufficiently covered by larger annual audits.

Annual SOFI plan

Number	Name
02	Care plans – IPU
03	Care plans – Community
04	Mental Capacity
05	Environment supports privacy and dignity
07	Informed consent – IPU
08	Assessment of risk within clinical and non-clinical areas
09	Reception area
12	Safeguarding people who use services
13	Using clinical equipment
14	Discharge Planning
18	Hand Hygiene
19	Nutrition
20	Whistle Blowing
21	Uniform/dress code: Hands on clinical
22	Uniform/dress code: Domestic
23	Maintenance and renewal
25	Catheter care
26	Storage of M&H equipment and spot check of servicing tool
27	Diabetic Management
29	Controlled Drugs Check (Six monthly)
30	Fall Toolkit IPU
31	Medicines Safety Thermometer Audit
32	Hand Hygiene. Domestic

3. Clinical Audit Group (CAG)

The Clinical Audit Group (CAG) meets every other month and, under the guidance of the Clinical Governance Committee, oversees all audit activity. Completed Audits are presented to the multidisciplinary team at the Clinical Audit Group. We also maintain a noticeboard dedicated to audit news, presentations and updates. The overall aim is to instil an ethos that encourages and recognises the advantages and value of audit within our organisation.

"He really wanted to die at St Francis Hospice and we shall be forever grateful that he got his wish. With the exception that he was taken from us too early, in all other ways his passing was the perfect ending that he had wished for, so that brings us some comfort at this strange and difficult time. Thank you for the support towards our whole family."
(Service user feedback May 2020)

Audits undertaken and presented at CAG 2020/2021

Audit Number	Date Presented	Audit Title and Presenter
156	02.09.2020	Co-ordinate My Care (CMC) data April / May 2020 Dr Mark Howard
156b	02.09.2020	An audit of quality of CMC records within Barking, Havering and Redbridge (BHR) community against urgent care standards Dr Corinna Midgley
155	04.11.2020	Audit to identify the quality of documentation on iCare of care received by a deceased person and those important to them after death Diane Drain, Sarah Miller and Michaela Sen
SOFI 31	04.11.2020	Pharmacist Audit Dr Corinna Midgley
154	06.01.2021	Paracentesis Audit Dr Anna Gray
149	06.01.2021	An audit to better understand the needs of nursing home patients Maria Stripe, Jane Elmer, Tricia Lowe-Dookie, Julia Bryan, Michaela Sen
153	03.03.2021	Outcome Assessment and Complexity Collaborative (OACC) data collection audit at SFH IPU (157) Specialist Community and Crisis Support Service (SCCS) & Hospice at Home (153) Dr Natalie Mills and Dr Mark Howard Dr Pia Amsler

We are committed to making continuous improvements and to aid this, all results following an audit are presented and discussed within our relevant teams as a learning opportunity. The results, and the outcomes of the team discussions, are used to develop an action plan specifying the overall owner of the audit, what actions are required, how this is to be achieved and who is responsible for the implementation of actions.

Some examples of changes made this year following audit include:

- 156 – 156b: Teaching sessions have been given to the Therapies and Wellbeing Team, and Family Support Team concerning Co-ordinate My Care (CMC). Work with the CMC users group continues and attempts are continually being made to include more Hospice representatives for signposting people to CMC
- 155: Work was undertaken in collaboration with the End of Life Service Improvement Group to develop and roll out an electronic version of the End of Life Framework on iCare. This was achieved by November 2020 and a re-audit will be undertaken in 2021
- 154: Consent procedure for amendment in local policy and identified risks incorporated into the consent form. A poster was accepted for presentation at Palliative Care Congress March 2021
- 149: Local processes and standards were reviewed by our Specialist Community and Crisis Support Service (SCCS). A new standard was commenced for those people being supported in nursing homes. A more active engagement with the End of Life Facilitators in the community has been maintained.

PART 5

REVIEW OF QUALITY PERFORMANCE

Quality Performance Overview

Saint Francis Hospice's accountable people are:

Pam Court
CEO and CQC Responsible Individual

Michaela Sen
Head of Nursing, Quality and Assurance (CQC registered manager)

Use of the CQUIN Payment Framework
Saint Francis Hospice income during 2020/2021 was not conditional on achieving quality Improvement and innovation goals through the Commissioning for Quality and Innovation payment framework. We will continue to look for target based/ QIPP opportunities for the year ahead in discussions with the CCGs that we work with and are contracted by. Through our sub contract arrangements with St Luke's Hospice we have also requested that any CQUIN or new business case proposals that they work to achieve in the future, that we are also considered in partnership to ensure we achieve consistent services within the Brentwood area of Mid Essex CCG.

