St Wilfrid’s Hospice

# Quality Accounts

## Reflecting on the past and looking to the future

## 2020 - 2021

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# Part One

## Chief Executive's Summary

**St Wilfrid's Hospice (Eastbourne) is the local hospice for Eastbourne, Seaford, Pevensey, Hailsham, Heathfield, Uckfield and all points in between, an area of c300 square miles. We serve a population of around 235,000 people and our mission is 'reaching out to transform end of life care'. We are celebrating our 40th anniversary in 2021.**

We put our mission into practice with a range of services in the hospice and in the local community. We seek to offer a holistic support service for people with advanced, life-limiting illness and their families and carers, meeting physical, psychosocial and spiritual need. Our multi-disciplinary workforce comprises palliative care consultants and Doctors, Nurses, Healthcare Assistants, Physiotherapists and Occupational Therapists, Counsellors, Social Workers and Spiritual Support Workers. This clinical team is supported by a strong back office of non-clinical teams (Finance, HR, Income Generation, Communications, Facilities, Housekeeping and clinical administration). Our 200-strong workforce is supplemented by several hundred volunteers who add value in many different roles.

In the past year we supported 2,322 patients and carers, which is an increase on the previous year. We are reaching more people than ever under our **Closer to You** strategic framework, which is focused on delivering support locally across the whole of our catchment area, reaching people earlier in their diagnosis and supporting more people with non-cancer conditions – last year this was a third of patients.

These **Quality Accounts** were prepared by senior clinicians leading the quality and safety and clinical effectiveness workstreams that make up the hospice's Clinical Governance Framework. They have been approved by the Clinical Governance Committee, a sub-committee of the Board of Trustees. Our Quality Accounts are streamlined this year, after an extraordinary period of dealing with the Covid pandemic. My thanks go to all of our workforce, employees and volunteers, for the way they rose to this challenge and kept the wheels turning.

To the best of my knowledge, the information present in these Quality Accounts is a fair and accurate representation of the services provided by St Wilfrid's Hospice (Eastbourne).

**David Scott-Ralphs**
Chief Executive

# Quality Accounts

This set of Quality Accounts differs from the usual presentation. They aim to provide an update for the full accounts published in October 2020. We plan to return to the usual timescales and content for the next publication. The hospice has continued to ensure quality improvement is at the centre of care delivery, and this document aims to concentrate on our Quality Improvement Priorities (QIPs) as one illustration for this.

QIPs for 2021-22 have been identified and form the core to these Quality Accounts. QIPs relate to the business plan, clinical strategy and reflect our core values.  They are used to guide goal setting for staff as part of their annual appraisal cycle. Embedding QIPs across the organisation creates a common goal for the whole hospice team to demonstrate quality improvement. Producing these Quality Accounts has played a part in providing a route to quality improvement.

# Part Two

## Quality Improvement Priorities for 2021-22

Quality Improvement Priorities 2021-22

To improve our response time within the community services

To develop and embed a Rehabilitative Care model for patients and carers

To build confidence on virtual consultation and deliver a training programme to staff on digital health

To improve our approach to suicide awareness and prevention

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### 1. To improve our response time within the community services.

**Why**

- Feedback received through VOICES, complaints, discussion with staff and analysis of data via the Electronic Patient Records (EPR), demonstrates a strong requirement to have a rapid responsive service to ensure patients and carers receive tailored care in a timely manner.

- The evidence suggests that the provision for specialist palliative care delivery should be extended across the day, to effect positive outcomes for patients and carers in their preferred place of care and death.

- System healthcare partners feedback that they feel there are gaps in meeting urgent need at home at the end of life. The national drive is to reduce the number of admissions to hospital at end of life as patients' preferred place of care (PPC) at end of life is within a home or within a hospice setting.

- Delays in the verification of death between the hours of 22:00 to 07:00 due to the limited out of hours service cause carers and external health care professionals distress.

### How

- Introduce an early and late visiting service which mirrors 24/7 Nurse Line and does not carry a caseload, thus enabling a rapid response.

- Introduce a Clinical Nurse Specialist (CNS) on call service to support Registered Nurses and Healthcare Assistant decision making Out of Hours.

