St Cuthbert's Hospice

Quality Account

2019 - 2020

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 seem 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 2019 - 2020. 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 costs. The remaining finance required to pay for our services is raised through fundraising, legacies and our nine 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 Clinical Services Manager 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 2020 – 31 MARCH 2021

2.1 INTRODUCTION

St Cuthbert's Hospice will continue to strengthen processes that support and demonstrate an ethos of continuous clinical quality assurance and enhancement across all levels of the organisation. We aspire to provide excellent 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 excellent 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 Institute for Health and Clinical Excellence (NICE) guidance that aims to make every day count and enhance their quality of life.

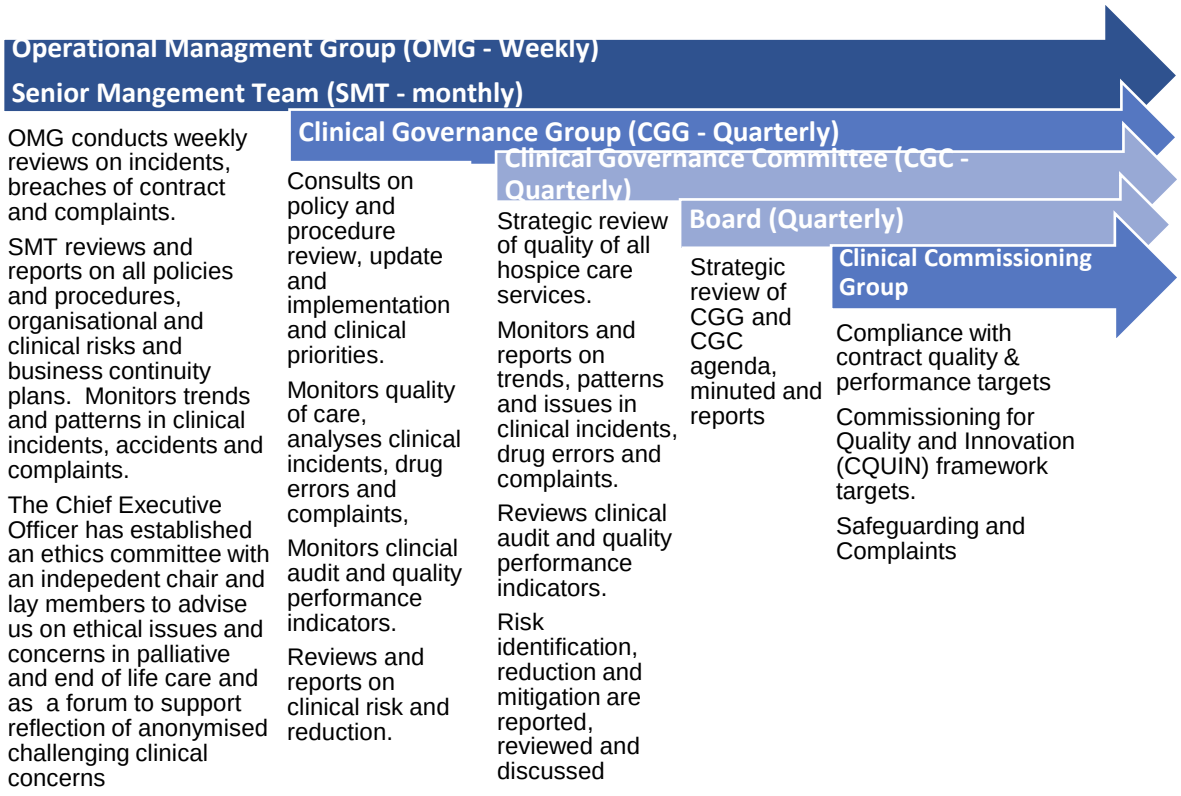
2.2 WELL LEAD

ASPIRATION 1: EMBEDDING OUR IMPROVEMENT TO CLINICAL GOVERNANCE AND SYSTEMS AND PROCESSES IN DAY TO DAY PRACTICE FROM BOARD TO FLOOR.

What is 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 2019 – March 2020 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.

Fig 1 Organisational processes and approaches to monitoring and responding to care service delivery.



During 2018-2020 we experienced changes to the senior management team with the appointment of a Medical Director, Nurse Consultant and new Head of Clinical Services. This enabled us to strengthen our clinical leadership and management at both a senior and service level. During the period 1 April 2020 – 31 March 2021 we aspire to enable empowering and to engage management and leadership at service level. We aspire to making improvements to our clinical governance, systems and processes more sustainable by embedding them in day to day practice from board to floor.

Figure 2. – Strengthening Clinical Governance.

How will we measure this aspiration?

Evidence of Link Practitioner activity e.g. notes from meetings, status slides, and new products such as risk assessments, audit tools, patient leaflets, and new processes.

Evidence of link practitioner activity at:

- Clinical Governance Sub-Committee (CGSC)
- The Clinical Governance Group (CGG)
- Senior Management Team (SMT)

Evidence of service managers and clinical teams participating in root-cause analysis methodology and report writing for SMT and CGSC.

Evidence of service managers participating in statutory notifications to CQC and reporting to local authority and the Commissioners via North East Commissioning Support Unit (NECS) in line with NHS England's Serious Incidents framework.

2.3 SAFE

ASPIRATION 1: REDUCING FALLS, PRESSURE ULCERS (PUs), URINARY TRACT INFECTIONS (UTIs) 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, UTIs 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.

Table 1: Safe care targets and achievement.

Safe Care Measures	Actual for 2017-18	Actual for 2018-19	Actual for 2019-20
Avoidable falls	11 falls of which 0 was 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)
Pressure ulcers (PUs) developed or deteriorated during stay in the Hospice	7 PUs acquired post admission 0 PUs deteriorated after admission.	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
Thromboembolism Assessments (VTE)	100% of patients had a VTE assessment within 24 hours of admission	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

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 take therapeutic risks.

What will we do to achieve this aspiration?

Actions proposed for 2020 - 2021 are:

- Complete the initial falls assessment within 4 hours of admission and develop a falls care plan within 8 hours of admission.
- Complete an assessment by a physiotherapist within 24 hours of admission.
- Periodically review falls risk and care plans at least weekly and following a fall.
- Document falls risk assessments and care plans in our revised SystmOne care record.
- Continue to use 'Call avoid the fall' signs introduced in 2018-2019.
- Place 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.
- Continue to use the new state of the art ultra-low profile bed (purchased in May 2016) and purchase a second such bed 2019.
- Further increase our stock of '*chair, bed, floor and remote sensor*' movement alarms and purchase mattress sensors.
- Continue to deploy sensors and use falls crash mats where indicated.
- Conduct a formal review of the falls risk assessment, for every patient, at our weekly multi-disciplinary team meeting.
- Embed the role of our physiotherapist as 'falls' link practitioner and establish a falls prevention link practitioner group.
- Encourage increased reporting of "near-misses" – where a fall did not occur but might have done.
- Ensure a close observation chart is used to in relation to people assessed as being at high risk of falls.
- Develop an Enhanced Observation Policy and undertake a review of the Falls Prevention Policy.
- Develop, test and implement an evidence based risk assessment tool and care plan for falls prevention.
- Make further revisions to SystmOne to ensure it reflects the revised policy and evidence based risk assessment and care plan.
- Use the risk assessment and care plan to develop an audit tool and complete a quarterly audit of falls.
- Include falls prevention in mandatory training for all clinical staff.
- Fit a new nurse call system to enhance remote monitoring of patient movement and early detection of falls.

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 2020 - 2021 are:

To continue to promote best practice and apply NICE Guidance to support monitoring, management of pressure ulcers. Interventions will include:

- Complete a pressure ulcer risk assessment, within 6 hours of admission using the validated 'Waterlow Risk Assessment tool.
- Use clinical photography to assess and evidence a patient's condition and the healing process from admission through to discharge.
- Complete a written care plan within 6 hours of admission, to mitigate against the risk of pressure ulcers.
- Continue to use pressure area mapping charts and rounding charts in patient rooms to record regular positional change regimes.
- Ensure risk assessments and care plans are recorded on SystmOne in line with the Hospice policy and procedures, recognised best practice and professional guidance.
- Finalise and print the patient information leaflet on pressure ulcers.
- Complete an incident report and notify the local authority safeguarding team and CQC, 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.
- Continue to implement the policy for the prevention and management of pressure ulcers (revised May 2019) that adopts the best practice as outlined by NICE '*Pressure*

ulcers: prevention and management of pressure ulcers'. Issued: April 2014 NICE clinical guideline 179. http://.guidance.nice.org.uk/cg179.