Statement from the Care Quality Commission
Saint Francis Hospice is required to register with the Care Quality Commission and is currently registered for Treatment of Disease, Disorder or Injury and Diagnostic and Screening procedures. We were not inspected during the period of this account and maintain our Outstanding quality rating. We have a proactive relationship with CQC and maintain all regulatory reporting as required. We have submitted two required framework reports during this past year both of which were met with very favourable response from CQC.

Saint Francis Hospice has the following conditions/variation on registration

- The service may only be provided for persons aged 17 years or over, this is agreed by way of an ongoing variation for those aged between 17 & 18 years.
- A maximum of 18 inpatients may be accommodated overnight. We adhere to the requirement that a Notification in writing must be provided to the Care Quality Commission at least one month prior to providing treatment or services not detailed in the Statement of Purpose. The Hospice was last inspected by the Care Quality Commission in April 2016 and awarded an Outstanding' for 4 of the 5 key lines of enquiry with a 'Good' for safety.

NHS Data Security and Protection Toolkit
Saint Francis Hospice has maintained the NHS Data Security and Protection Toolkit for 20/21.

Duty of Candour:
We have a Hospice Duty of Candour (DoC) sub-policy including a template letter that can be sent out to all families/carers of an indivdual who has experienced an adverse incident. This process is closely maintained and monitored with the Caldicott Guardian role and actions overseen and reviewed. Any such DoC actions are reported through to the Clinical Governance Committee and Board to ensure assurance and compliance with the DoC policy and procedure.

Quality Performance Overview Author Tes Smith.

Review of Quality Performance

The last 12 months have been challenging, with changed models across all services as a result of restrictions caused by the pandemic. Throughout, patients and families have been supported and have received care albeit delivered in different ways and often using virtual means.

Across all services, the number of patients cared for increased by 11.8% between 1st April 2020 and 31st March 2021. The number of people we care for with a non-cancer primary diagnosis continues to rise and is now 38%.

Inpatient Unit admissions increased by 7.5% despite periods when beds were not available due to Covid restrictions. Of those admitted, 66.5% died in the Hospice, 33.5% were discharged home (including to a care home).

Our Specialist Community and Crisis Support (SCCS) team has seen a significant increase in the number of face to face or telephone contacts with patients and relatives – 17,834, up from 16,565 (7.6%).

Our Hospice at Home team made 4,537 home visits to 585 people in the last few days of their life, working safely with PPE and social distancing where possible to ensure safety of all concerned.

Pemberton Place, our day hospice, was closed early in the pandemic, so only 47 people attended in person during the last twelve months. However, all who would normally attend were supported via phone and zoom calls and regular creative therapy packs.

The Family Support Team supported 192 people, with a further 513 people (including 76 children) who received bereavement counselling.