- Measure impact via data collection, surveys, VOICES, outcome measures, audit, people with personal experiences (PPE) initiatives, complaints and plaudits.

## 2. To further develop and embed a Rehabilitative Palliative Care model for patients and carers.

### Why

- Learning from the pandemic and patient and carer feedback has highlighted the importance of social connection and supporting patients and carers to engage in meaningful activities that are important to them. The Hospice UK Rehabiliative Palliative Care Model (RPC) model (2015) supports this in the context of East Sussex Healthcare Trust's (working in partnership with East Sussex County Council) Rehabilitation Transformation Programme that focuses on the following four pillars:
    - Decrease disability burden
    - Improve quality of life
    - Improve access to rehabilitation
    - Improve patient experience

- The Integration and Innovation White Paper (Feb 2021) highlights the need for health and social care to focus on the needs of the patient, deliver on improved outcomes and help people to live more independently for longer.

### How

- Re-engage staff in their awareness and understanding of the RPC model through training sessions.

- Embed routine goal setting by all clinicians on the Inpatient Unit (IPU) that guides hospice input in the context of the patient's symptom burden, daily routine and discharge planning where appropriate. This will be facilitated by the implementation of Situation Background Assessment Recommendation (SBAR), in addition to reviewing care plans, handovers, the use of the white boards and Multi-Disciplinary Team (MDT) meetings.

- Develop the concept of goal setting in the community to guide input that is demonstrated in care planning, proactive discharge planning, handovers and MDTs utilising SBAR. This will be demonstrated by an increase in community patients having the RPC window completed that supports their goals and what is important to them.

- Prepare the organisation for being a research site for the randomised trial ENeRgise (Exercise and Nutrition-based Rehabilitation versus standard care in people with life-limiting cancer) due to start in 2022.

## 3. To build confidence on virtual consultation and deliver a training programme to staff on digital health.

### Why

- Build on experience of the COVID-19 pandemic.

- Align with the national programme to ensure availability of virtual consultation as a choice.

- Ensure most effective approach to reaching more patients.

- Improve patient experience and access.

### How

- Learning and Development to run a series of drop-in events for training on use of a variety of apps including ACCURx for patient consultation.

- Develop learning resources on the use of remote patient consultations.

- Agree a hospice-wide definition of outpatient consultation to encompass virtual options.

- Report on numbers of virtual outpatient appointments.

- Undertake one PPE initiative to gain feedback on use of virtual consultation.

- Look at opportunities to fund a dedicated post to support improved digital capability across clinical teams.

- Explore options for patient inputting to their own information.

## 4.To improve our approach to suicide awareness and prevention.

### Why

- Learning from two incidents (completed suicides) in 2020-21 has highlighted that there is the need for and possibility of further improvement to our approach to suicide awareness and prevention.

- We have no evidence yet nationally that the current COVID-19 pandemic and lockdown have led to an increase in suicide rates although increases are predicted. What we do know (British Medical Journal (BMJ) editorial 12th November 2020) is that prevention can make a difference.

### How

- Review and strengthen Suicide Policy with regards to process where there are suicide concerns, including how to identify, assess, escalate, address and record concerns.

- Review and strengthen suicide policy with regards to staff emotional/wellbeing support needs regarding their practice in this area.

- Review staff and volunteer training needs to fully equip them to follow through in line with policy and implement training accordingly.

- Implement better methods for recording in electronic patient records to support identification, assessment and follow through for suicidal ideation to aid shared awareness amongst team.

- Embed organisational suicide awareness into everyday practice and culture, with related staff and volunteer feedback to evidence progress.

# Feedback on Priorities For Improvement 2020-21

The following section describes the activity which has taken place through the reporting year to address the QIPs.

## 1. To integrate a new care planning system which is directly linked to outcome measures – Effective and Safe.

- The Outcome Measures Group (OMG) and the Care Planning Working Group have amalgamated as both groups had similar terms of reference.
- Training delivered to all clinical staff on newly developed personalised care plans. Training included how the care plans linked to the Integrated Palliative Care Outcome Scale (IPOS).
- New personalised care plans were launched in all clinical areas in September 2020.
- A survey was completed to gain users' feedback on the care plans. Further changes were introduced following the survey.
- Advance Care Planning (ACP) is now captured within care plans.
- Data Collection is discussed, analysed and themes identified at the Outcome Measures and Care Planning meetings. There is cross representation from all patient-facing teams, which has increased engagement into this area of improvement.
- Effects of the pandemic have been examined and some key information obtained. Presentation on the last 5 years showed a difference in phase of illness on initial assessment, particularly in the Inpatient Unit. The aim is to continue to monitor for further trends as we move into the recovery phase of the pandemic.
- An audit on the use of care plans has been undertaken.