- Review the Hospice's policy and procedure for clinical photography.
- Establish the role of link practitioner for tissue viability and hold quarterly meetings.
- Continue to use the Hospice UK pressure ulcer audit tool (released April 2016) in line with the audit schedule and clinical governance arrangements agreed by Clinical Governance Sub-Committee.

VTE Assessments

What is 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.

What will we do to achieve this aspiration?

Actions proposed for 2020 – 2021 are:

- To continue to commence formal VTE (Venous Thromboembolism) assessments on all patients on 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 ulcer) 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.

Each Link Practitioner group 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 2019-2020 and will be 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 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.

During 2018-19 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).

We aspire to achieve a zero incidence of drug administration errors for 2020-21. 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 2020 - 2021 are:

- Undertake a review of the incident management policy and procedure. This will include identifying and exploring factors that enable incident reporting as well as factors that act as barriers to incident reporting.
- Continue 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.

- Explore opportunities to increase pharmacy capacity.
- Report and record all medication errors relating to the supply, storage, prescribing, administration and disposal, (including near misses).
- Report all CD incidents to our CD Local Intelligence Network (CD LIN) via a quarterly report.
- Internally investigate all medication errors in line with the Hospice's Incident Management Policy & Procedure and Root Cause Analysis Procedure.
- Implement weekly, monthly, quarterly medicines audits, adopting the Hospice UK Audit Tools and in accordance with the audit schedule and governance arrangement agreed with CGSC.
- Implement a comprehensive medicines optimisation training and development programme for all clinical staff involved in the supply, storage, prescribing, administration and disposal of medicines.
- Complete competency assessments and assess the drug calculation competence of our nursing staff and where relevant care staff on an annual basis.
- Continue to learn from incidents and drive improvement via the quarterly Medicines Optimisation Group established in early 2019.

How will we measure this aspiration?

We will demonstrate we have achieved our aspiration through:

- 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.
- Minutes from Medicines Optimisation meeting and Clinical Governance Group and CGSC.
- Staff training records.
- Completion of:
    - Weekly medicines audit
    - Monthly CD Audit
    - Annual accountable officer audit

ASPIRATION 3: PREVENT AVOIDABLE HARM FROM USE OF MEDICAL EQUIPMENT, DEVICES WITH KNOWN FAULTS, OR DRUG QUALITY TAINTED OR COMPROMISED IN PRODUCTION.

What is 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
- From the 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.

What will we do to achieve this aspiration?

Actions proposed for 2020 – 2021 are:

- Communicate 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
- Print off and update '**Alert Files**' available in Inpatient Unit, Day Care Services, Community Services and Guest Services where appropriate.
- Record 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).
- Record "Alert Update" as a standing agenda item on the Clinical Services team meeting.
- Ensure "Alert Update" and action logs are a standing agenda item for CGSC and CGG.
- Complete a baseline audit of the status of medical devices that includes servicing details, manufacturing information and staff training. Develop an action plan based on the findings from this audit and include this as an item on CGG and CGSC meetings.

How will we measure this aspiration?

- Action logs will record 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.
- There will be 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.
- All incident alerts that require action and recording in the alert log will be reported to CGSC.

- Progress on the actions from medical devices audit will be reported to quarterly CGSC.

2.4 EFFECTIVE

ASPIRATION 4: MEASURE THE EFFECTIVENESS OF OUR CARE, PALLIATIVE CARE INTERVENTIONS AND OUTCOMES

What is 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 have been unable to secure the support we need to realise the full benefits of this initiative.

We aspire to change this in 2020 – 2021 and 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 to our internal clinical governance structures and processes and external partners.

What will we do to achieve this aspiration?

Actions proposed for 2020 – 2021 are:

- Continue data collection, analysis and interpretation for the outcome measures already implemented.
- Share our findings with sector colleagues, our CGSC and those who use our services.

How will we measure this aspiration?

- Ability to evidence our care interventions for the outcome measure(s) implemented to date.
- Provision of detailed incident analysis and reporting including dashboard reporting to CGSC, CGG, SMT and Commissioners of outcomes measures achieved.

ASPIRATION 5: MEASURING PATIENT DEPENDENCY AND ACUITY TO BETTER INFORM OUR WORKFORCE PLANNING

What is 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 2015-16 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.

In 2020-2021 we aspire to learn from the implementation phase and ensure the effectiveness of this tool.

What will we do to achieve this aspiration?

Actions proposed for 2020 - 2021:

- Complete sense check and review how effective the tool is at measuring dependency/acuity.
- Revise and adjust the tool where indicated.
- Continue data collection, analysis and interpretation from the Dependency / Acuity tool.
- Review findings against data obtained from palliative care outcome measures.

How will we measure this aspiration?

- Evidence of the tool being used to inform day to day staffing levels.
- Evidence of the tool being used to review the current shift model and whether or not it is effectively meeting the needs of patients.
- Evidence of the tool being used to predict our workforce modelling and needs.
- Provision of detailed reports to CGSC, CGG, SMT and Commissioners of acuity as measured against palliative outcomes measures.

2.5 RESPONSIVE

ASPIRATION 6: TO REDUCE THE NUMBER OF SERIOUS INCIDENTS AND PREVENT ANY AVOIDABLE INCIDENTS OCCURRING

What is 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 2019 – 2020 in fulfilling our duty of candour, we reported all serious incidents, (Refer to Part 3 Table 6).

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.

In 2019 – 2020 we aspired to be more proactive in anticipating and minimising the risk of incidents occurring, and to continue to ensure 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. We agreed to continually review our incident reporting policy and procedures in light of lessons learned from near misses and reported incidents. We also created an electronic version of our accident and incident reporting forms as well as designed an incident management database.

Unfortunately, over time, the electronic version of the incident form has proven cumbersome and the new data base over time has become unwieldly. This raised a concern that the existing system and process may have become a barrier to incident reporting and that we may have an issue with under reporting, particularly in relation to medication errors. This in turn led to a review of the incident management procedures. This review included identifying and exploring factors that enable incident reporting as well as factors that act as barriers to incident reporting. Whilst many of these barriers were addressed in 2019-2020 we recognise that there is still more we could do.

We subsequently aspire to ensure that our policy framework and associated procedures support and enable the reporting of incidents and near misses, and the development of a safety culture and facilitate openness about failures so that incident management is not 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 2020 - 2021

- Explore opportunities to purchase or design a new incident management database.
- Review the electronic version of our accident and incident reporting forms.
- Review the root cause analysis procedure and associated tools and templates.
- Encourage 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.

How will we measure this aspiration?

- An initial Increase in incident reporting, including near misses.
- Evidence of comprehensive baseline data for the number, type and severity of incidents or near-misses reported.
- Evidence of this informing risk management at all levels of the organisation.
- Evidence of quarterly reviews of the incident log at all levels of the organisation.
- Evidence of learning, reflections and improvement in response to root cause analysis from floor to board.
- Evidence of trends and patterns being reported to CGSC, CGG, SMT.
- Development of an enabling and empowering leadership and management style.
- An eventual reduction in the number of serious incidents occurring.

2.6 CARING

ASPIRATION 7: IMPROVING SAFEGUARDING

What is 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).

What will we do to achieve this aspiration?

Actions proposed for 2020 – 2021:

- Review our policies framework for Safeguarding, both Adults and Children, Mental Capacity Act (MCA) and Deprivation of Liberties Safeguards (DoLS).
- Address gaps in our policy framework and develop policies for restraint, enhanced observations.

- Review our training provision and develop and deliver face to face training and work-based learning to facilitate application to practice and complement existing e-learning modules.
- Develop an audit tool and complete an audit of DOLs/MCA entries on SystmOne, the patient's electronic care record.
- Establish a link practitioner for safeguarding and drive improvement to safeguarding, MCA and DoLS through a quarterly link practitioner safeguarding meeting.

How will we measure this aspiration?

- Improved uptake of MCA and DoLS within the in-patient unit.
- Evidence of improvement against the CCG assurance visit report Oct 2019.
- Minutes of the quarterly safeguarding meeting and safeguarding status slide.

PART 3

REVIEW OF SERVICE QUALITY PERFORMANCE DURING THE PERIOD 1st APRIL 2019 - 31st MARCH 2020

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 new rehabilitative day care service in our refurbished Living Well Centre that offers:
    - Social work advice and support.
    - Care support including physiotherapy, occupational therapy and complementary therapies.
    - Community support including specialist Dementia support and Namaste.
- Family Support Team providing pre- and post-bereavement counselling as well as social support for patients, families and carers.
  In 2017-18 we successfully bid for and secured the contract from County Council of Durham to provide a children and young person's bereavement service for those bereaved as a consequence of suicide or sudden unexpected and traumatic death. This contract was renewed in February 2018 and again in February 2019 and has now been made a permanently commissioned service.

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 as outlined above. 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.