Activity based on the National Council for Palliative Care: Minimum Data Sets criteria	2020/21	2019/20	2018/19	2017/18	2016/17	2015/16
OVERALL SERVICE						
Patients cared for by the Hospice	1,872	1,674	1,663	1,693	1,614	1,573
% patients cared for with non cancer primary diagnosis	38.0%	37.2%	42.3%	28.8%	28.8%	25.9%
% patients cared for with cancer primary diagnosis	62.0%	62.8%	57.7%	71.2%	71.2%	73.9%
INPATIENT UNIT SERVICES						
Total number of admissions	398	370	352	371	373	374
Total number of patients cared for	325	305	322	336	343	338
% new patients	95.0%	89.0%	91.5%	92.9%	93.0%	92.6%
% occupancy	82.0%	77.8%	77.1%	77.9%	81%	85%
DIAGNOSIS						
% inpatients cared for with non cancer primary diagnosis	6.0%	23.6%	19.1%	14.3%	17.5%	9.8%
% inpatients cared for with cancer primary diagnosis	94.0%	76.4%	80.9%	85.7%	82.5%	90.2%
OUTCOME OF INPATIENT STAYS ENDING						
% died	66.5%	61.3%	66.4%	65.2%	64.9%	65.8%
% discharged to home (including care home)	33.5%	37.4%	33.5%	33.2%	34.5%	32.6%
% discharged to an acute hospital	0.0%	1.3%	0.1%	1.4%	0.5%	1.6%
% discharged to another setting	0.0%	0.0%	0.0%	0.3%	0%	0%
Average length of stay (days)	10.0	13.1	14.2	13.2	13.6	14.1
PEMBERTON PLACE						
Total number of patients attending	47	407	331	257	230	262
% new patients	49.0%	61.0%	77.6%	73.5%	64.4%	76.7%
SPECIALIST COMMUNITY AND CRISIS SUPPORT SERVICE						
Total number of patients supported	1589	1583	1496	1326	1254	1246
% new patients	67.6%	64.0%	67.0%	77.5%	77%	79.2%
% patients with non cancer primary diagnosis	34.8%	33.8%	37.2%	27.5%	26.6%	25.4%
% patients with cancer primary diagnosis	65.2%	66.2%	62.8%	72.5%	73.4%	74.6%
Number of face-to-face or telephone consultations with patient or relative / carer	17,834	16,565	20,467	15,578	12,456	11,872
Number of face-to-face or telephone consultations with a health professional	6288	5601	6890	7824	7259	7820
Average length of care (days)	86.3	100.06	92.6	90.2	92.1	64.3

Activity based on the National Council for Palliative Care: Minimum Data Sets criteria	2020/21	2019/20	2018/19	2017/18	2016/17	2015/16
HOSPICE AT HOME						
Total number of patients cared for	585	554	571	577	466	479
% new patients	71.1%	81.6%	93.1%	95.3%	95%	95%
% patients cared for with non cancer primary diagnosis	35.2%	33.7%	31.0%	28.7%	27.9%	25.9%
% patients cared for with cancer primary diagnosis	64.8%	66.3%	69.0%	71.3%	72.1%	74.1%
Total number of visits	4537	4799	2842	2839	2756	2852
% patients who died at home (including care homes)	98.5%	97.5%	96.1%	92.3%	92.9%	98.5%
Average length of care (days)	7.87	11.96	13.1	11.1	12.0	16.0
BEREAVEMENT SERVICE						
Total number of clients						
Adult	437	391	499	529	451	354
Children	76	118	100	106	102	101
Total	513	509	599	635	553	455
Number of support/counselling telephone or face-to-face consultations (including health professionals)	4346	4538	4888	3912	3368	4046
SPECIALIST MULTIDISCIPLINARY SUPPORT SERVICES						
Number of face-to-face or phone consultations with patient or relative/carer by service:						
Pastoral care support	533	1750	1748	1572	1394	2608
Complementary therapy	1863	1474	1232	985	1145	1183
Family services (excluding bereavement)	2556	1893	1413	1662	1448	2185
Occupational therapy	1516	1475	1434	1767	2743	2266
Occupational therapy equipment	552	853	1079	524	378	443

Report compiled by Chris Holmes

PART 6

EDUCATION CENTRE HIGHLIGHTS

As expected the education activity during 20/21 was dominated by the response to Covid19, which in many instances was immediate as needs arose across many partner organisations. The consistent aim that all are prepared to care to the highest standard through evidenced-based, quality-assured education and training remained at the centre of everything that we did.

In-house Training and Development

Our mandatory training programme has been sustained with virtual sessions and eLearning together with some essential face to face sessions, such as Basic Life Skills. These have been delivered in accordance with Working Safely Guidance, to keep everyone safe whilst ensuring that learning continued and compliance was achieved. Topics included Infection Prevention and Control including the use of Personal Protective Equipment, Fire Safety, Moving and Handling, Safeguarding, and Equality and Diversity. This year we have achieved a completion rate of 98.4%, which is excellent considering the challenges. There has been a continued focus on Mental Health and Wellbeing, with information and rota for staff support from the established team of Mental Health First Aiders. Additional sessions to support staff and offer tools to handle stress have been provided, and this has included Art Therapy, Staff Support and Resilience. Organisational development has continued, with a focus on Diversity and Inclusion across the organisation. Work around this has inclusion virtual sessions 'Communication & Connecting with People Who Identify as LGBTQ+'; approximately 100 staff and volunteers have attended this training.

