St Cuthbert's Hospice

Quality Account

2020 - 2021

Our Mission

To make every day count for those affected by life-limiting illnesses.

Our Vision

To be a centre of excellence within our community and to provide all-embracing, compassionate and individualised care to all those affected by life-limiting illnesses, at a time and a place that is right for them.

Our Values

- Respect
- Professionalism
- Choice
- Compassion
- Reputation
- Integrity

Our Philosophy of Care

At the heart of St Cuthbert's Hospice is the individual who is seen as a unique person deserving of respect and dignity. Our aim is to support each person and their family and friends, helping them to make informed choices and decisions affecting their lives.

Individual care is planned to support the total well-being of each person, taking into account their physical, psychological, social and spiritual needs.

We will work together to provide a warm and welcoming atmosphere that accommodates diverse cultures and lifestyles within a calm and compassionate environment. As a team, we will strive to provide care of the highest standard by ensuring staff are up to date with current research and training.

We are aware of the valuable work undertaken by individuals and agencies in the community and we will work in partnership with them to provide excellent services for the people of Durham.

We see life – and death – as a journey to be made in the company of others. We are rooted in our local community and we approach life and death through a philosophy based on support and hospitality.

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PART 1

Quality Statement

Welcome to our Quality Account for 2020 - 2021. This report is for our patients, their families and friends, the general public and the local NHS organisations that give us fifty per cent of our funding. The remaining finance required to pay for our services is raised through fundraising, legacies and our eight shops.

The aim of this report is to give clear information about the quality of our services so that our patients can feel safe and well cared for, their families and friends are reassured that all of our services are of a high standard, and that the NHS is receiving good value for money. It also underlines our commitment to continually review our services, and find ways to improve them so as to ensure patients remain at the centre of the services we provide and how we provide them.

In this document we give an account of how we have maintained our high standards, followed through on ways in which we can raise those standards even higher, and, very often, exceeded the expectations of those who have used our services. We also identify some priorities for continuing our progress towards excellence during the coming year.

We could not give such high standards of care without our hardworking staff and our volunteers, and together with the Board of Trustees, I would like to thank them all for their support.

The Account also details a number of initiatives that have taken place during the year to improve the quality of the service we offer. It is pleasing to see that the work being done in County Durham is attracting national and international recognition.

Our Head of Clinical Services is responsible for the preparation of this report and its contents. To the best of my knowledge, the information in the Quality Account is accurate and a fair representation of the quality of health care services provided by St Cuthbert's Hospice.

Paul Marriott

Chief Executive

PART 2

KEY ASPIRATIONS FOR IMPROVEMENT DURING THE PERIOD 1 APRIL 2021 – 31 MARCH 2022

2.1 INTRODUCTION

St Cuthbert's Hospice will continue to strengthen processes that support and demonstrate an ethos of continuous clinical quality assurance and improvement across all levels of the organisation. We aspire to provide outstanding care to all our service users, provided by qualified and well trained medical, nursing, allied health, counselling and social care staff and underpinned by research evidence and sector leading best practice in an environment and culture that supports compassionate person centred care.

We take our '*duty of candour*' seriously. We therefore aspire to reduce risk, prevent harm and promote safety as the foundation for providing effective and responsive care services that meet the unique needs of each of our service users. We will openly and honestly identify any shortfalls in our services to individuals in our care. We commit to act promptly to address or resolve such shortfalls and where necessary report them and our actions to resolve them to patients and their families and to relevant partners or regulatory agencies.

Our service users need to know that they will be treated with compassion, dignity and respect in clean and safe care settings that are effectively managed to protect them from the known harms, avoidable accidents, recognised clinical risks (such as pressure ulcers and falls) associated with health systems. They need to be confident that agreed and consented clinical interventions identified to meet their unique needs will be underpinned by research and sector leading best practice such as National Institutes for Health and Clinical Excellence (NICE) guidance that aims to make every day count and enhance their quality of life.

2.2 WELL-LED

ASPIRATION 1: TO FURTHER DEVELOP AND STRENGTHEN OUR MODEL OF QUALITY IMPROVEMENT.

What is our rationale for choosing this aspiration?

Senior leaders within St Cuthbert's Hospice recognise that embedding a quality improvement ethos within the Hospice is critical if we are to avoid complacency, retain our outstanding rating and realise our vision of becoming a centre of excellence. The board and senior management team recognise that within our approach to developing a culture of quality improvement it is important to:

- View quality improvement as a long term journey rather than a quick fix.
- Demonstrate visible leadership commitment from the board and senior management team.
- Ensure that barriers to staff involvement and engagement with improvement are broken down.
- Enable managers and front line staff to work together to deliver a shared and aligned mission and vision.
- Involve people using our services in this work.

In the autumn of 2020 the retirement of the Head of Retail and resignation of the Head of Human Resources created an opportunity to review the senior management structure. This has led to the introduction of two new posts, Head of Income Generation and a Human Resources Manager. In 2021 – 2022 we hope to advertise and recruit to a Head of Enablement post. The creation of a new senior management team within the context of a Covid-19 pandemic have challenged existing mental models and historical ways of working and have created a window of opportunity and platform for change.

What will we do to achieve this aspiration?

Actions proposed for 2021 – 2022 are:-

- Build on work to strengthen our governance arrangements and complete the actions from the Review of the Governance Framework completed in January 2021.
- Review and reinvigorate work to build and embed impact management practice in order to further enhance the organisation's performance in line with its mission and vision.
- Explore and introduce more agile ways of working in order to reduce waste and free up more time and resources to spend on direct care and other value adding activities.

- Further develop our quality improvement toolkit and shared understanding of quality improvement to enable senior leaders and front line staff to work together and continuously improve the quality of care we deliver to patients.
- Embed a more systematic and methodical approach to improving quality, safety and value within the Hospice, an approach grounded in improvement science.
- Review Enabling Services and related systems and processes within the Hospice with a view to maximising the value from Staff.Care, a workforce management tool the implementation of which commenced in the latter part of 2020.

How will we measure this aspiration?

- Delivery of the Review of Governance Framework Action Plan, (2020).
- Increased capacity and capability in impact management practice including support from Northumbria University to deliver four insight and impact projects:-
    - Prognostication
    - Donor insights
    - Admissions
    - Discharges
- Development of an operational plan for Enabling Services, e.g. Human Resource Department.
- Introduction of an audit schedule linked to providing assurance in relation to safeguarding.
- Development of a patient and public involvement strategy and communication and engagement plan, including a staff and volunteer survey, family and friends test, examples of where we have worked directly with patients and the local community to make beneficial changes.
- Commencement of workforce modelling to support delivery of the Hospices Model of Care and plan for Project Grow.
- Introduction of a suite of programme/project management and quality improvement tools and templates.

2.3 SAFE

ASPIRATION 1: PROTECT PEOPLE FROM AVIODABLE HARM THROUGH PREVENTION OF FALLS, SUSPECTED DEEP TISSUE INJURIES, PRESSURE ULCERS (PUs), AND THROMBOEMBOLISMS

What is our rationale for choosing this aspiration?

St Cuthbert's Hospice continues to view harm-free care for patients as an important priority. The principles outlined in the NHS Patient Safety Thermometer remain an effective method for surveying patient harms and analysing results via completion of an electronic spreadsheet for one day on a monthly basis. This measures harm in relation to three key areas: falls, pressure ulcers and, for in-patients, incidence of thromboembolism VTE assessment, (see Table 1).

Although no longer required to report via the national patient safety thermometers spreadsheet we continue to collect and monitor information on known harms associated with health care. This includes all falls as and when they occur, the incidence of acquired/deteriorating pressure ulcers, urinary tract infections (UTIs) and thromboembolism VTE assessment during and following admission and on a weekly basis thereafter.

Falls

What is our rationale for choosing this aspiration?

Many of our patients have limited mobility or are frail as a consequence of their illness, but retain 'capacity' and express their wish to remain as independently mobile as possible. In respecting patient preference, we also have to balance the need to keep our patients safe with the need to respect and promote their independence. In such situations some falls remain unavoidable.

However, we again aspire to have a zero rate of avoidable falls. To help us achieve this on admission all patients will be assessed for their individual risk of falls using a Falls Risk Assessment Tool (FRAT) and where appropriate a falls risk care plan is put in place to try and reduce the incidence of avoidable falls. Nevertheless, we recognise that falls can and still do occur if patients are to be supported to remain independent.

What will we do to achieve this aspiration?

Actions proposed for 2021 - 2022 are:

- Embed work completed in 2020 – 2021
- Make further revisions to SystmOne to ensure it reflects the revised policy and evidence based risk assessment and care plan.

Pressure ulcers

What is our rationale for choosing this aspiration?

We have again set an ambitious target of zero incidence of pressure ulcers (PUs) being acquired or deteriorating following admission for 2020-21. We recognise the challenges associated in meeting this ambitious target. Following the publication in June 2018 by NHS Improvement, '*Pressure ulcers: revised definition and measurement. Summary and recommendations'*, we have adopted the best practice for the categorisation of pressure ulcers and as recommended in the report no longer describe '*Kennedy Terminal Ulcers'.* Within the Hospice, for reporting purposes we use the term suspected deep tissue injury.

We recognise the difficulty of balancing the rights of patients with capacity and or the wishes of their loved ones who, after being made aware of the risk of harm, still decline positional change regimes or pressure relieving equipment in the final stages of end of life care against the goal of preventing avoidable injury or harm.

Consequently, there will continue to be occasions when, despite the implementation of a pressure ulcer risk reduction care plan, unavoidable pressure damage may still occur. Such measures include risk assessment, the use of pressure relieving equipment, regular positional changes, pressure prevention monitoring and the use of measures to protect the integrity of skin over bony prominences.

What will we do to achieve this aspiration?

Actions proposed for 2021 - 2022 are:

- Embed work completed in 2020 - 2021 and continue to promote best practice and apply NICE Guidance to support monitoring, management of pressure ulcers.
- Make further revisions to SystmOne to ensure it reflects the revised policy and evidence based risk assessment and care plan.

VTE Assessments

What is our rationale for choosing this aspiration?

In December 2014 we commenced formal Venous Thromboembolism (VTE) assessments on patients admitted to IPU to evidence decisions made with regard to anticoagulation therapy. In 2020 - 2021 99.25 % of VTE assessments completed within 24 hours of admission in 2021 - 2022 we aim to maintain our current performance.

What will we do to achieve this aspiration?

Actions proposed for 2021 - 2022 are:

- To continue to complete formal VTE assessments on all patients within 24 hours of admission.

How will we measure this aspiration?

All falls, suspected deep tissue injuries (pressure ulcers) on admission, acquired or deteriorating following admission, and failures to complete a VTE assessment will be reported and recorded as clinical incidents.

All falls, suspected deep tissue injuries (pressure ulcers) on admission, acquired or deteriorating following admission, will be recorded on our incident log and investigated using root cause analysis and any lessons learned will be shared with staff.

Link Practitioner groups for Falls and Tissue Viability will complete a quarterly status slide describing what has been achieved this quarter, what will be achieved in the next quarter and any risks and /or issues.

Status on improvement initiatives under the link practitioner initiative and lessons learned from RCA will be reported and monitored quarterly to the:

- Clinical Governance Sub-Committee (CGSC)
- The Clinical Governance Group (CGG)
- Senior Management Team (SMT)
- Clinical Commissioning Group (CCG) in our quarterly Contract Quality Performance Reports for 2021-2022 and will be made publically available on the Hospice website.

All pressure ulcers acquired or deteriorating following admission and graded at 2 or above and any falls that results in serious harm to a patient will be:

- Internally investigated adopting root-cause analysis methodology and a report compiled for SMT and CGSC.
- Statutorily notified to CQC by using the service statutory notification form for 'serious injury to a person' or 'allegation of abuse (safeguarding)'.
- Reported to the Commissioners via North East Commissioning Support Unit (NECS) in line with NHS England's Serious Incidents framework.

ASPIRATION 2: PREVENT ERRORS ASSOCIATED WITH THE SUPPLY, STORAGE, PRESCRIBING, ADMINISTRATION AND DISPOSAL OF MEDICINES (CONTROLLED DRUGS & NON-CONTROLLED DRUGS).

What is our rationale for choosing this aspiration?

St Cuthbert's Hospice offers symptom control and end of life care in its In-patient Unit (IPU). Drug therapy is an important part of this care and we prescribe and administer a variety of drugs, including controlled drugs (CDs). Errors involving CDs are extremely rare but because of the nature of the drugs and dosages involved, such errors can have serious unintended outcomes.

In 2020 - 2021, improved incident reporting and a more rigorous approach to RCA highlighted system failure as a feature of most medication errors (CDs & non-CDs) and risks and issues relating to supply, storage, prescribing, administration and disposal. (Appendix 1).

We aspire to achieve a zero incidence of drug administration errors for 2021 - 2022. We subsequently aspire to ensure that our policy framework and associated procedures support both the development of a safety culture and also facilitates openness about failures; that incident management is not be used as a means of apportioning blame, but as a mechanism for identifying risks, learning from mistakes and driving improvement.

What will we do to achieve this aspiration?

Actions proposed for 2021 - 2022 are to:

- Embed work completed in 2020 – 2021 and continue to promote best practice.
- Increase the capacity of a qualified pharmacist on a professional activity session basis to assist us to:

    - Achieve improved clinical and cost-effective prescribing.
    - Conduct review of stock drug holdings and prescribing practice.
    - Support our medical and non-medical prescribers.
    - Provide expert medicines advice to colleagues at multi-disciplinary team meetings, particularly the Medicines Optimisation meeting.
    - Conduct audits of storage, supply, prescribing, administration and disposal of medicines.
    - Review all policy and procedures related to storage, supply, prescribing, administration and disposal of medicines.
    - Contribute to a review of our arrangements for supply of wholesale stock drugs and medication supplied under FP10s.

How will we measure this aspiration?

We will demonstrate we have achieved our aspiration through:

- Reduction of waste through improvements to supply of wholesale stock drugs and prescribing practice
- Increased reporting of medication incidents, both CDs and non-CDs.
- Participation by relevant staff in root cause analysis and action planning in response to incidents.
- Participation by staff in reviews of policy and development of procedures
- Completion staff training and competency assessments
- Minutes from Medicines Optimisation meeting and Clinical Governance Group and CGSC.