We have met or made substantial progress in meeting all our key aspirations for improvement as outlined in our 2019-20 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.

During the period 1st April 2019 – 31 March 2020, we have continued to make significant progress in strengthening clinical governance at St Cuthbert's Hospice. 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. We routinely collect

'*Friends and Family Test*' feedback as part of our specific service user questionnaires. The summary of findings can be seen at Appendix 4.

During 2019-20, 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).

During December 2019 the CCG lead for Infection Prevention and Control conducted an external 'infection control inspection' of the hospice care settings and reported no concerns or requirements for remedial action.

During October 2019 the CCG for Safeguarding 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.

Awards.

In 2019 - 2020 St Cuthbert's Hospice was proud to announce that the work of the Hospice has been recognised through the award:

- Disability Confident Committed (Level One) September 2019
- Better Health at Work Award (Continuing Excellence level) December 2019
- Best Dementia Team Journal of Dementia Care November 2019

As part of our NHS contract requirements, St Cuthbert's Hospice provides North Durham CCG with quarterly Service Contract Quality Performance Reports and six-monthly Workforce Assurance 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 2019-20 we progressed work to fulfil CQUIN requirements agreed in partnership with our Clinical Commissioning Group (CCG) for 2019-20 which were:

CQUIN 1: Year 2

- Based on the intelligence gathered, adopt a recognised tool such as the Carer Support Needs Assessment 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 and improve patient care at home or in the community.

The progress in Year One (2019/20) 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 arrival of Covid-19 in Q4 also had an adverse impact as we had to re-focus our attention towards adapting our existing services to meet the needs of those who use our services. 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. In particular, we have delivered two programmes of our "Everything in Place" project specifically for Carers, with Durham Carers recruiting the participants, supporting their attendance and hosting the programme, 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.

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. Our Nurse Consultant has 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.

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. The Namaste Lead is currently developing an education package for carers.

Restructure of Family Support Team

Partly in response to the new Strategic Plan, the Hospice undertook a review of its Family Support Team in Q4 (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. Responsibility for delivery of the CQUIN Year 2 will be within the work plan of the social work team and we are currently in the process of recruiting two new members to that team.

Covid 19

Although the Hospice has kept the In-Patient Unit open throughout the period of lockdown, the staff in the Living Well Centre have maintained links with their patients and their carers throughout by means of regular well-being calls. We anticipate that these calls, which have often lasted an hour will give us new and fresh insight into the needs of carers. This learning will be taken into 2020–2022. In the IPU, necessary visitor restrictions have begun to add to the carer burden but the IPU team, together with Family Support staff have endeavoured to facilitate virtual visits and alternative means of creating a link between patients and those who care for them.

Dementia Services

Dementia Services are using a Carers Assessment tool and have developed an education package on Dementia for carers. We have carers on our Dementia Steering Group.

Living Well Centre

The Living Well Centre team has been able to deliver therapy sessions to carers where they have had the capacity to do so.

Family Support Team

Notwithstanding the restructure, the team has been focussed on providing more emotional support to family members of patients in the IPU over the last 12 months.

Performance – Patient Safety

In order to measure how safe our service was during the period 1 April 2019 to 31 March 2020, 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.

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 during 2019-20 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 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 Lead Infection Prevention and Control Nurse from North Durham Clinical Commissioning Group. External Lead Nurse has undertaken an external Infection Prevention and Control Audit at the Hospice on an annual basis and we have requested that this should continue for 2020 - 2021.

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.

A county-wide Infection Prevention and Control Audit has been carried out by an external Senior Lead Nurse for Infection Control from Durham County Council at our request. This audit is comprehensive covering 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. We have achieved and met the standards required.

3.1 Clinical Incidents during the period 1 April 2019 to 31 March 2020

St Cuthbert's Hospice had no "Never" events during 2019 - 2020. The following serious/potentially serious incidents were reported during 2019 - 2020:

Quarter One

Table 2: Summary of serious / potentially serious incidents and complaints.							
Incident log number	**Brief details of incident / complaint**	Reported to	Yes / No		Date	STEIS Number	Outcome
2019/0271	Patient admitted from hospital with a suspected deep tissue injury	CQC					No concerns or action taken by LA safeguarding team
		NECS					
		Safeguarding					
		CGC / SMT					
Incident log number	**Brief details of incident / complaint**	**Reported to**	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2019/0276	Patient admitted from hospital with category 3/4 pressure damage	CQC					No concerns or action taken by LA safeguarding team
		NECS*					
		Safeguarding		X			
		CGC / SMT					
Incident log number	**Brief details of incident / complaint**	**Reported to**	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2019/0277	Patient admitted from hospital with category 3 pressure damage	CQC					No concerns or action taken by LA safeguarding team
		NECS					
		Safeguarding					
		CGC / SMT					

Quarter Two

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
2019/0323	Patient disclosed husband had hit her	CQC	x				Patient reviewed by duty social worker prior to going home. Duty social worker will follow up in community
		NECS					
		Safeguarding	x		26/07/19		
		CGC / SMT	x		Q2		
Incident log number	**Brief details of incident**	**Reported to**	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2019/00324	Controlled drug error – Ketamine prescribing	CQC		x			Ketamine Shared Care Protocol Developed
		NECS*					
		Safeguarding		x			
		CGC / SMT	**x**				
Incident log number	**Brief details of incident**	**Reported to**	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2019/0326	Controlled drug error – Ketamine supply	CQC		**x**			Pharmacist with licence to stock Ketamine sourced
		NECS					
		Safeguarding		**x**			
		CGC / SMT	**x**		**Q2**		
Incident log number	Brief details of incident	Reported to	Yes / No		Date	STEIS Number	Outcome
2019/0330	Client unhappy about way in which information was communicated to her.	CQC					Apology given. Treated as informal complaint
		NECS					
		Safeguarding					
		CGC / SMT	x		Q2		
Incident log number	**Brief details of incident**	**Reported to**	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2019/0331	Client asked informally for change of key worker	CQC		x			LWC met with client and issue resolved to the client's satisfaction
		NECS*					

		Safeguarding		x			
		CGC / SMT	**x**				
		Safeguarding					
		CGC / SMT	**x**		**Q2**		
Incident log number	**Brief details of incident**	Reported to	Yes / No		Date	STEIS Number	Outcome
2019/0344	Controlled drug error – dispensing of Pregabalin (not administered)	CQC					Second incident of this nature, pharmacist informed
		NECS					
		Safeguarding					
		CGC / SMT	x		Q2		
Incident log number	**Brief details of incident**	**Reported to**	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2019/0347	Safeguarding – potential financial abuse	CQC	X				Safeguarding & CQC notified
		NECS*					
		Safeguarding	**X**				
		CGC / SMT	**x**				
Incident log number	**Brief details of incident**	**Reported to**	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2019/0352	**Controlled drug error – administration error (Tramadol from another patient's box of medication**	CQC		**x**			No harm to patient
		NECS					
		Safeguarding					
		CGC / SMT	**X**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	
2019 / 0358	**Controlled drug error – supply Ketamine**	CQC					CCG notified
		NECS					
		Safeguarding					
		CGC / SMT	**X**				

Quarter Three

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
2019/0364	Pressure ulcer on admission – Grade 3	CQC	X				CQC informed. Spoke with safeguarding, questions answered regarding pressure damage, not thought to be neglect, case closed.
		NECS					
		Safeguarding	x				
		CGC / SMT	x		Q3		
Incident log number	**Brief details of incident**	**Reported to**	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2019/00375	Controlled drug error –patient given s/c Oxycodone 15mg instead of oral Oxycodone 15mg	CQC					No harm to patient. Duty of candour fulfilled. Clinical Supervision with staff. Improvement to medicines management ongoing. MAR chart being revised to reduce the likelihood of human factors. Medicines management training, competency assessment & drug calculation tests on going.
		NECS*					
		Safeguarding					
		CGC / SMT	**x**				
Incident log number	**Brief details of incident**	**Reported to**	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
		CQC					