External Partnerships

We have been a Gold Standards Framework (GSF) Regional Training Centre since 2013. To date, we have supported 112 care homes to deliver more personalised end of life care, tailored to a person's wishes. Understandably it has not been possible to run a face to face course this year. We have however supported care homes in different ways, described below, and we discussing the delivery of more of this type of training in 2021/22. We know that at least one care home has been able to achieve GSF accreditation this year.

London South Bank University

Our partnership with London South Bank University (LSBU) remains strong, and we have delivered three specialist modules that form part of the Master's Degree in Palliative and End of Life Care, which began in 2016. This year we have had 45 student registrations across the modules, from a range of backgrounds and employers - a remarkable achievement given the workforce pressures. Some of this education was postponed due to COVID-19 and the final module of End of Life Care: Dementia and other Non-Malignant Condition was deferred and delivered in September 2020 alongside the three planned modules. The biggest change in academic teaching and student support has been the virtual delivery, involving redesign of many elements of the education content and processes.

London South Bank University

Throughout the pandemic we have continued to accept and provide a good learning environment for cohorts of student nurses on placement, as part of the BSc (Hons) Adult Nursing course. The student nurses are closely supported by Practice Development and Registered Nurses.

Bespoke Commissioned Education

The need for skills-based education and training has been exponential this year. Partners have needed this immediately, and in some instances our response has been overnight. Strong partnerships and effective joint working has been a key feature

of the year. The biggest piece of work was End of Life Care training for staff redeployed from their usual roles to work on the Covid19 wards established at Goodmayes and Brentwood Community Hospitals, as part of the response by the North East London NHS Foundation Trust (NELFT). The workshop on end of life care included symptom management, the use of syringe pumps, communication skills and self-care. This took place during the first lockdown, from March 2020, and in that time over 40 sessions were provided to over 400 staff. At the same time we were commissioned to design and deliver an eLearning module on Registered Nurse Verification of Expected Death; this was necessary to support the community services in carrying out this role at a time when national guidance was changing very quickly. We were able to deliver on this within 8 days.

Syringe pump training has been provided for staff across NELFT throughout the year, together with some sessions on advance care planning; both are key skills that enable community colleagues to deliver effective palliative and end of life care.

During the third lockdown, from December 2020, we were commissioned to provide education directly in two care settings and three members of the education team, who are also registered nurses, were able to support. First, we provided end of life care facilitator support two days a week to staff working at Brentwood Community Hospital and Thurrock Community Hospital, over a time period of eight weeks. This enabled staff to learn in practice and involved working alongside them to deliver care. Secondly we supported the NELFT Infection Prevention and Control Team three days a week with a focus on care home education and response rapid to outbreaks. In addition to providing this support, working relationships have strengthened even further with staff in these areas. During summer 2020 it was possible to deliver Advanced Communication Skills Training, and we provided one course for colleagues working in children's palliative and end of life care at Little Havens Hospices.

We have been able to run two virtual conferences this year, and both generated positive feedback from the participants.

- Palliative Care Research Conference (22nd October 2020)
- Ethical Challenges Relating to Covid19 (4th March 2021)

Author Bridget Moss

Service user feedback

To ensure delivery of our services to the highest possible standard, we continue to request feedback from our service users. We positively encourage suggestions and comments to enable us to improve and appraise the services we provide. This process is mainly undertaken via distribution of our Service User Questionnaire to the individuals that we support. We have ensured during this past year that the Questionnaire is now available for completion on our Website too.

During the last year and throughout the pandemic, many of our services have been delivered virtually and off-site. This has of course impacted on the usual questions set within our questionnaire and the distribution of such, for instance, feedback on our day services within Pemberton Place – which we have been unable to have on-site due to Government guidelines and Working Safely rules.

We have however endeavoured to gather together feedback from those people we have supported within our Inpatient Unit (also engaging in views on Care from the Outcome Assessment and Complexity Collaborative (OACC) Suite) and our Hospice at Home team have continued to gather real-time feedback from those we continue to support at home in the community. We have also continued to receive feedback from those that have been bereaved as they receive a questionnaire within their offer of bereavement support via the Hospice.