2.4 EFFECTIVE

ASPIRATION 1: BUILD THE CAPACITY AND CAPABILITY OF THE ORGANISATION IN RELATION TO INSIGHT DRIVEN PERFORMANCE IMPROVEMENT

What is our rationale for choosing this aspiration?

In 2018 – 2019, St Cuthbert's Hospice, built on work progressed through the Pitch Perfect Project, and secured funding from the Impact Management Programme (Growth Fund) to build and embed impact management practice in order to further enhance the organisation's performance in line with its mission and vision. This led to the following improvement interventions:-

- Established systems to routinely collect and report performance data that will enable impact reporting, and
- Creation of performance management dashboards to support strategic and operational decision-making.
- Development of a new performance management system to ensure individuals and teams are better focused on outcomes,
- Reshaping of our supervision and appraisal system so that it is aligned to the impact reporting framework

In the spring of 2021 the Hospice found itself having to respond to a global pandemic of Covid-19 and playing a full part in the local resilience forum response. Subsequently we have had to adopt a measured approach to embedding impact management practice during 2020 - 2021.

In view of this, in 2021 – 2022 we plan to focus on

- Building the capacity and capability of the organisation in relation to insight-driven performance improvement.

This work is seen as giving the organisation a significant strategic advantage, particularly in relation to strategic planning and future fundraising. It will also enable the organisation to evaluate the contribution a data analyst post could make to the long-term sustainability of the organisation.

What will we do to achieve this aspiration?

In 2021 – 2022 we aim to:

- Embed our use of systems established to routinely collect and report performance data that will enable impact reporting, and
- Embed our use of performance management dashboards to support strategic and operational decision-making.
- Embed our new performance management system to ensure individuals and teams are better focused on outcomes,
- Embed our reshaped supervision and appraisal system so that it is aligned to the impact reporting framework

How will we measure this aspiration?

- Dashboards being used to support strategic and operational decision making
- Use of an impact focused business planning cycle
- Staff who understand the model for improvement - what it is we are trying to accomplish, how we will know that the change is an improvement, what change we can make that is an improvement
- Staff employing plan do study act cycles for small, rapid-cycle tests of change.

2.5 RESPONSIVE

ASPIRATION 1: ESTABLISH A BASELINE INTELLIGENCE OF "CARER BURDEN" AND BASED ON THIS ADOPT A RECOGNISED TOOL TO ASSESS, PRIORITISE DECISIONS FOR THE IMPLEMENTATION OF A RANGE OF OPTIONS TO ENHANCE CARER SUPPORT AND REDUCE CARER BURDON

What is our rationale for choosing this aspiration?

Our 2019 to 2024 Carers Strategy sets out an ambitious vision: a responsive and collaborative approach to ensure we care, not only for the person with a life-limiting condition, but also those caring for the person living with a life-limiting condition.

St Cuthbert's Hospice recognise that many carers don't perceive themselves to be carers and often 'drift' into the role over time often taking on more and more caring responsibilities, *(Who cares? Support for carers of people approaching the end of life, The National Council for Palliative Care, 2013).*

We acknowledge there is a growing body of evidence that indicates that being an informal carer has a significant impact on finances, health, loneliness, social exclusion, personal relationships, work and caring, (*Facts about carers, Policy Briefing, Carers UK, 2019).*

We understand that many carers are passionate about their contribution to society and that they often feel this contribution goes unrecognised. Instead of being supported, their needs are over looked and they have to fight to get support. The support that is available is insufficient or poor quality and does not enable them to have a life alongside their role as a carer. Census results for 2011 show that there are approximately 59,000 adult carers living in County Durham, of which nearly 17,000 are providing 50hrs or more care a week.

There are 1,659 young carers aged between 5-17 years of age living in County Durham. There has been a 7.2% increase between 2001 and 2011 in the number of carers aged under 15 providing between 20 and 49 hours a week of unpaid care. As at 31 March 2016 there were 13,339 carers registered with Durham County Carers Support, which is a 9% increase on the number registered as at 30 June 2015 (12,210).

More recently, *"Worst hit: dementia during coronavirus" (Alzheimer's Society, September, 2020)* highlighted 92 million extra hours spent by family & friends caring for loved ones with dementia. 95% of carers reported negative impact on their mental and physical health. Dementia Advisors have seen noticeable uplift on requests for advice and support. 133,000

welfare calls have taken place since March 2020. These findings certainly resonate with our own experience of carers during the pandemic.

Although progress with implementation of the carers strategy has not been as planned during 2020 – 2021, the pandemic has created an opportunity for us and the wider health and social care economy to pause, reflect and learn, and in partnership with other carer's support organisations better understand:-

- What are we trying to accomplish?
- How will we know that our change is an improvement?
- What change can we make that will result in an improvement?

What will we do to achieve this aspiration?

In 2021 – 2022 we will build on existing work (dementia services, everything in place, family support and bereavement services) and will:-

- Forge new partnerships with carer support organisations
- Recruit a development leader who will:
  - Use carer questionnaires to engage with carers across Hospice services; identify number of informal carers; demographic data and nature of their caring roles. Use focus groups to better understand specific carer needs, personal situations and priorities.
  - Design and develop practical programmes and resources to support identified carer needs and improve carer resilience to possibly include: provision of information and training, both in person and on-line, in carer skills, social networking through support groups, volunteer roles
  - Engaging with partner agencies
  - Adopting recognised Carer well-being measures
  - Piloting programmes with groups of 10—15 self-selected Carers
  - Complete an evaluation using well-being measures, case studies and volunteer feedback

How will we measure this improvement?

- Evidence of partnership working
- Recruitment of a development leaders and delivery of a service improvement plan
- Improvements to the quality of life of carers measured through the use of the Warwick Edinburgh Mental Well-Being Scale; Zarit Carer interviews and Carer Support Needs Assessment Tool (CSNAT) measures.

2.6 CARING

ASPIRATION 1: TO DEVELOP A HOLISTIC MODEL OF CARE THAT FOCUSES ON INDIVIDUALS WHO ARE VULNERABLE DUE TO COMPLEX CONDITIONS OR CIRCUMSTANCES

What is our rationale for choosing this aspiration?

Everyone deserves caring and compassionate care that meets their individual needs and responds to their wishes and choices in the last years, months and days of life. However, time after time literature reviews and research suggests that people who are vulnerable due to complex conditions and/or circumstance find their unique needs and considerations, are not being recognised or understood. This needs to be addressed for everyone.

Many groups feel marginalised because they do not have the same level of access to services or feel they were treated differently to other people receiving palliative and end of life care. Commissioners, providers and professionals are required by law to organise and deliver end of life care that meets the diverse needs of individuals effectively, and it is concerning that barriers to accessing services are not being recognised or addressed in some areas. It is alarming that commissioners and providers are not always meeting the requirements of key legislation, including the Equality Act 2010 and Mental Capacity Act 2005.

What will we do to achieve this aspiration?

In 2021 - 2022 we will use evidence based practice to:

- Define and describe our service delivery model at St Cuthbert's Hospice and will develop pathways of care for:-
    - Community Services – (Dementia and Namaste Care)
    - Day Hospice
    - Living Well Services
    - Bereavement Support
    - Family Support
- Embed a holistic model of care with restorative, preventative, supportive and palliative goals, aimed at improving function, maintaining function through treatment and illness, and the transition towards deterioration and functional decline.
- Strengthen and develop partnership working with stakeholders in the local and national health and care sector including Her Majesty's Prisons, Alzheimer's Society.
- Explore how we can introduce experience based design as we inform development of a Palliative and End of Life Care Strategy for County Durham and develop thinking in relation to Project Grow.

How will we measure this improvement?

- Timely delivery of Operational Plans that explain how the service is delivered and include diagrams, a process view of the service delivery model including any critical

timeframes associated with the processes and documents and records that are maintained, performance and quality standards, performance monitoring and data, patient and public involvement plans.

PART 3

REVIEW OF SERVICE QUALITY PERFORMANCE DURING THE PERIOD 1st APRIL 2020 – 31 MARCH 2021

3.1 Background and Context

Opened in 1988 St Cuthbert's Hospice provides specialist medical and nursing care for the people of North Durham living with life-limiting conditions. The Hospice is based in the historic Park House, close to Durham city centre. Patients and relatives are welcome to enjoy the several acres of beautiful grounds with views across the Durham countryside.

Our team of highly qualified and trained staff and volunteers work together to provide individual, high-quality care in a peaceful environment, and to provide care and support for relatives and carers.

St. Cuthbert's Hospice provides:

- A medically supported 10 bedded in-patient unit.
- A rehabilitative day care service in our refurbished Living Well Centre that offers a holistic model of care including:
    - Family support services - social care advice and support.
    - Therapy support including physiotherapy, occupational therapy and complementary therapies.
    - Medical and nursing support
- A community based specialist Dementia Service and Namaste Care Project.
- Bereavement Support - pre and post-bereavement counselling for adults; a children and young person's bereavement service for those bereaved as a consequence of suicide or sudden unexpected and traumatic death; emotional support to the families of in patients.

St Cuthbert's Hospice accepts it is accountable for the standards of care it provides and has developed robust systems and processes to monitor, review, report and act in response to all clinical issues and incidences. The Hospice views harm-free care for patients as an important priority. We adopt the principles of the Safety Thermometer along with the collection of other internal data. This allows us to record evidence of patient harm which can be analysed to identify what measures could be implemented in order to minimise the risk of harm for patients in our care.

3.2 Evidence Based Practice

We have met or made substantial progress in meeting all our key aspirations for improvement as outlined in our 2020 - 21 Quality Account. However, we recognise that to maintain and continually improve our care services, we must ensure that the knowledge, skills, and competence of our staff and volunteers and the evidence that underpins our practice is updated in line with current best practice and research. To reflect best practise we have adopted the following NICE Guidance or Standards to inform both policy and enhance our practice:

- *Improving supportive and palliative care for adults with cancer*. NICE Cancer service guideline (CSG4) March 2004.

- *Nutritional support in adults: oral nutritional support, enteral tube feeding and parenteral nutritiona*l. (NICE) Clinical Guidance 32 (2006). www.nice.org.uk/Guidance/CG32. (Updated 4 Aug 2017).

- *Pressure ulcers: prevention and management.* NICE Clinical Guideline (CG179) April 2014.

- *End of life care for adults*. NICE Clinical Guideline (QS13) 7 March 2017.

- *Care of dying adults in the last days of life.* NICE Clinical Guideline (QS144) 2 March 2017.

- *Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes*. NICE guideline (NG5) March 2015.

- *Medicines optimisation* NICE Clinical Guideline (QS120) 24 March 2016.

- *Controlled drugs: safe use and management.* NICE Clinical Guideline (NG46) Published date: April 2016.

- *Palliative care for adults: strong opioids for pain relief.* NICE Clinical Guideline (CG140) May 2012. Last updated: Aug 2016.

- *Falls in older people*. NICE Quality Standard (QS86) Published March 2015. Updated January 2017.

- *Head injury: assessment and early management.* NICE Clinical Guideline (QS176). Updated 2017.

- *Mental Health Act* 1983 Code of Practice TSO, 2015.

- *Pressure ulcers: revised definition and measurement. Summary and recommendations*. NHS Improvement (NHSI) June 2018.

- *The incidence and costs of inpatient falls in hospitals: report and annexes*. NHS Improvement (NHSI) 2017.

3.3 Covid-19 Pandemic

In March 2020 the Hospice found itself having to respond to COVID-19 pandemic in the United Kingdom, part of the worldwide pandemic of coronavirus disease 2019 (COVID-19) caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

The virus first reached the country in late January 2020 and spread rapidly, with prognosis knowledge, vaccination potential, treatment options and interventions continually developing throughout 2020 - 2021. In March 2020, the UK governments imposed a stay-at-home order,

dubbed "Stay Home, Protect the NHS, Save Lives", banning all non-essential travel and closing most gathering places. Those with symptoms, and their households, were told to self-isolate, while those with certain illnesses were told to shield themselves.[16] People were told to keep apart in public. Police were empowered to enforce the measures, and the Coronavirus Act 2020 gave all four governments emergency powers[17] not used since the Second World War.[18][19] The Chancellor of the Exchequer, Rishi Sunak forecast that lengthy restrictions would severely damage the UK economy,[20] worsen mental health and suicide rates,[21] and cause additional deaths due to isolation, delays and falling living standards.

In response to this the Hospice completed a situational risk assessment and put in place actions necessary to mitigate against the COVID-19 pandemic.

In-patient Unit

The Hospice was designated as a “clean” area by the local resilience forum, and has kept the In-patient Unit open throughout the 2020 – 2021. A Covid-19 situational risk assessment has been ongoing and government guidance on personal protective equipment, screening and testing of patients and visitors, restrictions to visitors have been managed in line with government guidance.

During the period 21 December to 10 February we were classed, by Public Health North East (PHNE), as having a Covid outbreak. i.e. two or more positive cases in a twenty eight day period. Routine weekly PCR Covid-19 testing for clinical staff was introduced the 21 December 2020. By 26 December four members of staff tested positive. On 13 January we had another member of staff test positive and outbreak status was extended from the initial 28 Jan to the 10 Feb 2021.

During the outbreak we maintained contact with Public Health North East and fulfilled our Duty of Candour. We were unable to identify any breeches in government guidance. Public Health England assured us that they were satisfied that we have appropriate risk assessments in place and have been unable to identify any breeches in PPE. They advised us that the cause outbreak was unlikely to be work place transmission and is more likely to be community transmission.

In the period 1 April 2020 – March 31 2021 we have had a total of three patients test positive for Covid-19. One in-patient and two day-care patients. All three tested positive on admission.

During the period 1st April 2020 – 31 March 2021, we have been successful in ensuring we had strong clinical governance at St Cuthbert's Hospice. In March 2020 we completed a situational risk assessment in response to the covid pandemic and subsequently changed to a remote way of working. Our Board of Directors (Trustees), the Clinical Governance Sub-Committee, Senior Management Team, Clinical Governance Group and Clinical Commissioning Group received and reviewed comprehensive quarterly progress reports about care delivery, clinical audit, incidents, accidents, investigations and complaints. Each group has been rigorous in monitoring and critically reviewing the evidence provided about the safety and quality of care services and where necessary approved detailed action plans to support a culture of continuous service development and quality improvement.