2019/0378	Controlled drug error – s/c dose of Alfentanil administered sublingually rather than s/c	NECS	**X**				No harm to patient. Duty of candour fulfilled. Clinical Supervision with staff. Improvement to medicines management ongoing. MAR chart being revised to reduce the likelihood of human factors. Medicines management training, competency assessment & drug calculation tests ongoing.
		Safeguarding					
		CGC / SMT	**X**				
Incident log number	**Brief details of incident**	**Reported to**	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2019/0379	Avoidable patient fall – left proximal humerus fracture	CQC	**X**				The care plan written in the care record did not reflect the care being carried out. E.g. Falls assessment completed within agreed timeframe but time not recorded accurately. Lessons learned shared by email, during 121s, at team meeting 13 Nov. Staff advised that, falls risk assessment must be done within 4hrs of admission and recorded accurately in the care record, falls risk assessment must be reviewed in a timely manner post fall, all high risk patients must have falls mats (not withstanding consent). Quote obtained for under mattress falls sensors (patients step round mat sensors) Duty of Candour training being sourced for service managers.
		NECS				**2019/26402**	
		Safeguarding	**X**				
		CGC / SMT	**x**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2019/0394	Assault - Brother and Sister of patient in lounge having a discussion Staff heard raised voices and what sounded like a slap. Brother spoke with FST and stated had been hit by sister. Brother had hand print to face; no other injury.	CQC					FST spoke to sister about what is/is not acceptable within IPU and to offer support.
		NECS					
		Safeguarding					
		CGC / SMT	**x**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2019/0399	Suspected pressure ulcer on admission Patient admitted to IPU 20th Nov 2019. . Patient noted to have a suspected deep	CQC	**X**				Risk assessment & plan of care put in place for pressure ulcers. CQC notification form completed. Referred to safeguarding
		NECS				**2019/26412**	
		Safeguarding	**X**				

	tissue injury to her left heel with small darkened area ? SDTI Pin Point size to centre, skin remains intact – red area approx 4cm x 4cm. The right heel has a suspected deep tissue injury approx - 1cm x 1cm necrotic area surround skin red in total approx. 5cm x5cm.	CGC / SMT	**X**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2019/0405	Suspected deep tissue injury Patient has red heels and has continued to have red heels during her time at the hospice, staff attended to patient on 6/12/19 am to bed bath patient noted and documented the heels were discoloured, more so to the left but remained intact. PM patient transferred on a stretcher to UHND for a CT scan, she was at the appointment approximately an hour and on her return staff nurse noticed the left heel had changed to blue in colour and ? if this was a suspected deep tissue injury.	CQC	**X**				Patient assessed on return from hospital, husband informed in change of skin, already nursed on air flow mattress, Waterlow and care plan updated. Photographs taken with patients consent. Patient hemi paretic & reluctant for positional change does not spend time on sides as uncomfortable. Referred to TVN. Referred to safeguarding team who decided neglect had not paid a part in deterioration in skin. No further action taken. Skin went on to deteriorated over weekend area now dark almost black in colour unable to see wound bed, no breaks noted area 5cm x 2cm. CQC notification completed.
		NECS					
		Safeguarding	**X**				
		CGC / SMT	**x**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2019/0409	Pressure Ulcer Skin changes to sacrum noted on 10/12/19 small 1cm x 0.5cm maroon area identified suspected to be SDTI small broken area 0.5cm x0.5cm noted ? Grade 2 at this point.	CQC	**X**				Skin reviewed by staff at least 2-3 times a day depending if patient will allow. Proshield applied. Patient unable to tolerate lying on sides for long periods of times so when in bed predominately nursed on back, bed tilt altered. Family and patient informed of further skin breakdown. Referred to safeguarding & CQC notified. 13/12/19.
		NECS					
		Safeguarding	**X**				
		CGC / SMT	**X**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2019/0410		CQC	**X**				

	Patient admitted to St Cuthbert's hospice from home on 11/12/19. On admission skin assessed and though to have a Grade 4 pressure ulcer to L outer aspect of ankle. Risk assessment completed & care plan put in place. Nursed on air flow matters. Patient independently mobile and able to change own position without prompt, has capacity and is self-caring. Patient stated pressure damage noted on discharge from hospital ?in June 2019. Patient under the care of district nurse team and have been visiting to provide pressure area care.	NECS					11/12/19IR1 completed. Wound dressed with flaminal and dressing applied. Referred to TVN team who visited 13/12/19. 13/12/19 Assessed by TVN – Noted to be grade 3 pressure damage not grade 4. New dressing regime in place. Dressings ordered. Care plan updated. Referred to safeguarding who had no concerns about neglect. Note made on file. No further action required. CQC Notification completed. Patient and family informed of referrals to TVN, Safeguarding and CQC, happy with actions and they have no concerns.
		Safeguarding	**X**				
		CGC / SMT	**X**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2019/0412	Patient developed SDTI to L heel 2cm x 2cm	CQC	**X**				Patient aware. Nursed on airflow mattress, bed board removed from bed previous days. Position of foot to be altered as patient can tolerate currently floating off bed as bed board removed. Proshield being applied to area Photograph taken, care plan, water low, 18/12/19 Referral sent to TVN, CQC notification completed and emailed to C.S.M.
		NECS					
		Safeguarding	**X**				
		CGC / SMT	**X**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2019/0416	18/12/19 Admitted to hospice from hospital. On admission and transfer from ambulance stretcher staff unable to assess skin integrity	CQC	**X**				TVN referral made, husband aware of deteriorating skin condition, reported to safeguarding 30/12/19 - no concerns from
		NECS					
		Safeguarding	**X**				

	as patient in too much pain. 19:15pm Following analgesia staff able to roll patient and reposition but not able to full assess skin integrity as planned as patient could not tolerate being on sides for any length of time. From what could be seen was red area across (1) sacrum which appeared broken on both buttocks (butterfly effect), (2) dark area to upper leg/lower buttock. Unable to obtain photographs due to discomfort and pain.	CGC / SMT	**X**				them. CQC notification completed and emailed to clinical services manager to email forward. See attached sheets to incident for.
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2019/0417	Overall skin condition noted to be deteriorating. 1) Sacral dressing intact no strike through so left in place and changed on nightshift, surrounding skin pink – proshield applied for protection. 2) Upper leg/lower buttock – Dark red area remains ?SDTI, skin broken- proshield and foam dressing applied 3) R calf – Red area remains, not broken may deteriorate and develop into ? SDTI – Proshield applied 4) L calf ? SDTI approx. 2 cm x 1cm – proshield applied. 5) Elbows pink but intact – proshield applied 6) L ear – dark area noted ? SDTI, head favours L side, proshield applied and positioned as much as possible so ear not touching pillow but this is difficult due to patients head favouring L side.	CQC	**X**				Referral to tissue viability nurse made. Husband aware of deteriorating skin condition. Reported to safeguarding 30/12/19 - no concerns about neglect. CQC notification completed and emailed to clinical services manager to email forward. See attached sheets to incident form.
		NECS					
		Safeguarding	**X**				
		CGC / SMT	**X**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2019/0420	Patient prescribed 400mg gabapentin nocte. Dose omitted by staff. Staff were working	CQC					Reflective practice undertaken with both nurses. 31/12/19 Nurse new to unit and
		NECS					

	way through drug kardex when came to CD; were going to go back to it when all other non-CDs had been dispensed for the patient and forgot to go back to Gabapentin.	Safeguarding					previously had used computer system which would not allow you to move past medication without signing to say had been dispensed so staff member getting used to using paper kardex's. Discussed checking the kardex's once a patient's medications have been dispensed to ensure all medications for that medication round have been dispensed. No other issues noted with staff members' capabilities re the dispensing and administration of medication. 3/1/20. Reflected on omission and discussed learning re: not going back to CD's at end of that individuals drug dispensing but doing it at the time of getting to the CD drug, recommended this for ongoing practice. Support given.
		CGC / SMT	**X**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2019/0421	Patient prescribed 5mg oxycodone at night which had been omitted by staff.	CQC					Staff were working way through drug kardex when came to CD where going to go back to it when all other non-CDs had been dispensed
		NECS					
		Safeguarding					

		CGC / SMT	**X**				for the patient and forgot to go back to oxycodone. Nurse A – 30/12/19 - Senior Nurse informed nurse about incident and they spoke and reflected on the incident, Nurse new to unit and previously had used computer system which would not allow you to move past medication without signing to say had been dispensed so staff member getting used to using paper kardex's. Discussed checking the kardex's once a patient's medications have been dispensed to ensure all medications for that medication round have been dispensed. No other issues noted with staff members' capabilities re the dispensing and administration of medications. Ward sister spoke with staff member 31/12/19 reassured and supported member – no further action needed. Ward sister will speak with Nurse B on return to shift 3/1/20. 3/1/20 Spoke with Nurse B re omission, reflected on omission and discussed learning re: not going back to CD's at end of that individuals drug dispensing but doing it at the time of getting to the CD drug, recommended this for ongoing practice. Support given. No further action required.