The unprecedented situation we have all found ourselves in this past year has of course impacted on the amount of returned questionnaires we have received – so although our returns show that we are providing excellent care and services, the actual number of returns is lower than we would expect.

This next year we will concentrate on how we can continue to provide our services safely to those who we support and would expect some stability in the feedback that we are able to gather.

In 2020/21, **95%** of people that we surveyed strongly agreed/agreed that they would recommend our service to friends and family if they needed similar care.

We received **134** completed questionnaires. During 2021/22 we will prioritise alternative methods of collection of views and suggestions using a more IT based process. This will ensure that we are arming ourselves with the information required to show improvements and make comparisons.

The care and support for my late wife and myself from everyone at the Hospice was second to none. Since her death the support services have been wonderful to me. I cannot think how to develop an already brilliant service. (Service User feedback September 2020)
(Service User feedback December 2019)

Questions asked of all our service users 2020/21

My overall experience of using the Hospice services was good

Whilst using Hospice services, adequate written information was available

Telephone calls were dealt with adequately and I was satisfied with the response

Staff and volunteers were polite, friendly, welcoming and professional at all times

Privacy was respected at all times

I would recommend your service to family and friends if they needed similar care

Dignity was respected at all times

I feel I was appropriately assessed and offered the services I needed at the time

I was given time to ask questions or raise concerns

Physical needs were met at all times by Hospice services

If applicable: I was satisfied with the information provided to me at the time of the death of my loved one

Thinking back on my overall experience of Hospice services, I was satisfied with the care and support offered

AUTHORS Tracie Brennan and Brigid Hardy

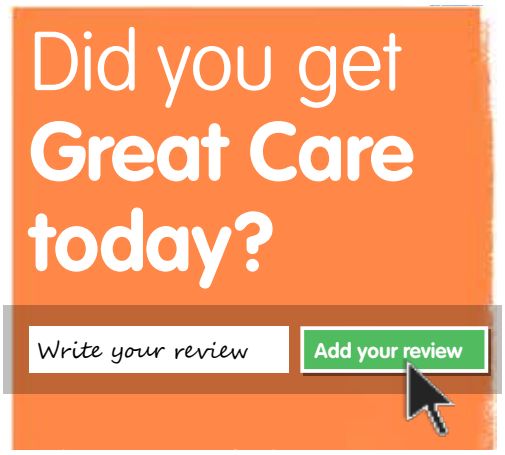
Where we could attribute an improvement action to a comment, we ensured we did

You said...

"All you need is a remarks book for families to express their feelings …. Each Hospice could save the cost of a survey".

We did...

We are currently in the process of investigating whether the online portal Iwantgreatcare.org is cost effective and beneficial for SFH.



You said...

"Perhaps you could email survey to reduce costs".

We did...

We do not have everyone's email address details to send by email. However, the survey can now be completed on the SFH website. A new print run of the survey was printed with a comment stating that the survey can now be completed online and a copy of the web link included.

You said...

"A leaflet telling families what they may need to purchase on discharge from IPU".

We did...

The leaflet 'Moving on – Planning discharge' will be reviewed and updated to consider including this suggestion in anticipation of a patient being discharged from the IPU and if necessary purchasing beneficial items.

saint francis hospice
living with dignity

Compliments and complaints

Compliments

In 2020/2021 we received 1568 compliments across our Hospice relating to the services we offer.

Complaints

Complaints guide us to look at the areas that we need to work on and help to identify any themes – we learn from complaints. In 2020/2021 we received 10 service-related complaints in the Hospice all of which were investigated thoroughly. We learnt from each, and ensured that learning was

I consider that the work that you undertake is vital and deals with death in a manner that takes account of the needs of the living at a time when support is most required and is second to none. I think that the work you do is wonderful.
Service user feedback April 2020 – Hospice at Home

To all the staff at Saint Francis Hospice. Thank you from the bottom of our hearts for caring and looking after our father over the past week. All of you have helped us as a family to cope with and deal with these difficult days. We really appreciate it and thank you, as we say in Arabic "a thousand times.
Service user feedback December 2020 – Family Support Services

I consider that the work that you undertake is vital and deals with death in a manner that takes account of the needs of the living at a time when support is most required and is second to none. I think that the work that you do is wonderful.
(SCCS Service User feedback February 2021)