We consider feedback from service users as being central in helping to ensure we are responsive to the needs of those who access and use our services. Under normal circumstances we routinely collect '*Friends and Family Test*' feedback as part of our specific service user questionnaires. However, in 2020 - 2021 there has been limited opportunity to do this due to temporary suspension of our living well and bereavement support services and restrictions on visitors to the In-Patient Unit. The summary of findings can be seen at Appendix 4.

During 2020-21, and because of the Covid-19 pandemic, St Cuthbert's Hospice was not subject to external inspection by the Care Quality Commission (CQC) or our Commissioners' quality assurance team at North Durham Clinical Commissioning Group (CCG). We have however provided assurance to the CCG and CQC via a variety of means including, quarterly contract quality meetings and relationship management meetings via zoom, monthly updates via email and regular telephone conversations.

Our last external 'infection control inspection' of the hospice care settings in December 2019, reported no concerns or requirements for remedial action.

During October 2019 the CCG Safeguarding team conducted an announced safeguarding assurance visit. Whilst overall the visit was positive, there were some areas that the organisation could improve on. In response to this the following policies have been reviewed:-

- Safeguarding Vulnerable Adults Policy
- Safeguarding Children Policy
- Mental Capacity Policy
- Deprivation of Liberty Policy

Staff have completed training in safeguarding, mental capacity, deprivation of liberty and duty of candour. Findings from an audit of mental capacity and deprivation of liberty and the completion of CQC notifications for both safe guarding and deprivation of liberties are evidence of an improved understanding amongst clinical staff. The action plan resulting from the October 2019 visit has been regularly updated and sent to the CCG team. CQC have been notified of all safeguarding concerns.

As part of our NHS contract requirements, St Cuthbert's Hospice provides North Durham CCG with quarterly Service Contract Quality Performance Reports. These are available on the website (www.stcuthbertshospice.com). Publication of these reports helps fulfil our duty of candour and enables our service users and those who support the Hospice to view and measure the quality of our performance over each quarter.

Over 2020 - 2021 we progressed work to fulfil CQUIN requirements agreed in partnership with our Clinical Commissioning Group (CCG) for 2019-2021 which were:

3.4 CQUIN 1 2019 – 2021

Improve the carer and practical support of carers by implementing aims outlined in the Hospice Carer Strategy.

Year 1: Establish a strategy implementation team to establish baseline intelligence of "carer burden" by co-ordinating the collection and interpretation of data about the extent of carer burden for those informal carers supporting patients who access our in-patient care or living well centre services.

Year 2: Based upon intelligence gathered, adopt a recognised tool and measures such as the Carer Support Needs Tool (CSNAT) to assess and prioritise decisions for the implementation of a range of interventions and measures outlined in the strategy, to enhance carer support and reduce carer burden.

Rationale – Improve identification of known factors that contribute to carer burden and strengthen carer resilience by implementing measures that reduce carer burden and improve patient care at home and in the community.

The progress in Year One (2019/2020) was not as we had planned. Responsibility for the delivery of the plan was included in the work plan of the Family Support Team Leader. Unfortunately, the post holder left the organisation early in the year and, although we moved quickly to replace her, her successor experienced ill health and subsequently left the organisation too.

The progress in Year Two (2020/2021) was not as planned. The arrival of Covid-19 in 2020 also had an adverse impact on our ability to deliver the CQUIN target as we had to re-focus our attention towards our contribution to local resilience plans and adapting our existing services to safely meet the needs of those who use our services. In response to the covid pandemic and government guidance, in March 2020 we were forced to temporarily suspended delivery of our living well and bereavement support services and implemented restrictions on visitors to the In-patient Unit. Nevertheless, the following progress has been made:-

Partnership with Durham Carers

We have been pleased to see the further development of this partnership during the year. Although the two face to face sessions for last year did not go ahead due to Covid-19 our Community Development Lead worked with Durham Carers to develop and deliver an “Everything in Place” project via zoom specifically for Carers, with Durham Carers recruiting the participants, supporting their attendance and with the Hospice delivering the programme. “Everything in Place” covers issues such as Advance Care Planning, Powers of Attorney, Will Writing, the Care Conundrum and Funeral Planning. These sessions have been evaluated very positively. Our Community Lead also responds to individual referrals from Durham carers where families need specific information. The Namaste Care course delivered specially to Durham County Carers was cut short due to Covid–19. However the Namaste service has used the interruption to service delivery caused by Covid-19 as an opportunity to develop a Care Academy course and Durham Carers will have access to this once it is finalised. The Namaste service has also added a prompt to their initial assessment form to ensure all our referrals are informed about the Durham County Carers.

Work with GRT and Homeless Communities

We have recognised the need to make Hospice services as accessible as possible to people from the Gypsy, Roma, Traveller (GRT) and Homeless communities. A “settled” and building-led service like a Hospice can be, or be perceived to be, culturally inappropriate for members of these more itinerant communities. Prior to the pandemic our Nurse Consultant had made strong links with agencies supporting and providing care for these communities in order to ensure that we are able to provide information and advice to the people they care for, as well as to help us to better understand and respond to their needs. Progress on this has stalled due to the pandemic.

Carer Innovation Fund

A challenge of the CQUIN is that sustainable improvement should be achieved without additional resources. The Hospice therefore submitted an application to the Government’s Carer Innovation Fund. Although this bid was submitted in September 2019, decisions were delayed because of the General Election and the subsequent arrival of Covid-19, with the Fund being pulled altogether in April 2020 because of a Department of Health decision to re-prioritise resources.

Namaste

Although the Namaste Care project was designed principally to benefit people with advanced dementia, an unintended outcome has been the impact on those who care for them. Initially, this was perceived primarily as respite, with the hour or so that the Namaste Volunteer spends with the person with dementia giving the person providing care a much-needed break. However, as a connection has been re-established with the “spirit within” of the person receiving the Namaste Care, family members have reported an improvement in their relationship with that same spirit.

With the Covid-19 pandemic and associated government guidance impacting on services across 2020 - 2021, the Namaste Care Project has very much had to shift their focus and provide more support to carers. The pandemic has highlighted the extreme social isolation of people living with dementia and their carers. The withdrawal of day services and other avenues of support, have resulted in some family carers reaching crisis point and some have made decisions about their loved one moving into a care establishment on a permanent basis, a decision that they would not have made so soon had it not been for the impact of Covid-19. The Namaste Care Project has therefore worked to support these transitions into care through interventions such as sharing the life stories, creating care plans for the care home and liaising with staff, as well as providing emotional support to the carer during this process. They have also developed, in partnership with the Care Academy, an online Namaste Care training package for professional and informal carers. This includes taught online content which is supplemented with a follow up session either online or face to face.

Restructure of Family Support Team

Partly in response to the new Strategic Plan, the Hospice undertook a review of its Family Support Team (Jan to Mar 2020). The outcome of this was to split the team into 3 (Bereavement Support, Social Work, Chaplaincy) with all three services coming under the management of the Day Services Manager. In 2020 – 2021 the focus has been on embedding this new structure, recruiting to vacant posts and agreeing the operational plan for Day Services. In 2021 we recruited two new social workers and responsibility for delivery of the CQUIN Year 2 is now within the work plan of the family support (social work) team.

Bereavement Services

In the IPU, necessary visitor restrictions have begun to add to the carer burden but the IPU team, together with bereavement services team have been focussed on providing more emotional support to family members of patients in the IPU, who were unable to visit. They have endeavoured to facilitate virtual visits and alternative means of creating a link between patients and those who care for them.

Although face to face and telephone counselling was temporarily suspended due to Covid-19 pandemic and associated government and professional guidance, the team have offered well-being calls to clients. Following a situational risk assessment they have been able to put arrangements in place that meant they could recommence telephone counselling (May) and face to face counselling (August). Furthermore, they have widened their referral criteria and are accepting referrals of people in need of bereavement support due to Covid-19.

Dementia Services

Dementia services have continued to support carers throughout 2020 – 2021. The Admiral Nurse Assessment Framework, Namaste Assessment Tool and Carers Support Needs Assessment tool have been used to fully engage with carers, assess wellbeing, identify needs and strategies for support. In 2020, when the pandemic first hit, most of this support was by telephone. However, this changed as in response to recognition that social isolation and the withdrawal of usual support services was impacting significantly on carers.

In response, the team created a RAG rating for recommencement of home visits aimed at ensuring the information and support needs of carers were met. A questionnaire was formulated and sent to carers to ensure that the input from the team was relevant and timely. The Dementia team have offered practical support on how to best manage aspects of care for someone with dementia to not only ensure the carer feels well supported but to also enhance quality of life for the person with dementia. They have, throughout the pandemic, continued to offer carers information, sign posting, and emotional support, particularly through during transitions into care, anticipatory grief and bereavement.

Living Well Centre

Under normal circumstances the Living Well Centre team has been able to deliver therapy sessions to carers where they have had the capacity to do so. However this has not been an option in 2020 – 2021 due to the Covid-19 pandemic and associated government guidance. They have however maintained links with guests and their carers by means of regular well-being calls. These calls, which have often lasted an hour have given us new and fresh insight into the needs of carers. Similar to Dementia Services and the Namaste Care Project they have witnessed an increase in the carer burden due to social isolation and the absence of support services. This learning will be used to inform our service development going forward.

3.5 Health Care Associated Infection (HCAI)

We recognise that there are a high number of factors that can increase the risk of acquiring an infection, but seek to minimise the risk by ensuring high standards of infection control practice. This ensures that residents are cared for in a safe, clean environment by addressing any deficits in standards requiring further action.

We have adopted the following systems and processes for Infection Prevention and Control within the Hospice:

- A nominated Senior Nurse acts as our link practitioner for Infection Prevention and Control across all clinical and non-clinical areas within the Hospice.

- The Infection Control Group continued to meet virtually during 2020 - 2021 and reported to the Clinical Governance Committee on a quarterly basis.

The Infection Control Group is represented by clinical and non-clinical members including a recently retired Consultant Medical Microbiologist

The terms of reference for this group were reviewed in 2020 – 2021 and are as follows:

- To review existing polices and ensure that these are updated as required.

- To develop new policies in line with national guidelines and submit to the Clinical Governance Sub Committee (CGSC) on a quarterly basis for approval.
- To hold quarterly Infection Control Meetings and submit minutes to the infection control lead for the CCG on a quarterly basis.
- To promote and raise awareness of Infection Prevention and Control across all areas of the Hospice e.g. signage for hand hygiene.
- To undertake Infection Prevention and Control Audits from Hospice UK. Audits from Hospice UK are carried out on a three-monthly basis across clinical and non-clinical areas. This enables the Hospice to be compliant with legislative and regulatory requirements from the Care Quality Commission, Department of Health and the Code of Practice for health and social care (on the prevention and control of infections under the Health and Social Care Act 2008).
- Audits are submitted to the Audit Group meetings and are also submitted to the infection control lead at the CCG on a quarterly basis.
- Lead Nurse to participate in the annual audit for Infection Control from external auditor and act on recommendations.

We have established close links with the Infection Prevention and Control team from Durham Clinical Commissioning Group. Their Lead Nurse undertakes an external Infection Prevention and Control Audit at the Hospice on an annual basis and covers thirteen domains requiring compliance. This enables our organisation to monitor our compliance, and put systems in place with infection control standards and policies where this has not previously been the case, thereby reducing the risks of healthcare-associated infections. This audit was completed in March 2021 and met the standards required.

The Hospices infection prevention and control link practitioner lead co-ordinates a schedule of infection prevention and control audits agreed and monitored via the Hospices Clinical Governance Sub Committee and Board. Infection Prevention and Control is a mandatory training requirement for staff and volunteers and is delivered twice annually. We also use e-learning and workbooks in relation to Infection Control, for staff and volunteers who have been unable to attend the mandatory training. Compliance with mandatory training is monitored via the Hospices Human Resources Sub Committee and Board.

3.6 Awards.

In 2020 – 2021 St Cuthbert's Hospice was proud to announce that the work of the Hospice has been recognised through the award:

Better Health at Work Award (Continuing Excellence level) has been maintained.

North East
Better Health
at Work Award
Continuing Excellence

3.7 WELL LEAD

Aspiration 1: Embedding our improvement to Clinical Governance.

What was our rationale for choosing this aspiration?

St Cuthbert's Hospice accepts it is accountable for the standards of care it provides and during the period 1 April 2020 – March 2021 made significant progress in strengthening its clinical governance and developing robust systems and processes to monitor, review, report and act in response to all clinical issues and incidences.

Review of progress against this aspiration

During the period 1st April 2020 – 31 March 2021, we have been successful in ensuring we had strong clinical governance at St Cuthbert's Hospice. In March 2020 we completed a situational risk assessment in response to the covid pandemic and subsequently changed to a remote way of working. (Refer to Section 3.3). In the autumn of 2020 the retirement of the Head of Retail and resignation of the Head of Human Resources created an opportunity to review the senior management structure. This has led to the introduction of two new posts, Head of Income Generation and a Human Resources Manager. The way in which our senior managers and service managers responded to these changes demonstrated a leadership culture that was responsive, enabling and empowering. Clinical governance and activity such as audit, policy reviews, incident management, and root cause analysis, Duty of Candour, learning and improving have continued throughout the pandemic, ensuring clinical governance, systems and processes are sustainable and embedded in day to day practice.

3.8 SAFE

Aspiration 2: Reducing Falls, Pressure Ulcers, and Thromboembolisms

What was our rationale for choosing this aspiration?

In order to measure how safe our service was during the period 1 April 2020 to 31 March 2021, we adopted the principles of the former Safety Thermometer. We measure harm in relation to two key areas: falls and pressure ulcers. Whilst we are no longer required to submit this data on a monthly and quarterly basis, we still routinely collect data internally on all falls including slips and trips as and when they occur. We also benchmark our performance against other hospices using the Hospice UK Patient Safety Benchmarking Data.

St Cuthbert's Hospice has in 2020 - 2021, continues to view harm-free care for patients as an important priority. The principles outlined in the NHS Patient Safety Thermometer remain an effective method for surveying patient harm.

Although no longer required to report via the national patient safety thermometers spreadsheet we continued to collect and monitor information on known harms associated with health care. This includes all falls as and when they occur, the incidence of acquired/deteriorating pressure ulcers, and thromboembolism VTE assessment during and following admission and on a weekly basis thereafter. Table 1 below provides a summary of our progress in reducing known harms and incidents.