Quarter Four **Table2: Summary of serious / potentially serious incidents and complaints.**							
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2020/0430	Patient prescribed co amoxiclav 625mg QDS instead of 625mg TDS.	CQC					Prescriber has reflected and learned from incident. No harm occurred. Human error. Policy followed re: being open and honest with patients and relatives
		NECS					
		Safeguarding					
		CGC / SMT	**X**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2020/0431	Miscount of patient's drug - oxycodone 50mg/1ml injection	CQC					Count in book corrected. IR1 completed. Copy of CD register taken and attached to IR1. C.S.M and hospice pharmacist aware. Plan to reflect with staff involved and learn from admin error. Wider team to be informed verbally and by email of the importance of thoroughly checking medications when they arrive from pharmacy and when counting CD drugs when dispensing drugs for patient.
		NECS					
		Safeguarding					
		CGC / SMT	**x**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2020/0437	Patient admitted to IPU from home with medications dispensed from own pharmacy. Bottle of morphine sulphate in correct box 10mg/5mls but patient label marked as morphine sulphate 20mg/ml give 2-3 mls which is a under dosage of required medicine. Bottle unopened on admission and not given during admission.	CQC					Wards Sister spoke with Pharmacist at chemist informed of dispensing error, he apologised and I accepted this. He will investigate incident from his end. He does not have anyone to collect bottle of medicine from us so had requested we return oramorph to our pharmacy to dispose of. Note made on bottle informing pharmacy of the labelling error to bottle so they are aware we are aware.
		NECS					
		Safeguarding					
		CGC / SMT	**x**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2020/0451	24 sevredol 20mg tablets signed into patients own stock in CD register and signed back out	CQC					
		NECS					

	to return to pharmacy for return at the same time as signed in as patient discharged and sent home with oramorph not sevredol. On collection of medications from Pharmacy, staff unable to locate 24 x sevredol tablets	Safeguarding					CSM sought advice from CDLIN. Concluded most likely to have been sent back to pharmacist or accidently disposed of rather than stolen. No further action required other than monitoring for similar issues in future.
		CGC / SMT	**x**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2020/0459	Staff came to administer medication and noticed measure not correct with what was recordered in CD register. Should have been total of 214mls corrected measure showed 198.5mls	CQC					To find out % of acceptable shortfall, I have read policy and am unable to obtain this information To start using medicine bottle bungs to stop leakage and waste – Ward sister to look into.
		NECS					
		Safeguarding					
		CGC / SMT	**x**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2020/0479	Strong smell of smoke noted on IPU. Consultant went to smoking area and noted a lot of smoke coming out of cigarette bin, fire extinguished with water by Consultant.	CQC					Sign in place warning users of the shelter that bin is only to be used for cigarette ends and nothing else. Ward Sister d/c with guest services manager provision for emptying the bin as from walk around maintenance team were taking over the emptying of the bin. I expressed concerns that the bin is often full and there was nothing in place to inform when the bin had been emptied I have requested a daily emptying of the bin. I have also requested a safer bin as people are still putting plastic wrappers into the bin. Guest services manager to order sand bin and maintenance manager will check and empty this daily mon-fri. Domestic staff who works a weekend happy to check new bin when it arrives on a Weekend. Ward Sister to r/v risk assessment if available if not to do a risk assessment.
		NECS					
		Safeguarding					
		CGC / SMT	**X**				

3.2 Performance - Clinical Effectiveness

The purpose of sharing the review of our Quality Performance during the period 1st April 2019 to 31st March 2020 is to demonstrate what we are doing well as well as to identify the areas that need improvement and how this will be achieved.

Measuring clinical effectiveness is important to St Cuthbert's Hospice as it enables us to have an accurate picture and understanding at all levels of activity across all the services provided. This helps us to identify areas for improvement and demonstrate to the community that we serve that the Hospice is meeting its goals

Full data reports have been submitted in accordance with data set requirements to the Commissioners. Specific key performance indicators (KPIs) with threshold targets allow our goals to be measured on a quarterly basis.

We have submitted the full data sets from 1 April 2019 to 31 March 2020 so that comparisons can be made within the specified period. Where we have not met the threshold target, this has been highlighted in red and a summary below the box highlights the reasons why these targets have not been met.

Although the National Minimum Dataset (MDS) is no longer formally collected following the merger between Hospice UK and the National Council for Palliative Care (NCPC), we have continued to collect a similar dataset on an annual basis to allow year on year comparison. (Refer to Table 4).

MDS groups returns from individual units against number of beds and number of patients seen across the different services provided, so that comparisons can be made like for like. We have been included as a small category since we have fewer than 11 beds on the In-patient Unit. All other services have been included as medium categories due to the total number of patients seen.

The KPIs highlighted below and reported to our Commissioners provide one method for measuring clinical effectiveness within our organisation to identify areas for improvement as well as assuring the Hospice and the community we serve that our services are achieving what we intended to achieve. (Refer to Table 3).

Please note that those KPIs that have not been met are clearly identified and the reasons why are explained in the comments column of the Table concerned

Table 3 - Results of Key Performance Indicators during the period 1 April 2019 to 31 March 2020

Table 3 – Hospice activity 2019-20									
Indicators.	**Threshold**	**End of Year. 2018-19**	**Met – Not met**	**2019-20 quarterly performance.**				**End of year 2019-20**	
				Q 1.	**Q 2.**	**Q 3.**	**Q 4.**		**Year 2019-20 Performance**
In-Patient Unit (IPU)									**COMMENTS.**
Total number of in-patient referrals received	N/A for monitoring purposes	**New KPI**	**-**	**78**	**89**	**93**	**86**	**346**	N/A for monitoring purposes
Average waiting time from referral to admission for inpatients (excluding weekends and planned respite).	**≤ 48 hours**	**New KPI**	**-**	**11.7**	**51.3**	**41.8**	**50.4**	**38.8**	MET In Q2 there was a change to the way we calculate hours.
Total number of inpatient admissions.	N/A for monitoring purposes	**171**		**49**	**55**	**57**	**62**	**223**	N/A for monitoring purposes
Percentage bed occupancy.	**≥ 85%**	**83.5**	**Not met**	**79.6**	**75.7**	**85**	**79.6**	**80**	NOT MET Reasons for refusing/delaying admissions are captured and reviewed via a monthly spreadsheet.
Percentage bed availability.	**≥ 95%**	**99.2**	**Met**	**99.5**	**98.5**	**100**	**100**	**99.5**	MET
Average length of stay for inpatients.	**≤ 15 days**	**New KPI**	**-**	**16**	**12**	**13.7**	**11.2**	**12.9**	MET Improved average LOS could be a consequence of additional management capacity & increased awareness of KPIs amongst staff
Number and percentage of inpatients that have been offered an Advance Care Plan.	**90%**	**94.2**	**Met**	**49 96%**	**52 92.9 %**	**53 96.4 %**	**60 92.3 %**	**214 94.4 %**	MET Potentially an indication of what has been recorded as offered rather than what has actually been offered

Number and percentage of patients who died at the hospice and have preferred place of death recorded.	N/A for monitoring purposes	**92.6**	**-**	**29 93.5 %**	**34 87.2 %**	**26 92.9 %**	**20 80%**	**109 88.4%**	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	**94**	**-**	**25 86.2 %**	**33 84.6 %**	**24 92.3 %**	**19 95%**	**101 89.5**	N/A for monitoring purposes
Patient's risk of falls to be assessed within 4 hours of admission.	**100%**	**New KPI**	**-**	**34.7**	**52.7**	**69.2**	**74.6**	**57.8**	NOT MET - Staff have been advised to record time of assessment rather than time of entry on to SystmOne.
Patient's written care plan tailored to address falls risk completed within 8 hours of admission.	**100%**	**New KPI**	**-**	**83.7**	**92.7**	**98**	**88.1**	**90.6**	NOT MET - Staff have been advised to record time of assessment rather than time of entry on to SystmOne.
Pressure ulcer risk assessment to be completed within 6 hours of admission. (Ref - NHS Improvement 2018 Pressure Ulcers: revised definition and measurement).	**95%**	**New KPI**	**-**	**57.1**	**61.8**	**82.7**	**83**	**71.1**	NOT MET - Staff have been advised to record time of assessment rather than time of entry on to SystmOne.
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%**	**New KPI**	**-**	**57.1**	**61.8**	**82.7**	**83**	**71.1**	NOT MET - Staff have been advised to record time of assessment rather than time of entry on to SystmOne.
Venous thromboembolism (VTE) risk to be assessed within 24 hours of admission to determine if prophylaxis required.	**100%**	**99**		**100**	**100**	**98.2**	**100**	**99.6**	NOT MET
Percentage of patients that report a positive experience of care via the Friends and Family Test.	**90%**	**New KPI**		**100**	**100**	**67**	**100**	**91.6**	MET Q3 - Only 3 responses received this quarter, 2 rated extremely likely, 1 rated don't know
Number of complaints and compliments received and actions taken	N/A for monitoring purposes	**New KPI**		**0**	**37 compliments**	**18 compliments**	**10 compliments**		N/A for monitoring purposes Refer to Sect 5.2 in rep[ort