We cannot see any way in which you could provide a better service. We cannot believe how much support we were given and the way in which your service just came in and guided us every step of the way. No words can express our gratitude.
(Hospice at Home Service User feedback May 2020)

A heartfelt thank you to all at St Francis Hospice and Hospice at Home nurses for the care and kindness shown to my husband. Your support was invaluable. Thank you to everyone at Saint Francis Hospice for the care and understanding shown to my husband in the last weeks of his life. The support and kindness shown to me and my daughters at such a sad and difficult time was invaluable. A special thank you to the two nurses from Hospice at Home who came and assessed his condition and then made all the arrangements to take him into the Hospice. I am sure their action made his last days comfortable for him and bearable for all the family.
Service user feedback August 2020 - IPU

To the amazing IPU team. I have lots of things I want to thank you all for but, I just want to say a huge thank you for all your care and love you gave my aunt whilst she was here. As a family we could not have hoped for better care for her during her last weeks. I know she was a sassy little madam and kept us all on our toes! Love always.
(Service User feedback April 2020)

I am so grateful for your help and support in my time of need. Having you to talk too, about my loved one, myself and family issues. You have been there for me and I am truly thankful. Your kind words and comfort has helped me through this difficult and sad time. Forever grateful. Thanks for being the one person that has been on my side. I felt you have been holding my hand.
(Family Support Service User feedback February 2021)

PART 8

STATEMENTS FROM OUR PARTNERS

Partnership working is vitally important to us at Saint Francis Hospice and we're grateful for the support and feedback that we receive from partners across the boroughs we work within.

This years quality account report was sent to the following organisations, with a request for any feedback or comments - Brentwood Council, Essex County Council, Redbridge Council, Havering Council, Barking & Dagenham Council, Redbridge HealthWatch, Havering HealthWatch, Essex Health Watch, Basildon & Brentwood CCG, West Essex CCG, Barking, Havering & Redbridge CSU, Havering CCG, Redbridge CCG and Barking CCG.

Responses were received in full from the following organisations which we have summarised due to size of reply – full replies are available upon request:

North East London Clinical Commissioning Group (NEL CCG)
reviewed and approved by Ceri Jacob, Managing Director, BHR ICP.
The Barking and Dagenham, Havering and Redbridge, (BHR), Integrated Care Partnership, (ICP), of the North East London Clinical Commissioning Group, (NEL CCG), would like to thank Saint Francis Hospice for requesting their input into the draft Quality Account, and also to give comments on the quality improvements both made and planned for the coming year.

Firstly, we would like to recognise the positive relationship between ourselves and Saint Francis Hospice and the open and transparent way of working together. We would also like to recognise and praise the significant work of Saint Francis Hospice and their hardworking staff, and the innovative work that has been undertaken to support the response to the COVID-19 pandemic, in order to maintain services while prioritising safety for all, in particular the increased throughput within the In- patient Unit and the increase of care provision via the community teams to avoid unnecessary hospitalisation.

This is a positive reflection of the leadership, commitment and dedication of the staff at Saint Francis Hospice. We would like to thank all involved for their hard work and ongoing commitment and determination to provide quality healthcare services to the residents of North East London during this time.

We are encouraged to see that Saint Francis Hospice, whilst recognising significant improvements have been made in relation to safe quality care, acknowledge that the demands of the Covid- 19 pandemic deferred the identified quality priorities from last year in being fully achieved and embedded. We welcome these identified quality priorities being a continued focus for the current year and working with Saint Francis Hospice to address these areas will be a focus for the BHRICP in the coming year.

We are supportive of the quality improvement priorities and objectives in place for 2021/22. We welcome the focus on the objectives of patient safety, clinical effectiveness and patient experience and the approach that has been taken to determine them. We welcome the review of the model of care for Occupational Therapy and Physiotherapy, further enabling a more holistic service during the patient's In-patient stay and the earlier involvement in discharge planning so that all necessary equipment and support can be provided in a timely manner. We also welcome the focus on widening access for people with dementia, people experiencing homelessness and for people of Black, Asian and other Minority Ethnic background. The implementation of the new patient experience and patient engagement feedback system is also supported, providing people with easier feedback options and co-production to enhance the delivery of quality services.