NB In 2020 - 2021 we reported a decrease in falls and within this an increase in avoidable falls due to significant investment in falls prevention work.

Table 1: Safe care targets and achievements.

Safe Care Measures	Actual for 2018-2019	Actual for 2019-2020	Actual for 2020-2021
Avoidable falls	38 falls of which 1 was avoidable (14 of these falls were for 5 patients)	24 falls of which 2 were reported as avoidable (reflects improved falls awareness & reporting)	17 falls 7 reported as avoidable 10 reported as unavoidable (reflects improved falls awareness & reporting)
Pressure ulcers (PUs) developed or deteriorated during stay in the Hospice	4 PUs acquired post admission 2 PUs deteriorated after admission	23 PUs on admission (18 People) 8 PUs post admission (5 people) 7 out of 8 PUs post admission developed from moisture lesions/redness observed on admission	12 PUs on admission 2 PUs post admission
Thromboembolism Assessments (VTE)	99% of patients had a VTE assessment within 24 hours of admission	99.6% of patients had a VTE assessment within 24 hours of admission	99.25% of patients had a VTE assessment within 24 hours of admission

Falls

What was our rationale for choosing this aspiration?

Many of our patients have limited mobility or are frail as a consequence of their illness, but retain 'capacity' and express their wish to remain as independently mobile as possible. In respecting patient preference, we also have to balance the need to keep our patients safe with the need to respect and promote their independence. In such situations some falls remain unavoidable.

However, we continue to aspire to have a zero rate of avoidable falls. To help us achieve this on admission all patients will be assessed for their individual risk of falls using a Falls Risk Assessment Tool (FRAT) and where appropriate a falls risk care plan is put in place to try and reduce the incidence of avoidable falls. Nevertheless,

we recognise that falls can and still do occur if patients are to be supported to take therapeutic risks.

Review of progress against this aspiration

In 2020 - 2021 we have:

- Ensured a falls assessment is completed within 4 hours of admission.
- Ensured a falls care plan is developed within 8 hours of admission.
- Ensured an assessment by a physiotherapist is completed within 24 hours of admission.
- Ensured falls risk and care plans at least weekly and following a fall.
- Continues to use 'Call, avoid the fall' signs introduced in 2018-2019.
- Placed patients, who are assessed as being at high risk of falls, under close observation near to the nurses' station to ensure prompt responses to the Nurse Call system.
- Continued to use the new state of the art ultra-low profile beds (purchased in May 2016 and 2019).
- Further increased our stock of '*chair, bed, floor and remote sensor*' movement alarms and purchased mattress sensors.
- Continued to deploy sensors and used falls crash mats where indicated.
- Conducted a formal review of the falls risk assessment, for every patient, at our weekly multi-disciplinary team meeting.
- Embedded the role of our physiotherapist as 'falls' link practitioner and established a falls prevention link practitioner group.
- Encouraged increased reporting of "near-misses" – where a fall did not occur but might have done.
- Ensured a close observation chart is used in relation to people assessed as being at high risk of falls.
- Developed an Enhanced Observation Policy and completed a review of the Falls Prevention Policy.
- Developed, tested and implemented an evidence based risk assessment tool and care plan for falls prevention.
- Made revisions to SystmOne to ensure it reflects the revised policy and evidence based risk assessment and care plan.
- Used the risk assessment and care plan to develop an audit tool and completed a quarterly audit of falls.
- Included falls prevention in mandatory training for all clinical staff.
- Used the new nurse call system, introduced in 2019, to enhance remote monitoring of patient movement and early detection of falls.

Pressure ulcers

What was our rationale for choosing this aspiration?

We once again set an ambitious target of zero incidence of pressure ulcers (PUs) being acquired or deteriorating following admission for 2020 - 2021. We recognise the challenges associated in meeting this ambitious target. Following the publication in June 2018 by NHS Improvement, '*Pressure ulcers: revised definition and measurement. Summary and recommendations'*, we have adopted the best practice for the categorisation of pressure ulcers and as recommended in the report no longer describe '*Kennedy Terminal Ulcers.* Within the Hospice, for reporting purposes we use the term suspected deep tissue injury.

We recognise the difficulty of balancing the rights of patients with capacity and or the wishes of their loved ones who, after being made aware of the risk of harm, still decline positional change regimes or pressure relieving equipment in the final stages of end of life care against the goal of preventing avoidable injury or harm.

Consequently, there will continue to be occasions when, despite the implementation of a pressure ulcer risk reduction care plan, unavoidable pressure damage may still occur. Such measures include risk assessment, the use of pressure relieving equipment, regular positional changes, pressure prevention monitoring and the use of measures to protect the integrity of skin over bony prominences.

Review of progress against this aspiration

In 2020 - 2021 we have continued to promote best practice and apply NICE Guidance to support monitoring, management of pressure ulcers, (April 2014). We have implemented our Prevention and Management of Pressure Ulcers Policy (revised May 2019) that adopts the best practice as outlined by NICE.

We have ensured:

- A pressure ulcer risk assessment, is completed within 6 hours of admission using the validated 'Waterlow Risk Assessment tool."
- A review of the Hospice's policy and procedure for clinical photography has been completed.
- Clinical photography is used to assess and evidence a patient's condition and the healing process from admission through to discharge.
- A written care plan is completed within 6 hours of admission, to mitigate against the risk of pressure ulcers.
- Pressure area mapping charts and rounding charts are used in patient rooms to record regular positional change regimes.
- Risk assessments and care plans are recorded on SystmOne in line with the Hospice policy and procedures, recognised best practice and professional guidance.
- A patient information leaflet on pressure ulcers has been developed and made available to patients and their families/carers.

- Incident reports are completed, the local authority safeguarding team and CQC are notified of all suspected deep tissue injuries (pressure ulcers) graded at 2 or above noted on initial admission assessment or acquired following admission as an in-patient.
- The role of link practitioner and for tissue viability has been established and the link practitioner group has held regular meetings.
- The Hospice UK pressure ulcer audit tool (released April 2016) has been completed in line with the audit schedule and clinical governance arrangements agreed by Clinical Governance Sub-Committee.

VTE Assessments

What was our rationale for choosing this aspiration?

In December 2014 we commenced formal VTE (Venous Thromboembolism) assessments on patients admitted to IPU to evidence decisions made with regard to anticoagulation therapy. We aspire to continue and maintain our current performance and have continued to commence formal VTE (Venous Thromboembolism) assessments on all patients on admission, achieving 99.25% in 2020 – 2021.

Review of progress against this aspiration

All falls, suspected deep tissue injuries (pressure ulcers) on admission, acquired or deteriorating following admission, and failures to complete a VTE assessment have been reported and recorded as clinical incidents.

All falls, suspected deep tissue injuries (pressure ulcer) on admission, acquired or deteriorating following admission, have been recorded on our incident log and investigated using root cause analysis and any lessons learned have been shared with staff.

Each Link Practitioner group has completed a quarterly status slide describing what has been achieved this quarter, what will be achieved in the next quarter and any risks and /or issues.

Status on improvement initiatives under the link practitioner initiative and lessons learned from RCA have been reported and monitored quarterly to the:

- Clinical Governance Sub-Committee (CGSC)
- The Clinical Governance Group (CGG)
- Senior Management Team (SMT)
- Clinical Commissioning Group (CCG) in our quarterly Contract Quality Performance Reports for 2020 - 2021 and have been made publically available on the Hospice website.

All pressure ulcers acquired or deteriorating following admission and graded at 3 or above and any falls that results in serious harm to a patient have been:

- Internally investigated adopting root-cause analysis methodology and a report compiled for SMT and CGSC.
- Statutorily notified to CQC by using the service statutory notification form for 'serious injury to a person' or 'allegation of abuse (safeguarding)'.
- Reported to the Commissioners via North East Commissioning Support Unit (NECS) in line with NHS England's Serious Incidents framework.

Aspiration 3: Prevent errors associated with the supply, storage, prescribing, administration and disposal of medicines (controlled drugs and non-controlled drugs)

What was our rationale for choosing this aspiration?

St Cuthbert's Hospice offers symptom control and end of life care in its In-patient Unit (IPU) and Day Services. Drug therapy is an important part of this care and we prescribe and administer a variety of drugs, including controlled drugs (CDs). Errors involving CDs are extremely rare but because of the nature of the drugs and dosages involved, such errors can have serious unintended outcomes.

During 2018 - 2019 we had no controlled drug administration errors involving maladministration of controlled drugs. We acknowledge that this may indicate we are achieving best practice or alternatively are under reporting. (Refer to Aspiration 6).

In 2019 - 2020, improved incident reporting and a more rigorous approach to RCA highlighted system failure as a feature of most medication errors (CDs & non-CDs) and risks and issues relating to supply, storage, prescribing, administration and disposal, (Refer to Part 3 Table 6).

In 2020 - 2021 we aspired to achieve a zero incidence of drug administration errors and to ensure that our policy framework and associated procedures support development of a safety culture; facilitates openness about failures; that incident management is not be used as a means of apportioning blame, but as a mechanism for identifying risks, learning from mistakes and driving improvement.

Review of progress against this aspiration

In 2020 - 2021 we have:

- Undertaken a review of the incident management policy and procedure. This included identifying and exploring factors that enable incident reporting as well as factors that act as barriers to incident reporting.
- Continued to engage the services of a qualified pharmacist on a professional activity session basis to assist us to:

    - Achieve improved clinical and cost-effective prescribing.
    - Conduct review of stock drug holdings and prescribing practice.
    - Support our medical and non-medical prescribers.
    - Provide expert medicines advice to colleagues at multi-disciplinary team meetings, particularly the Medicines Optimisation meeting.
    - Conduct audits of storage, supply, prescribing, administration and disposal of medicines.
    - Review all policy and procedures related to storage, supply, prescribing, administration and disposal of medicines.
    - Contribute to a review of our arrangements for supply of wholesale stock drugs and medication supplied under FP10s.

- Explored opportunities to increase pharmacy capacity.
- Reported and recorded all medication errors relating to the supply, storage, prescribing, administration and disposal, (including near misses).
- Reported all CD incidents to our CD Local Intelligence Network (CD LIN) via a quarterly report.
- Internally investigated all medication errors in line with the Hospice's Incident Management Policy & Procedure and Root Cause Analysis Procedure.
- Implemented weekly, monthly, quarterly medicines audits, adopting the Hospice UK Audit Tools and in accordance with the audit schedule and governance arrangement agreed with Clinical Governance Sub Committee, (CGSC).
- Implemented comprehensive medicines optimisation training and development programme for all clinical staff involved in the supply, storage, prescribing, administration and disposal of medicines.
- Completed competency assessments and assessed the drug calculation competence of our nursing staff and where relevant care staff.
- Continued to learn from incidents and drive improvement via the quarterly Medicines Optimisation Group established in early 2019.

We have subsequently seen evidence of:-

- Increased reporting of medication incidents, both CDs and non-CDs.
- Participation by relevant staff in root cause analysis and action planning in response to incidents.
- Evidence of all staff having had the opportunity to comment on reviews of the existing policies and procedures related to the supply, storage, prescribing, administration and disposal of medicines.
- Clinical staff involved in CD administration will continue to complete and pass the annual drug calculation assessment with a 100% pass mark.
- Medicines Optimisation meetings and Clinical Governance Group driving improvements to medicines optimisation
- Clinical Governance Sub Committee providing not only monitoring but also support and challenge.

Aspiration 4: Prevent avoidable harm from use of medical equipment, devices with known faults, or drug quality tainted or compromised in production

What was our rationale for choosing this aspiration?

The risk of harm to patients and staff through incorrect use of, or using medical equipment and devices known to be faulty and or tainted/compromised drugs, is well recognised, ever present and avoidable. St Cuthbert's Hospice receives medical equipment device and drug alerts from NHS central alerting systems. These include:

- Department of Health CAS https://www.cas.dh.gov.uk/Home.aspx
- Medicines & Healthcare products Regulatory Agency
- https://www.gov.uk/government/organisations/medicines-and-healthcare-products-regulatory-agency
- Controlled Drugs Local Intelligence Network

We aspire to prevent avoidable harm to our patients and staff associated with the use of faulty medical equipment and devices and tainted/compromised drugs and to continue to embed a robust procedure to minimise risks and aim to respond promptly to all safety alerts.

Review of progress against this aspiration

In 2020 – 2021 we have no reported incidences of harm to patients and staff as a result of incorrect use of or using faulty medical equipment, devices and or tainted/compromised drugs.
We have:-

- Communicated all electronic alerts to all medical, nursing and allied health professional staff via email with open and read receipts to confirm that staff have read the alerts
- Printed off and updated '**Alert Files**' available in Inpatient Unit, Day Care Services, Community Services and Guest Services where appropriate.
- Recorded the alert on an alert action log for those alerts that impact on medical equipment, devices and or drugs used in our services. (Estates related alerts are managed via our Support Services Team).
- Recorded "Alert Update" as a standing agenda item on the Clinical Services team meeting.
- Ensured "Alert Update" and action logs are a standing agenda item for CGSC and CGG.
- Completed a baseline audit of the status of medical devices that includes servicing details, manufacturing information and staff training. Developed an action plan based on the findings from this audit and include this as an item on CGG and CGSC meetings.
- Recorded any such medical equipment/device fault alerts and/or drug alerts pertaining to products used by our services and what has been done to respond as per procedure.

- Reported to CGSC, all incident alerts that require action and recording in the alert log; progress on the actions from medical devices audit.

3.9 EFFECTIVE

Aspiration 5: Measure the effectiveness of our care, palliative care interventions and outcomes

What was our rationale for choosing this aspiration?

Those who use our services need to know that the interventions and care we implement to meet their individual needs is responsive, informed by evidence and best practice and makes a difference to their symptoms and quality of life.

We want people to feel confident to discuss their health needs with staff. This is important to ensure that people are regularly involved in monitoring changes in their health status or needs and that these are fully discussed with them. Review of care plans already happens on a regular basis. The implementation of palliative care outcome measures in 2018 – 2019 means we and our patients are able to be better informed about the clinical effectiveness of our care and interventions.

Although in 2019-2020 we continued to collect and collate the set of data from the suite of palliative care outcome measures we were unable to secure the support we need to realise the full benefits of this initiative.