Number of clinical and non-clinical incidents and actions taken	N/A for monitoring purposes	**New KPI**		**-**					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	**-**		**141**	**144**	**145**	**130**	**257**	N/A for monitoring purposes
Number and percentage of Living Well Centre patients receiving a care plan	**100%**	**100**		**100**	**100**	**100**	**100**	**100**	MET
Percentage occupancy	**≥ 80%**	**93.1**		**96.6**	**101.7**	**103.7**	**97**	**100**	MET Level of over booking has been better informed by data overtime
Time from referral to Living Well Centre and contact to arrange home visit / assessment	**90% within 7 days**	**91.9**	**Met**	**93.8**	**95.7**	**94.6**	**94.1**	**94.6**	MET
Time from first referral in LWC to Physiotherapy assessment	**100% within 21 days**	**New KPI**	**-**	**92.9**	**90.9**	**100**	**100**	**96**	NOT MET - 1 service user. Reduced capacity within OT/Physiotherapy due to staff absence
Time from referral in LWC to Occupational therapy assessment	**100% within 21 days**	**New KPI**	**-**	**100**	**100**	**100**	**100**	**100**	MET
Percentage of patients that report a positive experience of care via the Friends and Family Test	**90%**	**New KPI**	**-**	**88**	**82**	**100**	**100**	**92.5**	MET Q1 - 8 forms – 1 did not return Q2 – 17 forms, 2 not completed
Dementia services									**COMMENTS**
Total number of patients attending Dementia Support Service	N/A for monitoring purposes	**169**	**-**	**112**	**114**	**97**	**124**	**140**	N/A for monitoring purposes
Time from referral to Admiral Nurse for first contact and appointment arranged for assessment.	**95% within 15 days**	**94.9**	**Not met**	**88.5**	**100**	**100**	**100**	**97.1**	MET

Time from referral to Namaste care for first contact and appointment arranged for assessment.	**95% within 15 days**	**New KPI**	**-**	**100**	**98**	**95.5**	**100**	**98.4**	MET
Percentage of patients who provide feedback and report a positive experience of care	90%	**New KPI**	**-**	**100**	**83**	**100**	**100**	**95.8**	MET Q2 – Only 6 forms returned
Number of complaints and compliments received and actions taken	N/A for monitoring purposes	**New KPI**	**-**	**1**	**0**	**0**	**3**	**4**	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	**New KPI**	**-**						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	**343**	**-**	**78**	**58**	**64**	**68**	**147**	N/A for monitoring purposes Refer to Sect 5.2 of report Pull for psychological support on IPU in Q4
Number and percentage of clients contacted within 15 working days of receipt of referral	**95%**	**100**		**100**	**100**	**100**	**100**	**100**	MET All referrals to counselling services contacted within 7 days
Number and percentage of written assessments of needs and action plans agreed with clients	**100%**	**100**		**100**	**100**	**100**	**100**	**100**	MET
Percentage of clients that report a positive experience of care via the Friends and Family Test	**90%**	**New KPI**		**100**	**100**	**90**	**0 responses**	**96.7**	MET No responses received in last quarter
Number of complaints and compliments received and actions taken	N/A for monitoring purposes	**New KPI**		**11 compliments**	**8 compliments**	**3 compliments**	**8 compliments**		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

Table 4 - Comparing St Cuthbert's Hospice Dataset 2018 – 2019 to 2019 – 2020.

Service Area	Indicator	Hospice 2018-19	Hospice 2019-20
Inpatient Services	Total Number of Patients within a year treated	171	223
Inpatient Services	Total New Patients	147	194
Inpatient Services	Re-referred Patients	9	20
Inpatient Services	Average Bed Occupancy (%) NB Length of Spell greater than 15 days increased year from 31.7% in 16-17 to 41.6% in 17-18	83%	80%
Inpatient Services	Cancer Diagnosis (%)	83.6%	98.2%
Inpatient Services	Non Cancer Diagnosis (%)	16.4%	1.8%
Inpatient Services	Average Length of Stay (days)	17.9	12.9
Inpatient Services	Died in Hospice (%)	63.5%	54.1%
Inpatient Services	Discharge Care Home (%)	3.5%	4%
Inpatient Services	Discharge Acute (%)	1.2%	1.8%
Inpatient Services	Discharge Home (%)	30.6%	40.1%
Inpatient Services	Discharge Hospice (%)	1.2%	0%
Day Hospice	Total Number of Patients Treated	268	257
Day Hospice	Number of New Patients	175	162
Day Hospice	Total Available Places	3675	3675
Day Hospice	Total Places Attended	3424	3487
Day Hospice	Total Booked Places DNA	1521	1507
Day Hospice	Average length of care (Days)	72	63
Day Hospice	Cancer Diagnosis (%)	46.3%	45.1%
Day Hospice	Non-Cancer Diagnosis (%)	53.7%	54.9%
Day Hospice	Access to Physiotherapist (total number of Hospices in UK)	Yes	Yes
Day Hospice	Access to Medical Consultant (total number of Hospices in UK)	Yes	Yes
Day Hospice	Access to Occupational Therapist (total number of Hospices in UK)	Yes	Yes
Day Hospice	Access to Spiritual Support Worker (total number of Hospices in UK)	Yes	Yes
Day Hospice	Access to Complementary Therapist (total number of Hospices UK)	Yes	Yes
Bereavement Services[1]	Total number of patients seen within year	186	147
Bereavement Services[1]	Total new patients	146	77
Bereavement Services[1]	Total continuing patients	43	47
Bereavement Services[1]	Face-to-face by trained & professionally accredited counsellor	973	838

3.3 Hospice Quality and Key Performance Indicators

Information relating to patient datasets, Hospice quality, performance indicators and CQUIN targets have been submitted to the Commissioners on a quarterly basis during the period 1 April 2019 to 31 March 2020. This information has been collected from several sources extracted from SystmOne with additional back-up using Excel spreadsheets.

Clinical Audits

Clinical Audit is defined as “a quality assurance and enhancement process”. It is a means of reviewing performance to ensure that what should be done is being done, and provides a framework to enable improvements to be made. A comprehensive programme of clinical audits has been undertaken over the period 1 April 2019 – 31st March 2020. This audit timetable will be repeated over 2020-21. An overview of clinical audits undertaken 2019-120 is included at Appendix Three at the end of this document.

Patient and Carer Experience

Safety, experience and positive outcomes are of vital importance to our Hospice and it is essential that our environment and the delivery of high quality care meet the needs, wishes and preferences for all our patients, carer and service users. We deal with all complaints as per our Complaints Policy and Procedure and over 2019-20 dealt with two informal complaints, (Refer to Table 3, Incident No 2019/0330 and 2019/0331).

We value the feedback of patients, carers and visitors about their experiences, whether this is positive or not, Feedback will not only provide a framework against which we can gauge our current performance but also serve as a basis from which to continuously improve our services. Analysis of the data which we collect from a variety of sources allows us to identify areas where we are recognised as providing an optimal service (so we can ensure that standards are maintained), and where we should make progress in areas where this is not the case.

This year we include Friends and Family Test service user feedback collated for all services please see Appendix 1. Analysis and evaluation of data collated during the period 1 April 2019 to 31 March 2020 has provided valuable information in support our commitment to continually develop our services. During this period we have used a range of methods (questionnaires as well as interviews) to collect information from patients and carers across the range of services including the In-patient Unit, day services in our Living Well Centre, Family Support Team and our dementia and Namaste services.

We collect service user feedback from a variety of different sources including comments made in questionnaires, from one to one interviews and comments made in letters and cards received during the period 1 April 2019 to 31 March 2020. In order to facilitate further improvements for engaging with patients, families, carers and friends, we have updated our website to make this more interactive, have increased the use of social media to include Facebook and Twitter, and have left suggestion boxes in communal areas across the Hospice. The comments made in the suggestion boxes are attached as Appendix 2.

3.4 Statement of Assurance from the 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 2019 to 31 March 2020 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, arts and crafts, 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 commissioned by Durham County Council

During the period 1 April 2019 to 31 March 2020, St Cuthbert's Hospice provided or sub-contracted 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 2019-20 represents 100% of the total income generated from the provision of NHS services by St Cuthbert's Hospice Durham for 2019-20. 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.

Goals agreed with Commissioners

A proportion of St Cuthbert's income in 2019-20 was conditional on achieving quality improvement and innovation goals agreed between St Cuthbert's Hospice and any person or

body entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

CQUIN 1:

- Based on the intelligence gathered, adopt a recognised tool such as the Carer Support Needs Assessment 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 and improve patient at home or in the community.

Although progress was not as we had planned, we met and made progress against the requirements for the CQUIN goals identified above for the period 1 April 2019 to 31 March 2020.