Clearly a priority for NEL CCG is greater collaboration between organisations within the North East London footprint in order to improve quality and patient safety. We would welcome working with Saint Francis Hospice and wider organisations on patient pressure ulcer pathways to enhance communication between organisations as well as shared learning opportunities to embed learning and development.

We look forward to working together to deliver innovation and transformation of care for our residents as we move towards an Integrated Care System (ICS) approach and thank you for your support and care to the residents of BHR ICP.

St Luke's Hospice, Basildon
Joanne McCollum
Director of Care and Commissioning and Caldicott Guardian

"The document provides an overview of the hard work and achievements made in the year of 2020/2021 by the team at Saint Francis Hospice. It demonstrates a commitment to strive for Quality of service delivery for the benefit of the local community that it serves.

I would like to commend SFH on their achievements during the past year when the Hospice was navigating the unprecedented events of COVID-19 which dramatically impacted and affected the services offered by the Hospice and the traditional models of care and ways of working. The account demonstrates how staff have adapted during these times and continue to strive to achieve Quality improvements even during these difficult times.

The accounts provide evidence of how the work that SFH undertake is truly patient centred, inclusive and of high quality and that the patient/carer/family are the focus for quality or service improvements. It demonstrates a commitment to delivering safe care reflecting and learning lessons from complaints.

Thank you for all you do and the part you play in delivering specialist Palliative and End of Life Care to the people and families of Brentwood."

Richard Vann
Healthwatch Officer
Healthwatch, Barking & Dagenham
"Thank you for the opportunity to see your Quality Account. There is a lot of content that focuses on both on the achievements and plans going forwards which was very informative.

In terms of format - I feel it would be particularly helpful if you could provide an Easy Read version to compliment your full version. This could be helpful for individuals with learning disabilities or cognitive challenges, whilst also making the information accessible to people from BAME backgrounds where English isn't their first language."

Tes Smith
Director of Quality, Care & Support Services & Caldicott Guardian at Saint Francis Hospice
replies: "Thank you Richard. We will ask our special interest group for those with learning difficulties to look at the provision of an easy read version going forward."

NHS Redbridge Gladys Xavier
Deputy Director of Public Health at NHS Redbridge
"First of all, a huge thank you for your hard work during this difficult times and congratulations for the way you stood up to the continuous challenges of this pandemic.

You have demonstrated the ability to adapt and change, developing new ways of communicating and caring for our local population, remaining always committed to help anyone in our communities affected by a life-limiting illness and to ensure they receive excellent person centred care when they need it, ideally in a place of their choosing.

Patient safety projects

1. Clinically Assisted Nutrition and Hydration
Well done on establishing the Electronic End of Life Care Framework and identifying care and support in the provision of nutrition and hydration in the last days and weeks of life as an essential part of the framework. Daily consideration of nutrition and hydration with the implementation of an individualised approach of fluid management in the last days of life are great improvements to your service.

Gaining regular feedback from bereaved families, with specific emphasis on handling and communication of hydration and nutrition at EOL, will be crucial not only to monitor your progress for this goal, but also to ensure families are supported as needed.

2. Co-ordinate My Care
Well done on introducing CMC system which will make a huge difference to your patients, their families and all the professionals involved in a crisis. Your inpatient staff needs to be confident in using CMC so that service provision can be smooth throughout the all collecting feedback from paramedics, GPs and other colleagues involved in a crisis is essential to help understanding which information are needed to support professionals in a crisis and what difference a good report could make.

3. Move and Groove Exercise and Lymphoedema Support
The move and groove exercise programme is a great addition to your service. We understand that the deployment of this programme has been negatively impacted by Covid-19 pandemic, forcing you to change the group sessions to individual or virtual ones.

The same comments above apply for the Lymphoedema Wellness Management Virtual Sessions, which are a great addition to your service and can make a huge difference for your patients. Again, we encourage you to change the virtual sessions to face-to face groups as soon as feasible, to fully benefits your patients.

Clinical Effectiveness Projects

1. Embedding UltraSound Scanning into clinical practice
Increasing the capacity for bladder scanning and abdominal USS is an important priority and a great improvement to your service. The importance of bladder scanning to identify urinary retention and to guide catheterisation is well known in Palliative Care and equipping your staff with the competencies for bladder scanning will significantly benefit your patients, both avoiding unnecessary transfer to hospital and assuring their comfort at all times. The same applies to ascites assessment to guide drainage.