Review of progress against this aspiration

In 2020 – 2021 we have continued with data collection, analysis and interpretation. However, due to the constraints of the Covid-19 pandemic we have been less successful in provision of detailed incident analysis and reporting including dashboard reporting to CGSC, CGG, SMT and Commissioners of outcomes measures achieved; sharing our findings with sector colleagues, our CGSC and those who use our services.

We were unable to secure a Business Analyst/Solution Designer from Northumbria University to review and strengthen our incident log and our capacity to provide detailed incident analysis and reporting including dashboard reporting of clinical incident trends and patterns. We have however, managed to secure support from data scientist students who have used an analysis of historical IPOS patient data to describing patients experience of hospice care. This aspiration is something we aim to revisit in 2021 – 2022.

Aspiration 6: Measuring patient dependency and acuity to better inform our workforce planning.

What was our rationale for choosing this aspiration?

The Board of Trustees and Senior Management Team (SMT) of St Cuthbert's Hospice recognise that patient numbers, levels of dependency and acuity of care need impact on the number and skill mix of care staff needed at any one time to meet care needs. They also acknowledge that patient dependency changes dynamically and the care needs of patients and their loved ones change over time.

St Cuthbert's Hospice aspires to increase incrementally the number of beds open to admissions on the In-patient Unit from ten to thirteen and thus better data about the impact of acuity and dependency will enhance our workforce planning and modelling.

During autumn of 2015-2016 we implemented a new In-patient Unit (IPU) dependency and acuity tool. The tool has been designed and adapted from the principles of the Shelford Group NHS 'Safer Care Nursing Care Tool' as recommended by NICE. https://www.nice.org.uk/news/press-and-media/first-toolkit-endorsed-by-nice-for-safe-staffing

We have also adapted the Richmond Agitation-Sedation Scale modified for palliative care inpatients (RASS-PAL): to acknowledge the known increasing levels of dependency and acuity associated with terminal agitation in the dying patient.

Review of progress against this aspiration

In 2020-2021 we aspired to learn from the implementation phase and ensure the effectiveness of this tool. However, we have been unable to secure the support needed to progress this aspiration. This is something we hope to revisit in 2021 – 2022.

3. 10 RESPONSIVE

Aspiration 7: To reduce the number of serious incidents and prevent any avoidable incidents occurring.

What was our rationale for choosing this aspiration?

St Cuthbert's Hospice takes the provision of safe care seriously and recognises there is no room for complacency. During 2020 – 2021 in fulfilling our duty of candour, we reported all serious incidents, (Appendix 1).

We have established robust processes for incident reporting using a standard incident report form and recording all details on a central spreadsheet incident reporting log. Our expectation is that Hospice staff are diligent and professional in ensuring all

incident reports are completed in a timely manner and that appropriate follow-up actions are logged as and when they occur.

Review of progress against this aspiration

In 2020 – 2021 we have:-

- Been more proactive in anticipating and minimising the risk of incidents occurring.
- Encouraged greater engagement and ownership of root cause analysis, learning and improvement by service managers and front-line staff.
- Provide face to face training as well as work-based learning on incident management and root cause analysis.
- Ensured comprehensive reporting of 'near-misses' – in other words, incidents that could have developed into an accident but for a fortunate break in the chain of events.
- Reviewed our incident reporting policy and procedures and embedded use of an electronic version of our accident and incident reporting forms and incident log.
- Commenced a review of our electronic incident reporting forms, root cause analysis procedure and associated tools and templates
- Increased incident reporting, including near misses.
- Collected comprehensive baseline data for the number, type and severity of incidents or near-misses reported.
- Used baseline data to inform risk management at all levels of the organisation.
- Completed quarterly reviews of the incident log at all levels of the organisation.
- Used learning from incidents to drive improvement
- Reported trends and patterns being reported to CGSC, CGG, SMT.
- Worked to develop an enabling and empowering leadership and management style.
- Had 1 serious incident, a fall, resulting in harm to a patient.

3.11 CARING

Aspiration 8: Improving safeguarding

What was our rationale for choosing this aspiration?

Improvements to systems and processes supporting incident management has enabled the identification of themes. Safeguarding was one such theme and as such has been recorded on the corporate risk register.

During October 2019 the CCG's Safeguarding Team conducted an announced safeguarding assurance visit. Whilst overall the visit was positive, there were some areas that the organisation could improve on, specifically:

- The Safeguarding Vulnerable Adults Policy and Procedure and the Mental Capacity and Deprivation of Liberty Safeguards policy requires reviewing.
- Recording of Mental Capacity Assessments and Best Interest Assessments by Clinical staff.

We aspire to do all we can to ensure people who use our services are protected from suffering any form of abuse or improper treatment while receiving care and treatment. Improper treatment includes discrimination or unlawful restraint, which includes inappropriate deprivation of liberty under the terms of the Mental Capacity Act (2005).

Review of progress against this aspiration

In 2020 – 2021 we have:-

- Reviewed our policies framework for Safeguarding, both Adults and Children, Mental Capacity Act (MCA) and Deprivation of Liberties Safeguards (DoLS).
- Addressed gaps in our policy framework and developed policies for restraint, enhanced observations.
- Reviewed our training provision and developed and delivered face to face training and work-based learning to facilitate application to practice and complement existing e-learning modules.
- Developed an audit tool and completed an audit of DOLs/MCA entries on SystmOne, the patient's electronic care record.
- Established a link practitioner for safeguarding and drive improvement to safeguarding, MCA and DoLS through a quarterly link practitioner safeguarding meeting.
- Improved uptake of MCA and DoLS within the in-patient unit.
- Evidenced improvement against the CCG assurance visit report Oct 2019.
- Fulfilled our Duty of Candour reporting safeguarding concerns to the local authority and CQC.

4. Statement for Board of Directors

The following are statements that all providers must include in their Quality Account. Many of these statements are not directly applicable to Hospices and therefore they are included at Appendix 4 where further clarification is provided as appropriate.

During the period 1 April 2020 to 31 March 2021 St Cuthbert's Hospice provided the following services:

- A 10 bedded In-patient Unit offering 24-hour care.
- Day care in our Living Well Centre offering treatment, advice, support and activities. Including:
- Physiotherapy, Occupational Therapy, social care, counselling and a wide range of cognitive therapy and memory work, exercise and breathlessness groups, fatigue management sessions and complementary therapies
- Community Support – Everything in Place project
- Family Support Team providing pre and post-bereavement counselling as well as expert social care support for patients, families and carers.
- The Children and Young Persons bereavement service.

During the period 1 April 2019 to 31 March 2020, St Cuthbert's Hospice provided or subcontracted five NHS services (In-patient services, day-care services, and bereavement support services, a specialist bereavement support service for children and young people and Palliative Care Consultant support for community services in North Durham).

The income generated by the NHS services received in 2020 - 2021 represents 100% of the total income generated from the provision of NHS services by St Cuthbert's Hospice Durham for 2020 - 2021. The income generated represents approximately 50% of the overall costs of running these services.

What this means

St Cuthbert's Hospice is funded by both NHS income and by Fundraising Activity. The grants allocated by the NHS funding contribute to approximately 50% per cent of Hospice total income needed to provide these services.

This means that all services are partly funded by the NHS and partly by Charitable Funds.

For the accounting period 2019 - 20 St Cuthbert's Hospice signed an NHS contract for the provision of these services.

5. Statement of Assurance from County Durham Clinical Commissioning Group

5th July 2021

Mr Paul Marriott
Chief Executive
St Cuthbert's Hospice
Park House Road
Durham
DH1 3QF

Dear Mr Marriott

St Cuthbert's Hospice Quality Account 2020/21.
Response on behalf of NHS County Durham Clinical Commissioning Group (CCG)

NHS County Durham CCG is pleased to have had the opportunity to review and comment on the Quality Account for St Cuthbert's Hospice for 2020/21.

Commissioners felt that the report was well written and presented in a meaningful way for both stakeholders and service users. The report provides an open account of where improvements in priorities have been made and the CCG would like to commend the Hospice on its achievements during a challenging 2020/21.

The CCG acknowledge the significant improvements that continue to be made to patient care and experience. The structured approach to governance, audit and quality improvement at St Cuthbert's is reflective of the desire to continually improve the quality of care, not only through internal quality systems but also through making best use of the Commissioning for Quality and Innovation (CQUIN) scheme. The CCG note that the Hospice faced challenges in 2020/21 relating to staffing and COVID-19 but is pleased to see that despite these challenges, work progressed to fulfil all CQUIN requirements.

Although the NHS Safety Thermometer was not developed directly for hospices, St Cuthbert's embraced its principles throughout 2020/21 demonstrating their commitment to delivering high quality care. The CCG are particularly pleased to note the extensive work the Hospice has undertaken to reduce falls including embedding the Falls Link Practitioner role and development and implementation of an evidence-based risk assessment tool and care plan for falls prevention. As a result of the ongoing work and commitment in this area the number of reported falls reported continues to reduce.

Commissioners recognise St Cuthbert's commitment to reducing the risks of healthcare associated infections and are pleased to note that despite the challenges of the COVID-19 pandemic this remained a priority for the organisation. The Hospice continued to participate in internal and external audits and the Infection Control Group continued to meet virtually, addressing any deficits in standards requiring further action.

Through out 2020/21 St Cuthbert's continued with data collection, analysis and interpretation in an attempt to measure the effectiveness of care and interventions. Disappointingly, the Hospice was unable to secure a Business Analyst to strengthen incident reporting and analysis processes. However, the CCG is pleased to note that St Cuthbert's have now secured support from Data Scientist students and intend to continue this work in 2021/22. The CCG looks forward to hearing how this work progresses.

St Cuthbert's reported one serious incident during 2020/21. All serious incidents are managed in line with the national guidance via the Serious Incident process and the CCG will continue to work with the organisation to identify and share learning and ensure appropriate improvement actions are embedded.

The Hospice is to be congratulated on their success in achieving Better Health at Work (Continuing Excellence level) Award.

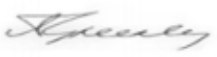
The CCG is pleased to note that despite the challenging year the hospice continues to undertake a range of clinical audits and patient feedback programmes to drive forward improvements.

Commissioners fully endorse the quality priorities identified for 2020/21 and are pleased to see these are based around the five CQC domains to ensure a high quality of service for patients and carers.

Finally, the Commissioners recognise that 2020/21 was a challenging year due to the COVID-19 pandemic and would like to applaud all staff for the continued commitment and dedication demonstrated through this difficult time.

We look forward to continuing to work in partnership with the hospice to assure the quality of services commissioned in 2020/21.

Yours sincerely



Anne Greenley
Interim Director of Nursing & Quality
NHS County Durham CCG

Appendix 1

Table 2: Serious Incidents and complaints

Quarter 1: 1 April 2020 - 30 June 2020

Table 2: Summary of serious / potentially serious incidents and complaints.							
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2020/0480	**Fall** Patient fell whilst attending a hospital admission elsewhere for chemotherapy. Hospital did not advise hospice staff of fall on return from hospital.	CQC		**x**			Incident referred to Hospital for investigation. No lasting harm to patient.
		NECS		**x**			
		Safeguarding		**x**			
		CGC / SMT	**x**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2020/0482	**Other** Husband of patient displaying covid symptoms whilst staying overnight.	CQC		**x**			Compliance with Government Covid guidance. Review of risk assessment.
		NECS		**x**			
		Safeguarding		**x**			
		CGC / SMT	**x**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2020/0483	**Unavoidable Fall** No harm to patient.	CQC		**x**			Family informed to fulfil duty of candour.
		NECS		**x**			
		Safeguarding		**x**			
		CGC / SMT	**x**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2020/0486	**Challenging behaviour** Patient with delirium. 121 observation in place.	CQC		**x**			Risk assessment and care plan reviewed. Documentation improved to reflect actual practice.
		NECS		**x**			
		Safeguarding		**x**			
		CGC / SMT	**x**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2020/0487	**Challenging behaviour** Patient with delirium. 121 observation in place. Links to Incident 2020/0486	CQC		**x**			Risk assessment and care plan reviewed. Documentation improved to reflect actual practice. Nurses to carry call bell when undertaking 121 supervision.
		NECS		**x**			
		Safeguarding		**x**			
		CGC / SMT	**x**				

Incident log number	Brief details of incident	Reported to	Yes / No		Date	STEIS Number	Outcome
2020/0488	**SDTI on admission** Upgradable necrotic area to sacrum with moisture damage to surrounding skin on admission	CQC	**x**				CQC notification completed. Safeguarding alerted – no concerns re abuse/neglect. Patient and family made aware in line with Duty of Candour.
		NECS		**x**			
		Safeguarding	**x**				
		CGC / SMT	**x**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2020/0489	**DoLs application.** Patient admitted who lacks capacity.	CQC	**x**				DoLs application made and accepted
		NECS		**x**			
		Safeguarding	**x**				
		CGC / SMT	**x**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2020/0490	**DoLs application.** Patient admitted who lacks capacity.	CQC	**x**				DoLs application made and accepted
		NECS		**x**			
		Safeguarding	**x**				
		CGC / SMT	**x**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2020/0491	**DoLs application.** Patient admitted who lacks capacity.	CQC	**x**				DoLs application made and accepted
		NECS		**x**			
		Safeguarding	**x**				
		CGC / SMT	**x**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2020/0497	**CD Medication Error** Dispensing error (Ketamine)	CQC		**x**			Incident referred to pharmacy. No harm to patient. Next of kin notified in line with Duty of Candour.
		NECS/CDLIN	**x**		**29/07/20**		
		Safeguarding		**x**			
		CGC / SMT	**x**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2020/0499	**SDTI on admission**	CQC	**x**				