The Clinical Commissioning Group are again adopting the Commissioning for Quality and Innovation (CQUIN) framework for some of our contract payment 2020 - 21.

National Initiatives

St Cuthbert's Hospice is required to register with the Care Quality Commission and its current registration status is for the following regulated activities:

- Diagnostics and screening procedures.
- Services for everyone.
- Treatment of disease, disorder or injury.

The Care Quality Commission has not taken enforcement action against St Cuthbert's Hospice during the period 1 April 2018 to 31 March 2019.

St Cuthbert's Hospice has not participated in any special reviews or investigations since registering with the Care Quality Commission in 2010.

St Cuthbert's Hospice has not been subject to an unplanned inspection by the Care Quality Commission over 2018-19.

Data Quality

A Service Quality Performance Report was submitted to the Commissioners in each of the four quarters within the period 2019 - 20. Information relating to patient datasets, Hospice quality and performance indicators (key performance indicators) as well as the data collection for CQUIN measures has been included in these reports. This information has been collected from several sources extracted from SystmOne (our clinical recording system) with additional back-up using Excel spread sheets.

St Cuthbert's Hospice has complied with submitting data and for the reporting of incidences in accordance with local quality requirements.

Information Governance Toolkit Attainment.

St Cuthbert's Hospice has complied with the standards outlined in the NHS Data Security and Protection Toolkit in 2019/20.

3.5 Statement of Assurance from County Durham Clinical Commissioning Group

17th December 2020

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

Dear Mr Marriott

St Cuthbert's Hospice Quality Account 2019/20.
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 2019/20.

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 in 2019/20.

The CCG recognises the significant improvements that continue to be made to patient care and experience. The structured approach to governance, audit and quality improvement at the hospice 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 acknowledges that the hospice faced challenges in 2019/20 relating to staffing and COVID-19 but is pleased to note that despite these challenges work progressed to fulfil all CQUIN requirements. The continued engagement with CQUIN for 2020/21 is recognised and appreciated.

Although the NHS Safety Thermometer was not developed directly for hospices, St Cuthbert's embraced its principles throughout 2019/20 and it is pleasing to see that this will continue throughout 2020/21.

The CCG acknowledges the work undertaken in relation to infection control and reducing the risks of healthcare associated infections and is pleased to note that a repeat audit will be undertaken in 2020/21 to ensure that the standards of achievement are sustained.

The hospice is to be congratulated on their success in achieving the Disability Confident Committed Level 1 and Better Health at Work Award.

The CCG is pleased to see that the quality priorities identified for 2020/21 are based around the five CQC domains and fully supports the inclusion of these to ensure a high quality of service for patients and carers.

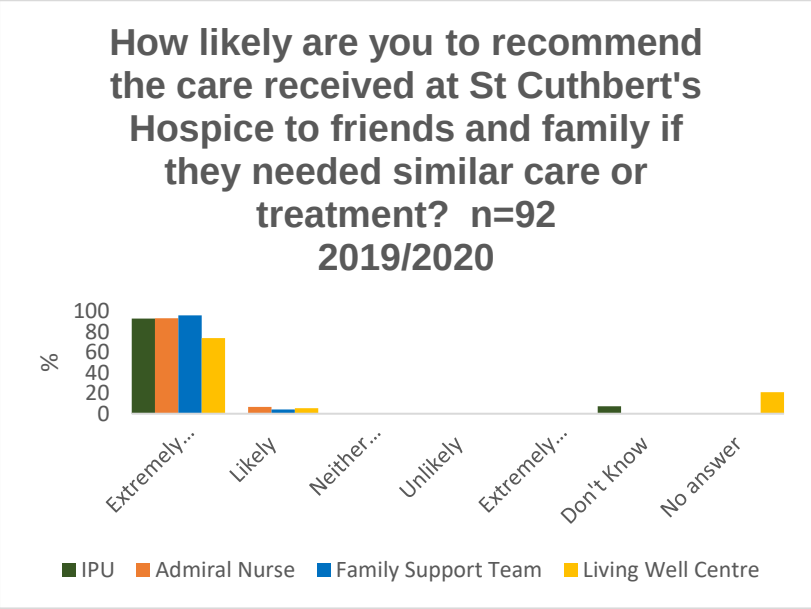
We look forward to continuing to work in partnership with the hospice to assure the quality of services commissioned in 2020/21.

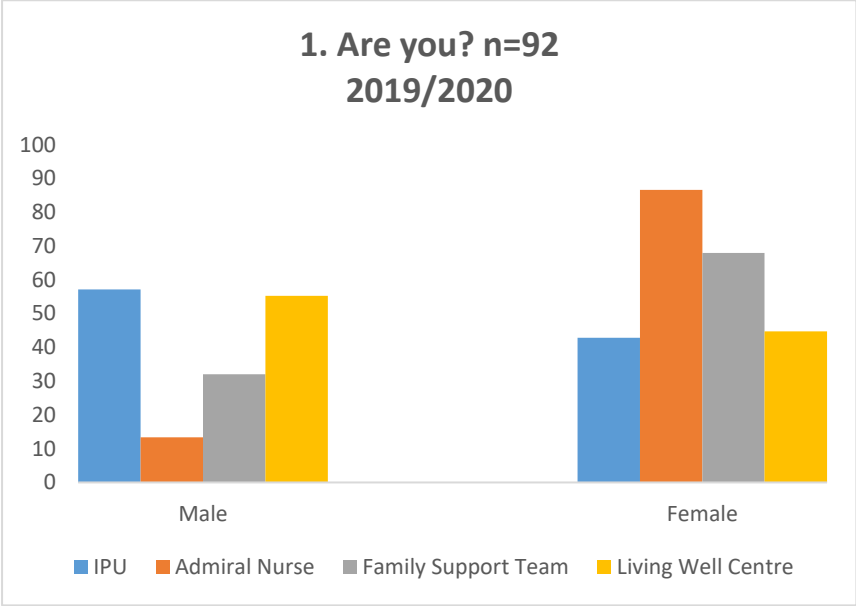
Gillian Findley
Director of Nursing and Quality
NHS County Durham CCG