## 2. To improve our response to community need – Responsive.

- Following a successful pilot there is a now a CNS working across seven days providing an excellent example of collaboration and support for the wider community at an enhanced level.
- The CNS role has a defined work plan which supports all of the hospice staff and key community stakeholders.
- The Community Team has embedded a team working system based on five hubs linked to Primary Care Networks, which has enabled all community patients to be under one caseload.

- The wellbeing caseload has been fully integrated into one of the five community hubs to increase safety and quality across the community service.

- Video and telephone consultations are now offered as an initial assessment. This initiative was accelerated at the beginning of the pandemic.

- Staff have had access to multiple teaching sessions on virtual consultations. There are still some learning needs but staff are willing to learn.

- An audit was completed to capture feedback from patients and carers in relation to the mode of contact from hospice services throughout the pandemic.

- Audit feedback was extremely positive and demonstrated the impact of hospice services, whether that be in the building, visiting at home or supporting via the telephone. There was a clear theme of isolation and loss, which is inevitable given the length of time that the Wellbeing Service had been running. The feedback has given reassurance to the level and quality of the hospice's response as a community service during the pandemic and has provided some clarity to gauge next steps for future planning of the service.

## 3. To develop and embed a systematic approach to learning from deaths – Safe and Effective.

- Learning from Deaths group has been created. The aim of the group is to ensure that our services operate within the recommendations made in the Gosport Report and the NHS England Learning from Deaths guidance.

- The Learning from Deaths group identifies deaths which need more reflection and it has looked at deaths in greater detail in order to learn from what the hospice is doing well and what we could improve on.

- All deaths from COVID-19 are looked at within the Learning from Deaths Group.

- All deaths are discussed at the IPU and Community MDT.

- Learning from Deaths feedback sessions are now part of the Quality and Audit Assurance Forums. As these sessions are repeated throughout the year this has enhanced the culture of learning from deaths.

- There has been regular attendance at East Sussex Healthcare Trust Frailty mortality meetings.

- Care After Death Procedure has been updated in line with reference to Hospice UK new guidance.

- The hospice has taken part in the national research into palliative care services response to the Covid pandemic (which includes care of those dying from COVID-19).

## 4. To strengthen our approach to working with carers – Caring.

- A Carers Task and Finish Group was created to work on reviewing the carers' documentation and the process of completion.

- Carers' assessment has been reviewed and implemented. Engagement with the completion of the documentation has started to increase.

# Part Three

## Our response to the COVID-19 pandemic

An extraordinary team effort has resulted in the hospice responding and continuing to operate its services at and above normal capacity during the COVID-19 pandemic. We adapted our support previously delivered in our Wellbeing Centre, as patients were not able to attend day services at the hospice during periods of surge in transmission. This involved rapid deployment of equipment and increasing skills in our teams to enable our workforce to communicate with patients using video consultation. Our Community Team continued with home visits where indicated, and our 24/7 Nurse Line provided invaluable support to both patients and families and local health and social care partners.

Throughout the period, while our Inpatient Unit remained at high occupancy, we did have to close to admissions in January 2021 due to an outbreak of COVID-19. Working closely with the local Clinical Commissioning Group Infection Prevention Leads and Health Protection Teams, we were able to safely re-open to admissions after a month.

The Head of Quality Improvement completed an internal investigation into the outbreak using the Yorkshire Contributory Factors Framework. The findings of the investigation and the lessons learnt were shared with staff and volunteers as part of one of the Quality and Audit Forums. Trustees were kept fully informed during the outbreaks and have received a copy of the investigation. A Pandemic Planning Group, comprising both the executive and wider leadership team, was formed to oversee and guide the ongoing response. This included invoking the hospice's Major Incident Policy on two occasions.

St Wilfrid's Hospice

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