	SDTI & upgradable pressure sore on admission .	NECS		x			CQC notification completed. Safeguarding alerted – no concerns re abuse/neglect. Patient and family made aware in line with Duty of Candour.
		Safeguarding	x				
		CGC / SMT	x				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2020/0503	**Unavoidable Fall** Patient lowered to the floor with assistance No harm to patient	CQC		x			Next of kin made aware in line with Duty of Candour.
		NECS		x			
		Safeguarding		x			
		CGC / SMT	x				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2020/0504	**CD Medication Error** Dispensing (Oxycodone)	CQC		x			Incident referred to pharmacy. No harm to patient. Next of kin notified in line with Duty of Candour.
		NECS/CDLIN	x		**29/07/20**		
		Safeguarding		x			
		CGC / SMT	x				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2020/0506	**Avoidable fall** Patient fell within 2hours of admission to the unit and had not been clerked in by Dr/nurse No lasting harm to patient	CQC		x			Need to complete timely risk assessment addressed with staff. Next of kin notified in line with Duty of Candour.
		NECS		x			
		Safeguarding		x			
		CGC / SMT	x				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2020/0509	**SDTI on admission** SDTI x4 on admission	CQC	x				CQC notification completed. Safeguarding alerted – no concerns re abuse/neglect. Patient and family made aware in line with Duty of Candour. Referred to Tissue Viability Nurse.
		NECS		x			
		Safeguarding	x				
		CGC / SMT	x				

Quarter Two: 1 July 2020 – 30 September 2020

Table 3: Summary of serious / potentially serious incidents and complaints.						
Incident log number	**Brief details of incident**	Reported to	**Yes / No**	**Date**	**STEIS Number**	**Outcome**
2020/0512	**SDTI** Necrotic area on admission	CQC	**x**			CQC notification completed. Safeguarding alerted – no concerns re abuse/neglect. Patient and family made aware in line with Duty of Candour.
		NECS	**x**			
		Safeguarding	**x**			
		CGC / SMT	**x**	**5/11/20**		
Incident log number	**Brief details of incident**	Reported to	**Yes / No**	**Date**	**STEIS Number**	**Outcome**
2020/0513	**SDTI** SDTI on admission	CQC	**x**			CQC notification completed. Safeguarding alerted – no concerns re abuse/neglect. Patient and family made aware in line with Duty of Candour.
		NECS	**x**			
		Safeguarding	**x**			
		CGC / SMT	**x**	**5/11/20**		
Incident log number	**Brief details of incident**	Reported to	**Yes / No**	**Date**	**STEIS Number**	**Outcome**
2020/0519	**Unavoidable Fall** Unwitnessed fall in the bathroom. Fractured humerus	CQC	**x**			CQC notification completed. Safeguarding alerted – no concerns re abuse/neglect. Patient and family made aware in line with Duty of Candour.
		NECS	**x**	**19/10/20**	**2019/14852**	
		Safeguarding	**x**			
		CGC / SMT	**x**	**5/11/20**		
Incident log number	**Brief details of incident**	Reported to	**Yes / No**	**Date**	**STEIS Number**	**Outcome**
2020/520	**SDTI** SDTI x3 on admission	CQC	**x**			CQC notification completed. Safeguarding alerted – no concerns re abuse/neglect. Patient and family made aware in line with Duty of Candour. Referred to Tissue Viability Nurse.
		NECS	**x**			
		Safeguarding	**x**			
		CGC / SMT	**x**			
Incident log number	**Brief details of incident**	Reported to	**Yes / No**	**Date**	**STEIS Number**	**Outcome**
2020/0523	**SDTI** Grade 4 pressure damage on admission	CQC	**x**			CQC notification completed. Safeguarding alerted – no concerns re abuse/neglect. Patient and family made aware in line with Duty of Candour. Referred to Tissue Viability Nurse.
		NECS	**x**			
		Safeguarding	**x**			
		CGC / SMT	**x**			

Incident log number	Brief details of incident	Reported to	Yes / No		Date	STEIS Number	Outcome
2020/0526	**Unavoidable fall** Patient did not call for assistance No serious harm to patient	CQC		**x**			Review of risk assessment and care plan. Review of Falls Prevention Policies & Procedures. Revision of falls template on SystmOne Commencement of mandatory falls prevention training for staff. Review of Physiotherapist input on IPU
		NECS		**x**			
		Safeguarding		**x**			
		CGC / SMT		**x**			
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2020/0527	**Unavoidable Fall** Unwitnessed fall. Nurses heard thud. Patient found on floor. No serious harm to patient	CQC		**x**			Review of risk assessment and care plan. Review of Falls Prevention Policies & Procedures. Revision of falls template on SystmOne Commencement of mandatory falls prevention training for staff. Review of Physiotherapist input on IPU
		NECS		**x**			
		Safeguarding		**x**			
		CGC / SMT	**x**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2020/0541	**SDTI** Grade 2 pressure ulcer & SDTI x2 on admission	CQC	**x**				CQC notification completed. Safeguarding alerted – no concerns re abuse/neglect. Patient and family made aware in line with Duty of Candour. Referred to Tissue Viability Nurse.
		NECS		**x**			
		Safeguarding	**x**				
		CGC / SMT	**x**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2020/0545	**SDTI** Patient noted to have developed SDTI to inner buttocks.	CQC	**x**				Verbal duty of candour. CQC notification. Safeguarding referral made.
		NECS		**x**			
		Safeguarding	**x**				
		CGC / SMT	**x**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2020/0546	**CD Medication Error** Dispensing (Alfentanil)	CQC		**x**			Incident referred to pharmacy and reported to CD Lin.
		NECS	**x**		**19/10/20**		
		Safeguarding		**x**			
		CGC / SMT	**x**				

Quarter Three: 1 October 2020 – 31 December 2020

Table 3: Summary of serious / potentially serious incidents and complaints.							
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2020/0548	**CD Medication Error** Dispensing **(**Oxycodone)	CQC					.Incident referred to pharmacy and reported to CD Lin.
		NECS					
		Safeguarding					
		CGC / SMT	**X**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2020/0555	**CD Medication Error** Dispensing **(**Midazolam)	CQC					Incident referred to pharmacy and reported to CD Lin.
		NECS					
		Safeguarding					
		CGC / SMT	**X**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2020/0556	**Unavoidable Fall** Patient lowered herself to floor whilst walking with assistance from husband. No harm to patient.	CQC					No evidence of shortfalls in risk assessment of care planning.
		NECS					
		Safeguarding					
		CGC / SMT	**x**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2020/0566	**Unavoidable Fall** **P**atient fell whilst adjusting bedding. Daughter present. No harm to patient.	CQC					No evidence of shortfalls in risk assessment of care planning.
		NECS					
		Safeguarding					
		CGC / SMT	**x**		**27/10/2020**		
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2020/0568	**CD Medication Error** Dispensing (Metoclopramide / Midazolam)	CQC		**x**			Incident referred to pharmacy and reported to CD Lin.
		NECS	**x**				
		Safeguarding		**x**			
		CGC / SMT	**x**		**30/10/2020**		

Incident log number	Brief details of incident	Reported to	Yes / No		Date	STEIS Number	Outcome
2020/0572	**Avoidable Fall** Patient fell during transfer with ambulance crew. No lasting harm to patient.	CQC		x			Incident referred to Ambulance Service. Safeguarding alerted. CQC notification sent.
		NECS		x			
		Safeguarding		x			
		CGC / SMT	x				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2020/0574	**SDTI on admission** Hospice advised by discharging hospital that patient had no pressure damage. On arrival noted to have dressing to L heel.	CQC	x				Safeguarding alerted. CQC notified. NOK made aware in line with Duty of Candour.
		NECS		x			
		Safeguarding	x		**19/11/20**		
		CGC / SMT	x				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2020/0576	**SDTI** Patient developed Grade 2 PU	CQC	x				NOK made aware in line with Duty of Candour. No evidence of shortfalls in risk assessment of care planning.
		NECS		x			
		Safeguarding	x				
		CGC / SMT	x				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2020/0578	**Unavoidable Fall** Patient found on floor. Appeared to have climbed over bed rails. Had been observed sleeping with nurse call to hand.	CQC		x			No evidence of short falls in risk assessment and care planning. Need to review falls risk assessment and care plan post fall reinforced with staff. NOK informed in line with Duty of Candour.
		NECS		x			
		Safeguarding		x			
		CGC / SMT	x				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2020/0579	**CD Medication Error** Prescribing (Hydromorphone)	CQC		x			No harm to patient. Supervision with prescriber. Staff to revisit annual drug calculation test and complete a supervised medication round.
		NECS	x				
		Safeguarding		x			
		CGC / SMT	x				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**

2020/0585	**SDTI** SDTI post admission due to deteriorating condition. TVN already involved in care of patient.	CQC	**x**		**31/12/20**		No evidence of shortfalls in risk assessment or care planning. Safeguarding alerted. CQC notified. NOK informed in line with Duty of Candour.
		NECS		**x**			
		Safeguarding	**x**				
		CGC / SMT	**x**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2020/0587	**SDTI** SDTI post admission due to deteriorating condition	CQC	**x**				No evidence of shortfalls in risk assessment or care planning. Safeguarding alerted. CQC notified. NOK informed in line with Duty of Candour.
		NECS		**x**			
		Safeguarding	**x**				
		CGC / SMT	**x**				

Quarter Four: 1 January 2021 – 31 March 2021

Table 3: Summary of serious / potentially serious incidents and complaints.							
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2021/0599	**CD Medication Error** Administration (Gabapentin)	CQC		**x**	**22/01/21**		No harm to patient. Reflective practice undertaken with staff. Duty of Candour to patient fulfilled.
		NECS	**x**				
		Safeguarding		**x**			
		CGC / SMT	**x**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2021/0600	**Safeguarding (Vulnerable Adult)** Unsafe discharge from Hospital due to sub-standard information and concerns about treatment during episode of care in hospital.	CQC	**x**		**17/02/21**		Incident referred to Hospital. Safeguarding referral made and CQC notified. Duty of candour fulfilled with patient.
		NECS		**x**			
		Safeguarding	**x**				
		CGC / SMT	**x**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2021/0597	**SDTI** SDTI on admission	CQC	**x**		**5/2/21**		Referred to Tissue Viability Nurse. CQC notification sent. Safeguarding referral made. Patient and next of kin made aware in line with Duty of Candour.
		NECS		**x**			
		Safeguarding	**x**		**05/02/21**		
		CGC / SMT	**x**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2021/0596	**DoLs Application** MCA completed - lacks capacity. DoLs application completed and emailed to DoLs team. Family aware. CQC notification completed and emailed	CQC	**x**		**03/02/21**		MCA 1+2 completed. DoLs application accepted. CQC notified. Family informed in line with Duty of Candour.
		NECS		**x**			
		Safeguarding		**x**			
		CGC / SMT	**x**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2021/0591	**Grade 2 Pressure damage** Admitted to IPU with grade 2 pressure damage. Family and patient aware.	CQC	**x**				Continuation of good quality care for pressure sore prevention and protection, monitoring and reporting of findings.
		NECS		**x**			
		Safeguarding	**x**				

		CGC / SMT	x				Verbal duty of candour
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2021-0587	**SDTI** Acquired SDTI	CQC	x				Continuation of pressure area care, prevention and protection, monitoring and reporting of findings. Referred to safeguarding, TVN, CQC notification, verbal duty of candour
		NECS		x			
		Safeguarding	x		**1/1/21**		
		CGC / SMT	x				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2021-0614	**DoLs** MCA completed - lacks capacity.	CQC	x		**16/3/21**		MCA completed, DoLs application completed and emailed to DoLs team. Family aware. CQC notification completed and emailed
		NECS		x			
		Safeguarding	x		**12/3/21**		
		CGC / SMT	x				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2021-0613	**SDTI on admission**	CQC	x		**18/3/21**		Continuation of pressure area care, prevention and protection, monitoring and reporting of findings. Referred to safeguarding, TVN, CQC notification, verbal duty of candour Verbal duty of candour - husband aware. Referred to TVN. Safeguarding Referral made. CQC notification completed.
		NECS		x			
		Safeguarding	x		**12/3/21**		
		CGC / SMT	x				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2021/0608	**Safeguarding** Inappropriate admission of patient requiring aerosol generating procedure	CQC		x	**16/02/21**		Risk assessment undertaken and patient managed appropriately. Government guidance, Hospice Policies and Procedures reinforced relevant staff.
		NECS		x			
		Safeguarding		x			
		CGC / SMT	x				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2021/0612	**CD medication Error**	CQC		x			

	Administration / Prescribing (Midazolam) On admission, no midazolam in syringe driver. Midazolam prescribed on card section for regular medication instead of as required medication.	NECS	x				Incident referred to community services for investigation.
		Safeguarding	x				
		CGC / SMT	x				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**

Appendix 2

Table 3: Hospice Key Performance Indicators (KPI's)

Hospice activity 2020-2021									
Indicators.	**Threshold**	**End of Year. 2019-2020**	**Met – Not met**	**2020-2021 quarterly performance.**				**End of year 2020-2021**	
				Q 1.	**Q 2.**	**Q 3.**	**Q 4.**		**Year 2020-2021 Performance**
In-Patient Unit (IPU)									**COMMENTS.**
Total number of in-patient referrals received	N/A for monitoring purposes	**346**	**-**	68	74	65	56	263	N/A for monitoring purposes
Average waiting time from referral to admission for inpatients (excluding planned respite)	**≤ 48 hours**	**38.8**	**Met**	24.9	45.3	45.7	34	37	Acuity of patients & staff absence due to covid. Patients requiring paracentesis (day care) included.
Total number of inpatient admissions.	N/A for monitoring purposes	**223**	**-**	53	52	38	37	180	N/A for monitoring purposes
Percentage bed occupancy.	**≥ 85%**	**80**	**Not met**	52.1	67.3	79.2	58.8	64.35	A reflection of the wider system
Percentage bed availability.	**≥ 95%**	**99.5**	**Not Met**	98.5	100	95.3	100	98.45	
Average length of stay for inpatients.	**≤ 15 days**	**12.9**	**Met**	9.7	11.4	16.5	10	11.9	
Number and percentage of inpatients that have been offered an Advance Care Plan.	**90%**	**214 94.4%**	**Met**	**98.2**	**93.5**	**97.7**	**100**	**97**	
Number and percentage of patients who died at the hospice and have preferred place of death recorded.	N/A for monitoring purposes	**109 88.4%**	**-**	**18 94.7**	**21 95.5**	**13 81.3**	**6 60**	**58 80**	N/A for monitoring purposes