Audits looking at the effectiveness of an early identification of urinary retention in terms of patient's experience will be extremely useful.

Patient Experience Projects

1. To create a visibly inclusive service for all

Well done in aiming to create a solid and visible inclusive service for all and focusing on LGBT people. Recognising that access to Palliative Care can be difficult to certain groups and that LGBT people face a lot of barriers getting End of Life Care as they fear hostility and discrimination is vital when aiming to offer a service which is inclusive for all.

2. Corneal Donation

Congratulations on your achievement of 100 corneal donations! This is a great success in your commitment to improve corneal donation rates within Saint Francis Hospice and to honour patient's wishes for organ and tissue donation at end of life.

PRIORITIES FOR IMPROVEMENT

Priority 1: Patient Safety

Occupational Therapy and Physiotherapy: a new model of care

The aim to provide a more holistic and thorough Occupational and Physiotherapy Services for people during their stay on the IPU is a key priority. Early assessment of newly admitted patients by the Therapies team and daily attendance of the Occupational and Physiotherapy Team at handovers and MDTs will make a huge difference to the patients' experience and quality of care.

Priority 2: Clinical Effectiveness

Widening Access to People with Dementia

A referral pathway for colleagues in primary and secondary care for PwD (people with Dementia) into Specialist Palliative care is needed and crucial so well done in developing one. Recognising that PwD accessing your service are increasing and are expecting to increase further is indeed a priority which required a structured approach that you have demonstrated in the goals you set.

Priority 3: Patient Experience

Individual experience feedback

Well done in aiming to invest in the iWantGreatCare system to get a real insight, with feedback that provide the opportunity to ensure continuous improvement of all the services you offer.

Sleep well Initiative – IPU Priority

Sleeping issues while an inpatient are a well-recognised distress for our patients so we strongly support your goal to ensure good quality of sleep for your patients. Incorporating questions about sleeping into the Therapies team assessment is a great idea as well as introducing work on relaxation and sleep promotion techniques with people who are finding sleep hard.

Widening Access Group Project for People - Experiencing Homelessness

People who are homeless are frequently poorly engaged with the healthcare system and this leads to an inequity of care which represent a big challenge for our healthcare system. Recognising and aiming to address this inequity in regard to End of Life care is an important priority and we strongly support your commitment in developing relationships with the local homeless community in order to facilitate better access to palliative and end of life care at SFH.

Widening access to hospice services for people of black, Asian and other minority ethnic background

Exploring why there is an under-referring of people from black, Asian and minority ethnic groups into your services and how barriers to access can be broken down is a key priority which will require continuous and extensive work as already set out on your goals for this priority. Well done in aiming to develop links into our faith communities via your pastoral care team, to listen and to learn from their understanding of and experience of hospice care

Keyring Keepsake – IPU Priority

Great project – families of patients who sadly passed away at SFH will love it.

Glossary

BAME: Black, Asian, Minority ethnic

BHR: Barking, Havering and Redbridge

CBE: Commander of the British Empire

CAG: Clinical Audit Group

CCG: Clinical Commissioning Groups

CMP: Clinical Management Plan

CNS: Clinical Nurse Specialist

CQC: Care Quality Commission

CQUIN: Commissioning for Quality and Innovation

CSU: Commissioning Support Unit

DNACPR: Do Not Attempt Cardiopulmonary Resuscitation

EOLF End of Life Framework

GP: General Practitioner

GSF: Gold Standards Framework

GSL: General Sales List

H@H: Hospice at Home

IEMG: Individual Experience Management Group

iPOS: Integrated Palliative Outcome Scale

IPU: Inpatient Unit

KLOE: Key Lines of Enquiry

LGBTQ: Lesbian, Gay, Bisexual, transgender and queer

LSBU: London South Bank University

MDT: Multi-Disciplinary Team

NICE: National Institute for Health and Care Excellence

NELFT: North East London Foundation Trust

NMC: Nursing and Midwifery Council

NMP: Non-Medical Prescribing

OACC: Outcome Assessment Complexity Collaborative

PP: Pemberton Place (day therapy unit)

POM: Prescription Only Medicine

QIPP: Quality, Innovation, Productivity and Prevention

SCCS: Specialist Community and Crisis Support Service

SOFIs: Short Observation Framework Inspection

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