Number and percentage of patients who died at the hospice who stated their preferred place of death and achieved this.	N/A for monitoring purposes	**101 89.5%**	**-**	**18 94.7**	**18 81.8**	**13 81.3**	**2 50**	**13 77**	N/A for monitoring purposes Q4 x2 PPC hospice/PPD home, died in Hospice.
Patient's risk of falls to be assessed within 4 hours of admission.	**100%**	**57.8%**	**Not met**	**86.8**	**78.8**	**79**	**94**	**85%**	Time of record keeping being recorded rather than time of assessment – deep dive falls audit completed. Revisions to SystmOne needed to mistake proof this. Support from CCG Digital Team required.
Patient's written care plan tailored to address falls risk completed within 8 hours of admission.	**100%**	**90.6%**	**Not met**	**100**	**94.2**	**100**	**94**	**97%**	As above
Pressure ulcer risk assessment to be completed within 6 hours of admission. (Ref - NHS Improvement 2018 Pressure Ulcers: revised definition and measurement).	**95%**	**71.1%**	**Met**	**94.3**	**94.2**	**100**	**94**	**97%**	
Patient's written care plan tailored to address pressure ulcer risk within 6 hours of admission (Ref - NHS Improvement 2018 Pressure Ulcers: revised definition and measurement).	**95%**	**71.1%**	**Met**	**94.3**	**94.2**	**100**	**94**	95%	
Venous thromboembolism (VTE) risk to be assessed within 24 hours of admission to determine if prophylaxis required.	**100%**	**99.6%**	**Met**	**100**	**100**	**100**	**97%**	**99.25 %**	
Percentage of patients that report a positive experience of care via the Friends and Family Test.	**90%**	**91.6%**	**Met**	**100**	**100**	**100**	**100**	**100%**	1 person
Number of complaints and compliments received and actions taken	N/A for monitoring purposes	**65 compliments**	**-**	**-**	**-**	**-**	**-**	**-**	N/A for monitoring purposes Refer to Sect 5.2 in report

Number of clinical and non-clinical incidents and actions taken	N/A for monitoring purposes		**-**	**-**	**-**	**-**	**-**	**-**	N/A for monitoring purposes Refer to Sect 5.2 in report
Living Well Centre									**COMMENTS**
Total number of patients attending the Living Well Centre	N/A for monitoring purposes	**257**	**-**	**76**	**66**	**68**	**47**	**257**	N/A for monitoring purposes 0 attendance during lockdown. Guests remained on caseload and received well-being calls instead. Caseload review undertaken in Q4 and guests discharged.
Number and percentage of Living Well Centre patients receiving a care plan	**100%**	**100%**	**-**	**100**	**100**	**100**	**100**	**100%**	
Percentage occupancy	**≥ 80%**	**100%**	**Not Met**	**0**	**53.5**	**44**	**52**	**37%**	Refer to Sect 2 of report. Consolidation of day's treatments being offered from January onwards.
Time from referral to Living Well Centre and contact to arrange home visit / assessment	**90% within 7 days**	**94.6%**	**Met**	**100**	**100**	**100**	**86%**	**74%**	Telephone assessment due to PHE guidance. Identified 3 cases in Q4 in which 7 day target not met. Investigated, action taken, improved process.
Time from first referral in LWC to Physiotherapy assessment	**100% within 21 days**	**96%**	**Not Met**	**0**	**100**	**100**	**100**	**100%**	All LWC guests are now routinely reviewed by physiotherapist on admission.
Time from referral in LWC to Occupational therapy assessment	**100% within 21 days**	**100%**	**Met**	**0**	**0**	**100**	**100**	**100%**	
Percentage of patients that report a positive experience of care via the Friends and Family Test	**90%**	**92.5%**	**Not Met**	**0 returned**	**0 returned**	**0 returned**	**3 returned**	**0.75%**	Limited response from attendees. Changes to the way the form is completed have been made and this should improve uptake in 2021/22.

Dementia services									COMMENTS
Total number of patients attending Dementia Support Service	N/A for monitoring purposes	**140**	**-**	**52**	**59**	**44**	**47**	**202**	N/A for monitoring purposes
Time from referral to Admiral Nurse for first contact and appointment arranged for assessment.	**95% within 15 days**	**97.1%**	**Met**	**100**	**100**	**100**	**100**	**100%**	Telephone assessments being conducted. A shift to caseload in response to covid elsewhere in the system was evident.
Time from referral to Namaste care for first contact and appointment arranged for assessment.	**95% within 15 days**	**98.4%**	**Met**	**100**	**100**	**100**	**100**	**100%**	Telephone assessments. Home visits Rag rated and only undertaken if assessed as essential.
Percentage of patients who provide feedback and report a positive experience of care	90%	**95.8%**	**Met**	**0 returned**	**0 returned**	**0 returned**	**0 returned**	**0 returned**	Alternative evaluation now being used.
Number of complaints and compliments received and actions taken	N/A for monitoring purposes	**-**	**-**	**-**	**-**	**-**	**-**	**-**	N/A for monitoring purposes Refer to Sect 5.2 of report
Number of clinical and non-clinical incidents and actions taken	N/A for monitoring purposes	**-**	**-**	**-**	**-**	**-**	**-**	**-**	N/A for monitoring purposes Refer to Sect 5.2 of report
Family Support Services									**COMMENTS**
Total number of clients accessing Family Support Services	N/A for monitoring purposes	**147**	**-**	**50**	**50**	**43**	**41**	**184**	N/A for monitoring purposes Refer to Sect 5.2 of report
Number and percentage of clients contacted within 15 working days of receipt of referral	**95%**	**100%**	**Met**	**100**	**100**	**100**	**100**	**100%**	
Number and percentage of written assessments of needs and action plans agreed with clients	**100%**	**100%**	**Met**	**0**	**100**	**100**	**100**	**100%**	

Percentage of clients that report a positive experience of care via the Friends and Family Test	**90%**	**96.7%**	**Not Met**	**0 returned**	**0 returned**	**0 returned**	**0 returned**	**0 %**	Nil response from attendees.
Number of complaints and compliments received and actions taken	N/A for monitoring purposes	**30**	**-**	**-**	**-**	**-**	**-**	**-**	N/A for monitoring purposes. Service leads are now dating & saving complement cards/letters. Complaints are recorded on the Incident Log. Refer to Sect. 5.2 of report.
Number of safeguarding incidents and actions taken	N/A for monitoring purposes	**-**	**-**	**-**	**-**	**-**	**-**	**-**	N/A for monitoring purposes Refer to Sect. 5.2 in report

Appendix 3

Quality Outcome Indicators:

Bereavement Services: Children and Young People

In accordance with Durham County Council contract requirements for the Children and Young Persons (CYP) Bereavement Service the following charts outline how we continue to meet the minimum dataset requirements set out in the Quality Outcome Indicators (QOI's) and summarise performance to end of quarter four (2021). The data set will be updated and submitted in subsequent quarterly reports. The following figures 1-6 and comments at 2.3 reflect how we have met Quality Outcome Indicator 1: A Basic data set describing those using the service.

Figure 1. Number of referrals.

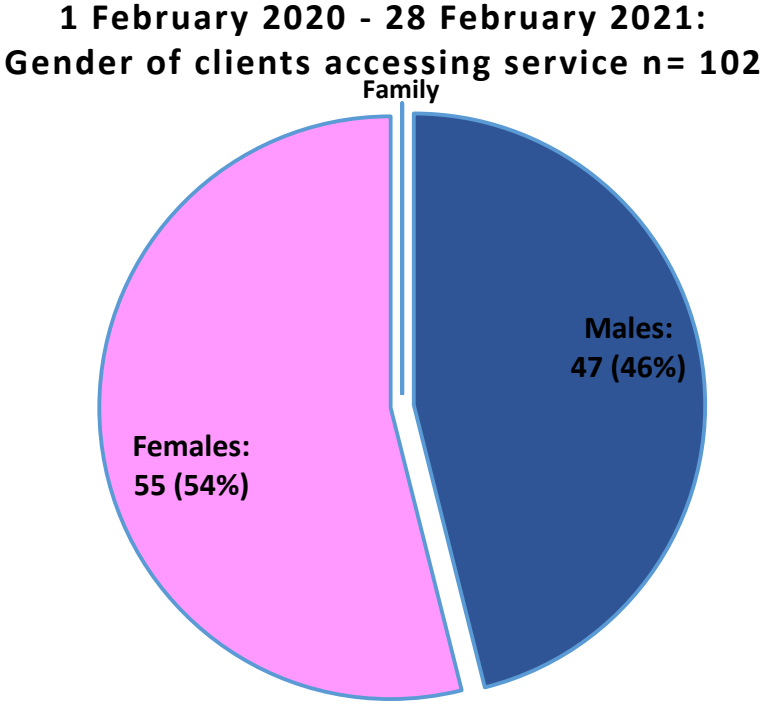
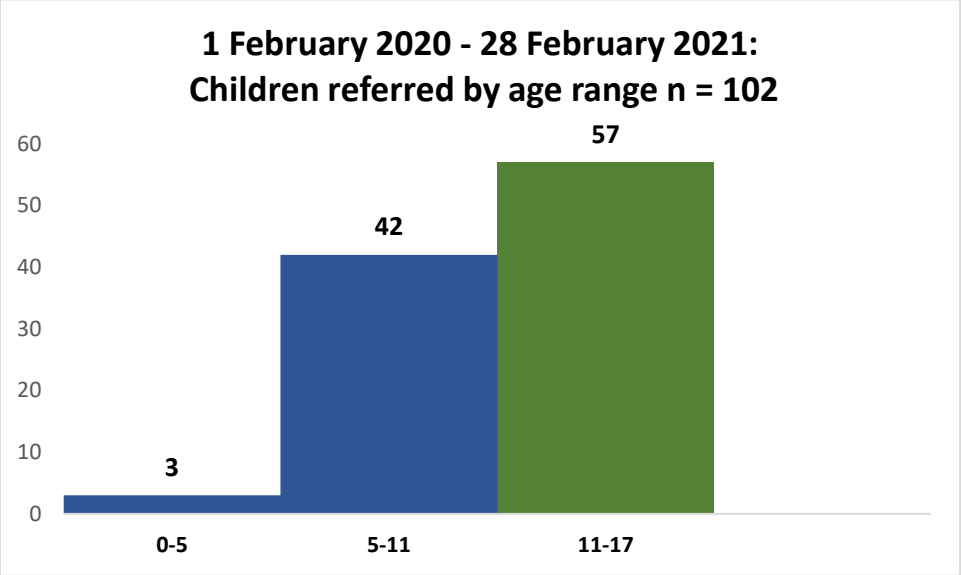


Figure 2. Children referred by age range.



Religion and Ethnicity

We have recorded that 100% of CYP service users have recorded their ethnicity as white British and 96.5% have declared Christianity as their faith with 1.2% Agnostic and 2.3% as Atheist

Figure 3. Source of referrals.

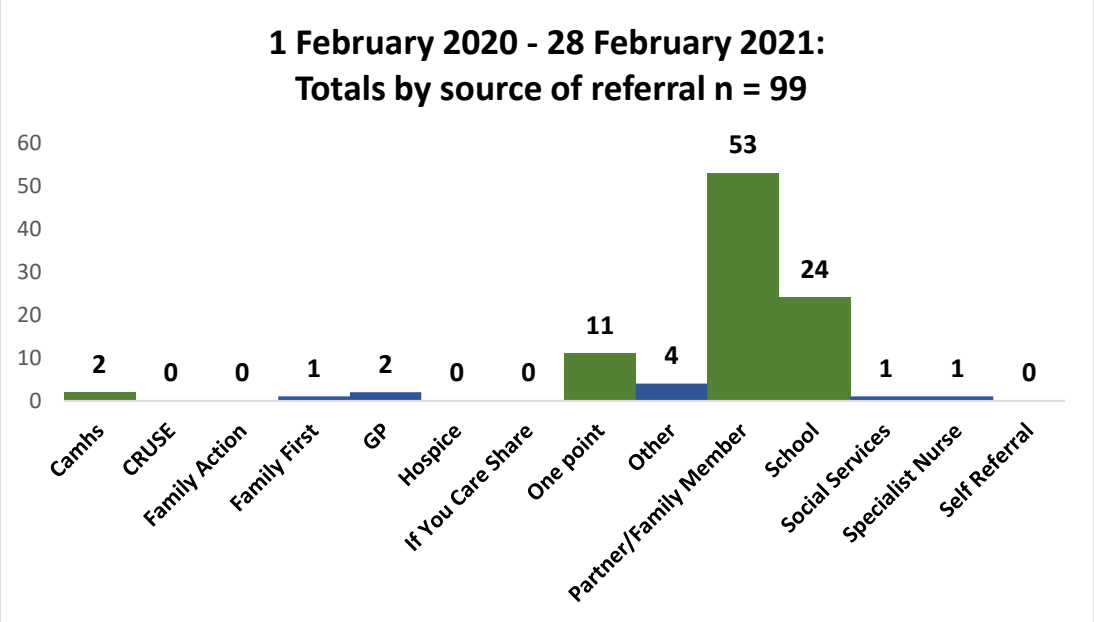


Figure 4 – Child referral by locality.

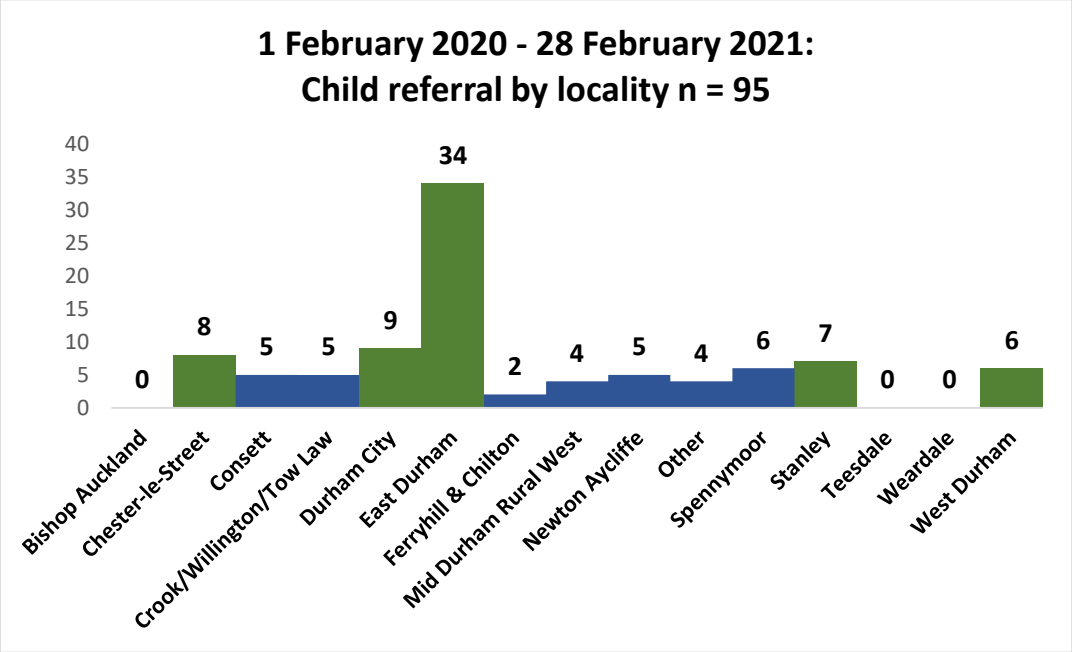


Figure 5. Cause of death where known.

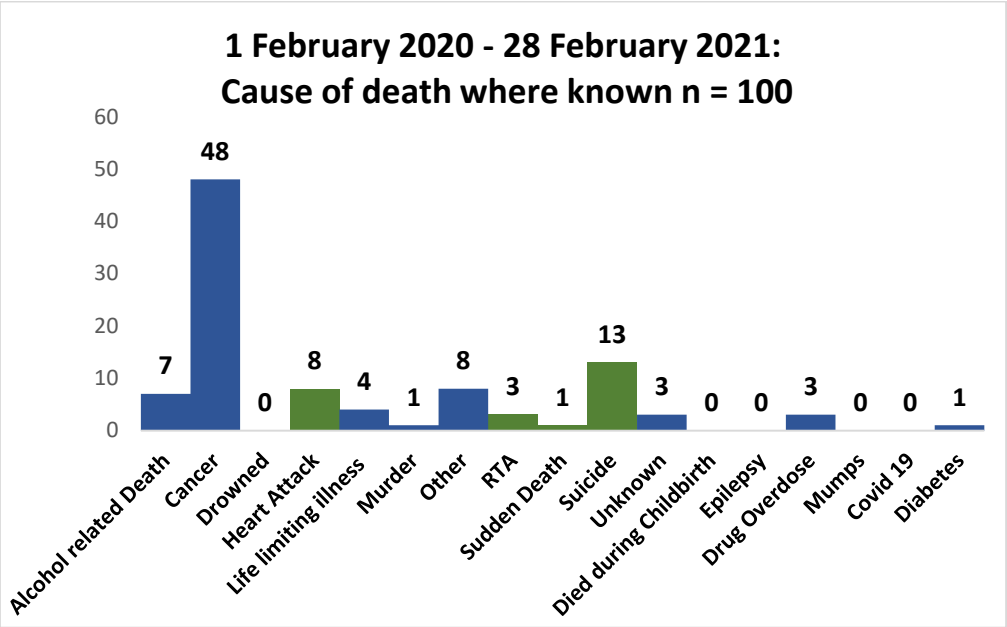


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Figure 6. Number of counselling session provided in this quarter.

We are again pleased to record that of the 453 sessions offered some 374 were attended (83%) and only 25 or 5.52% of planned counselling sessions were cancelled by our service

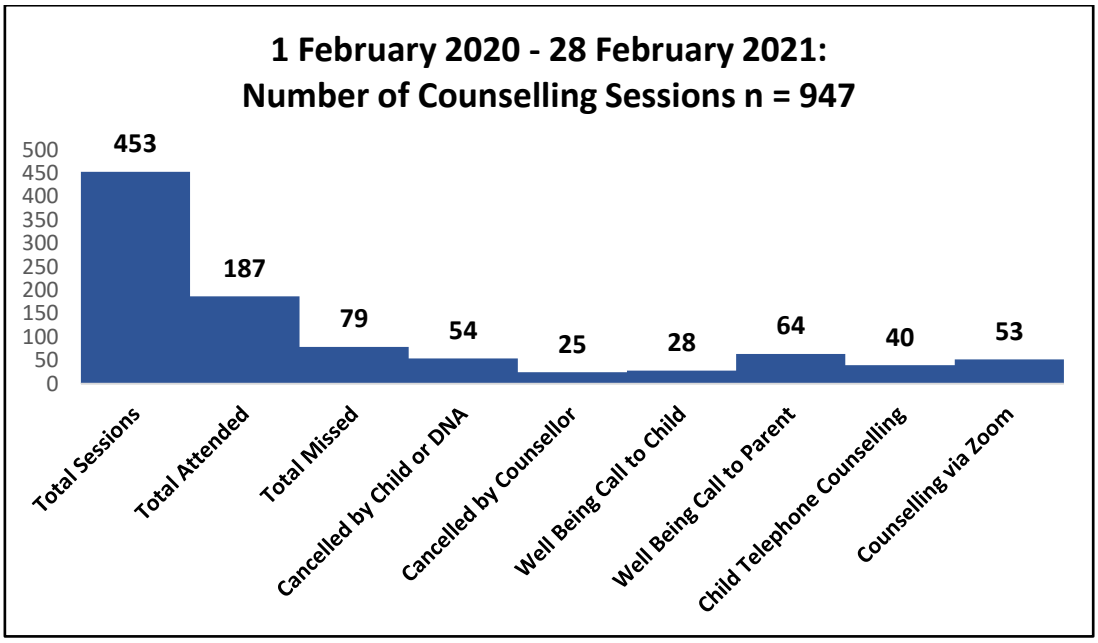

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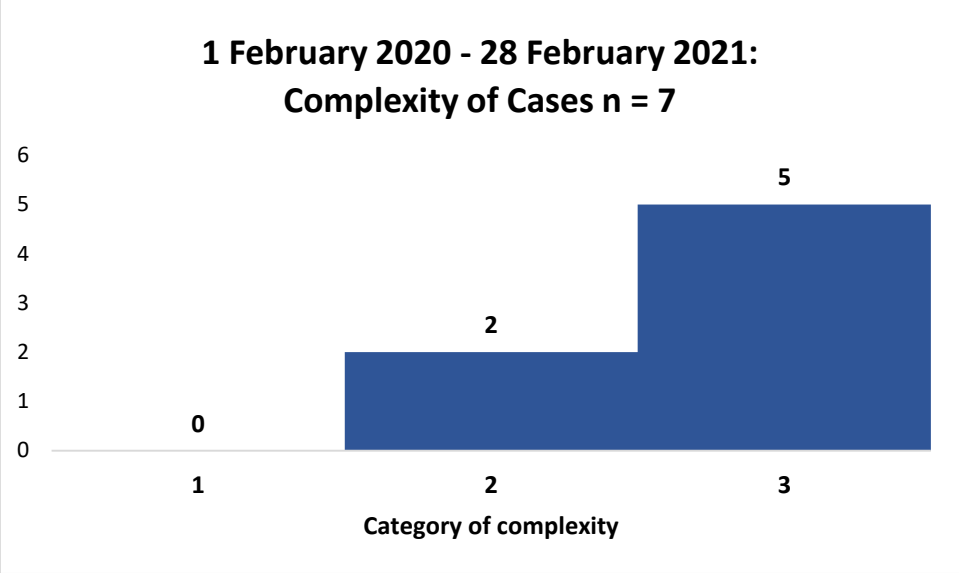
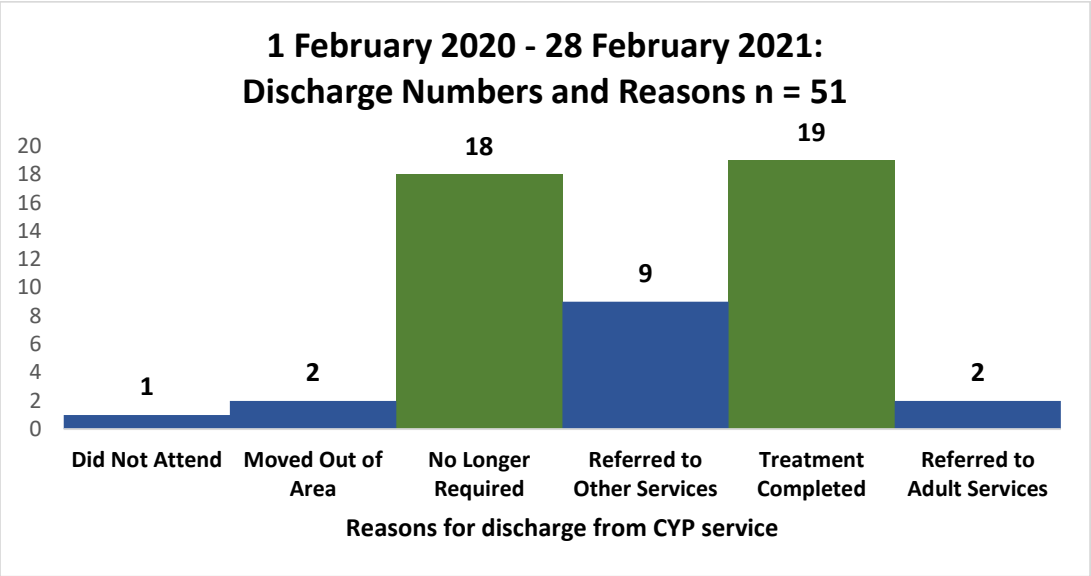
Figure 7. Complexity of cases 1 non-complex through to 3 complex.



3.12 Figure 8. Treatment completion, leaving the service discharge



Contract Key Performance Indicators (KPI's).

We have recorded data for 100% of referrals that indicate:

- Source of referral
- Gender
- Age
- Ethnicity
- Faith
- Geographic area of referral
- Cause of death

NB* *denotes cause of death either not stated or not declared and therefore recorded as unknown.*

Appendix 4

Table 4: Audit Schedule

Audit Schedule			***Quarter 1***			***Quarter 2***			***Quarter 3***			***Quarter 4***		
Reviewed by: Allison Welsh	Apr-21													
AUDIT TOOL	Frequency		***APR***	***MAY***	***JUN***	***JUL***	***AUG***	***SEPT***	***OCT***	***NOV***	***DEC***	***JAN***	***FEB***	***MAR***
Family & Friends Test	Monthly	Service Managers x4												
LWC/Day Hospice Admission	Quarterly	Service Manager LWC												
In-patient Admission	Quarterly	Service Manager IPU												
INFO GOV AUDITS														
IPU	Quarterly	Medical team												
LWC	Quarterly	Medical team												
Dementia	Quarterly	Medical team												
FST	Quarterly	Medical team												
Caldecott	Annually	Medical team												
TISSUE VIABILITY AUDITS														
Pressure Ulcers	Quarterly	Staff Nurse												
FUNDAMENTAL ASPECTS OF CARE AUDIT														
Nutrition IPU	Quarterly	Snr Staff Nurse												
Nutrition LWC	Quarterly	Snr Staff Nurse												

Bereavement	Twice year	Co-Ordinator												
Falls (KPI)	Quarterly	Physiotherapist												
LWC/Day patient pain	Quarterly	Staff Nurse												
In patient pain	Quarterly	Staff Nurse												
MEDICINES OPTIMISATION AUDITS														
General Medicine Management	Quarterly	Pharmacist												
Medicine Compliance	Weekly at MDT	Pharmacist												
Controlled drugs	Quarterly	Snr Staff Nurse												
Accountable Officer Audit	Annually	Head of CS												
INFECTION CONTROL AUDITS														
Code of Practice	Annually	Infection control group												
Mattresses	Monthly	Senior HCA												
Clinical Rooms - IPU	Annually	Infection control group												
Clinical Rooms - LWC	Annually	Infection control group												
Domestic Rooms IPU	Annually	Infection control group												
Domestic Rooms LWC	Annually	Infection control group												
Care of deceased	Annually	Infection control group												
Hand Hygiene - IPU	Twice year	Infection control group												

Hand Hygiene - LWC	Twice year	Infection control group												
Patient areas - IPU	Annually	Infection control group												
Patient areas - LWC	Annually	Infection control group												
Offices within patient areas - IPU	Annually	Infection control group												
Offices within patient areas - LWC	Annually	Infection control group												
Sluice/Dirty Utility	Annually	Infection control group												
Sharps IPU	Annually	Infection control group												
Sharps LWC	Annually	Infection control group												
Toilets for Public Use - IPU	Annually	Infection control group												
Toilets for Public Use - LWC	Annually	Infection control group												
Kitchen Areas	Annually	Infection control group												
Public Areas - IPU	Annually	Infection control group												
Public Areas - LWC	Annually	Infection control group												
Patient Toilets - IPU	Annually	Infection control group												
Patient Toilets - LWC	Annually	Infection control group												

Patient bathrooms - IPU	Annually	Infection control group												
Patient bathrooms - LWC	Annually	Infection control group												
Policies and Protocols	Annually	Infection control group												
Protective Equipment	Annually	Infection control group												

Service User Feedback

Table 5 - Service user feedback questionnaire charts and comments.

 IPU Carer Questionairre Analy	 LWC Friends and Family Test- 2020 20	 Dementia Team Survey Aug 2020- Fe  Friends and Family Test Admiral Nurse N  Survey Aug 2020- Feedback summary.(	 FST Friends and family test 2020 202

Appendix 6

Mandatory Statements that are not relevant to St Cuthbert's Hospice

The following are statements that all providers must include in their Quality Account but which are not directly applicable to Hospices and are therefore included as an appendix (Appendix 6) with clarification provided.

Participation in Clinical Audits

During 2020 - 2021 no national clinical audits and no national confidential enquiries covered NHS services provided by St Cuthbert's Hospice.

During 2020 - 2021 St Cuthbert's Hospice did not participate in any national clinical audits and no national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

Consequently, the national clinical audits and national confidential enquiries that St Cuthbert's Hospice was eligible to participate in during 2020 - 2021 are not listed below.

St Cuthbert's Hospice was not eligible to participate and therefore there is no information or data to list or submit.

St Cuthbert's has not reviewed any national audits during 2020 - 2021 and therefore has no actions to implement.

Research

The number of patients receiving NHS services provided or sub-contracted by St Cuthbert's Hospice in 2020 - 2021 that were recruited during that period to participate in research approved by a research ethics committee was none.

There were no appropriate, nationally, ethically approved research studies in palliative care in which St Cuthbert's Hospice could participate.