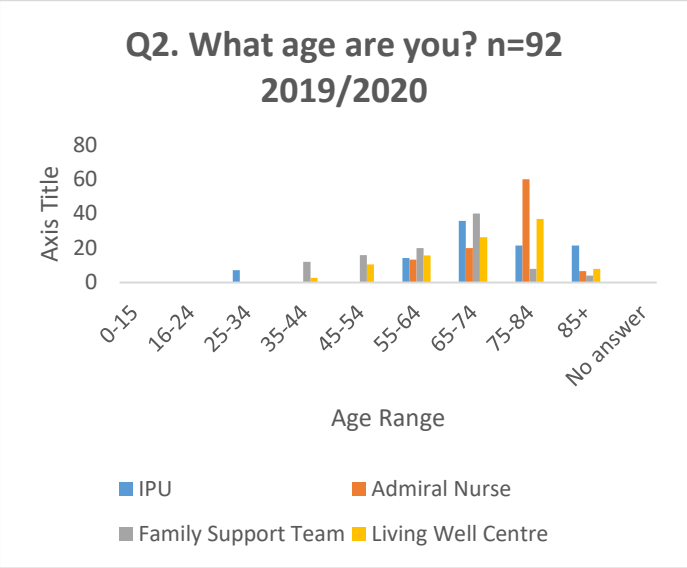
Appendices

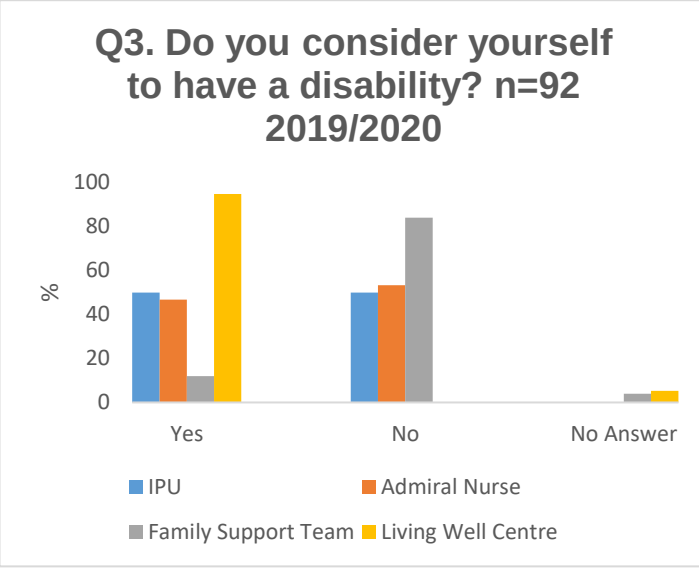
Appendix One

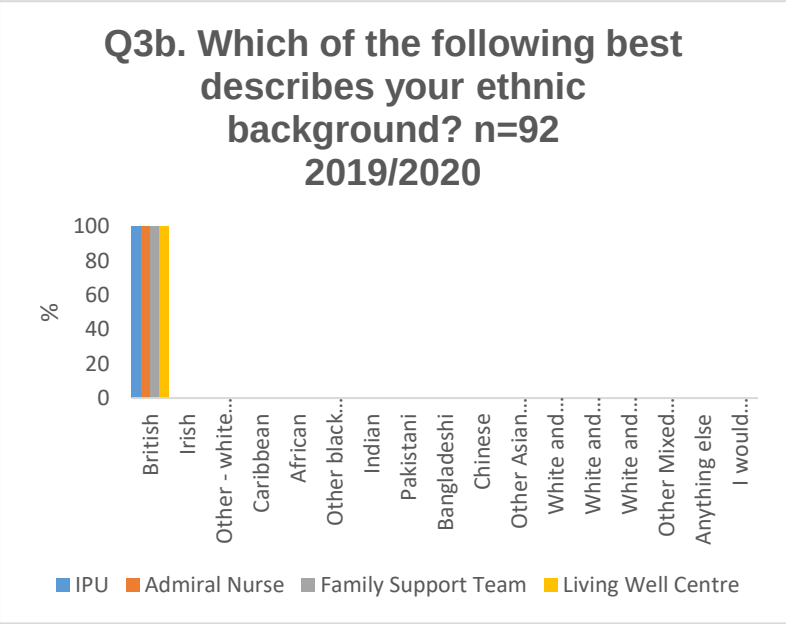
Friends and Family Test Results 2019/2020

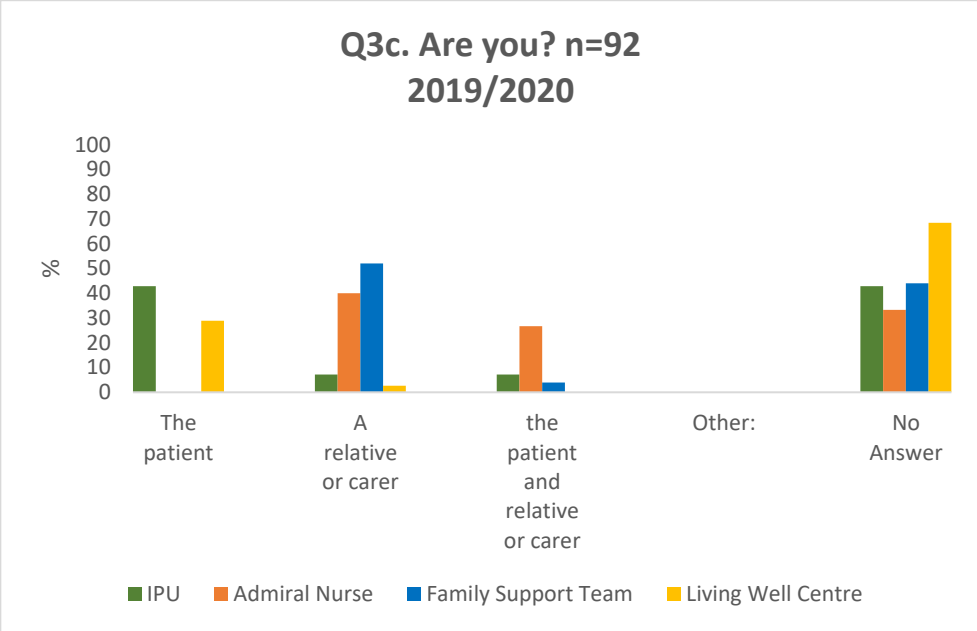





Q2. What age are you? n=92
2019/2020
Axis Title
80
60
40
20
0
0-15
16-24
25-34
35-44
45-54
55-64
65-74
75-84
85+
No answer
Age Range
IPU
Admiral Nurse
Family Support Team
Living Well Centre


Q3. Do you consider yourself to have a disability? n=92
2019/2020
%
100
80
60
40
20
0
Yes
No
No Answer
IPU
Admiral Nurse
Family Support Team
Living Well Centre


Q3b. Which of the following best describes your ethnic background? n=92
2019/2020
%
100
80
60
40
20
0
British
Irish
Other - white...
Caribbean
African
Other black...
Indian
Pakistani
Bangladeshi
Chinese
Other Asian...
White and...
White and...
White and...
Other Mixed...
Anything else
I would...
IPU
Admiral Nurse
Family Support Team
Living Well Centre


Q3c. Are you? n=92
2019/2020
%
100
90
80
70
60
50
40
30
20
10
0
The patient
A relative or carer
the patient and relative or carer
Other:
No Answer
IPU
Admiral Nurse
Family Support Team
Living Well Centre

Appendix Two

Summary of suggestion box comments.						
2019-20	**Source**	**Individual**	**Idea**	**Benefits**	**Additional comments**	**Action**
Quarter 1						
April	IPU	Service User	I strongly believe and strongly recommend a known volunteer should become part of the St Cuthbert's team. She would be a great asset for everyone.	This volunteer totally relaxes you, she gave me a head, neck and shoulder massage and it helps in so many ways mentally and physically.	This volunteer is such a lovely lady, she really cares about those who she sees – she also has a good talk with you and gives very good and honest advice. I just really feel having her as a member of your staff would be another great asset to the team.	We appreciate the contribution of all of our volunteers and the added value they bring. There are currently no vacancies for a paid complementary therapist. A number of staff within IPU and the Living Well Centre are trained to deliver this service.
May	None received					
June	Reception	Volunteer	Possibly have more recycling facilities located in the café area/corridor to the art room/art rooms themselves? Could be a bin for non-recyclables beside a bin for recyclables (clearly marked)	Less plastic sent to landfill. Greater recycling rates.		To liaise with the Guest Services Manager.
June	Reception	Staff member	E-cards on our website	Fundraising opportunity (and better for environment!)	Marie Curie offer e-cards on their website for £1 - could we do something similar? If unable to set this up ourselves there are companies that may host this for us e.g. dontsendmeacard.com and we can add our own designs	E - Cards are being looked at as a possibility by the retail team alongside the Hospice selection of actual Christmas cards that we sell.

Quarter 2						
July	IPU	Supporter	Could domestic workers have brighter uniforms than black - quite depressing!	Uplift patients' morale being brighter	Fantastic staff + nothing is too much trouble - from sisters + all staff including cleaners	Before the current uniforms were implemented, staff were consulted and it was determined that the uniforms needed to be Airtex, super cool, non-iron, and ventilated as well as able to be washed at a suitable temperature for infection control. We discovered that uniforms of this quality were only available in black or dark navy and staff agreed black would be the most practical.
August			None received in August			
September	Reception		Better seating in training room	Comfort for full days of training		
September	Reception		My family has been in more than once. I only think you should treat all staff the same not just ones who are high up. I don't think housekeepers are. Just because they are cleaners. They are very important.			

Quarter 3						
October	IPU	Staff member	Ice making machine for IPU	Would have regular ice supply for patients as we are always running out	Over time would save Hospice money as regularly purchase bags of ice.	This was investigated and we identified there were a couple of occasions when our supplier was unable to supply us with ice, usually this is available. However, we also looked into purchasing an ice machine but have been advised that we would encounter installation problems but more importantly that they may be a risk. We don't intend to progress this.
October	Reception	Volunteer	Provide transport e.g. a small coach for people to go to Strictly Come Dancing	People who are unable to get there by car can still go to the show	More people - more funds for the Hospice!!	The Community and Events Team are currently looking into the feasibility of this ahead of tickets going on sale early next year.
October	Reception	Volunteer	Provide transport for people who don't drive to go to Strictly Come Dancing	People who can't drive can go to Strictly meaning an increase in takings		The Community and Events Team are currently looking into the feasibility of this ahead of tickets going on sale early next year.
October	Reception	Volunteer	People leaving the building to let Reception know if they will be back or how long they will be			Staff have been advised to let reception staff know when they leave the building and when they are expected to be back.

November	IPU	Service User	Dog waste bin	Every visiting dog owner can dispose of their dog waste.	My husband brought my dog to visit and after picking up the waste found there was nowhere to dispose of it and had to carry it in his pocket for rest of visit until he went home and disposed of it.	We have contacted the local council and they are going to erect a dog waste bin just outside the Hospice, near to the Park entrance
November	Reception	Volunteer	Could someone be designated to replace the bottles on the water coolers regularly? I volunteer on a Thursday in IPU and they are always empty. I have replaced them myself but am not willing to put my back in jeopardy.	Visitors will have access to water		Please don't attempt to replace the bottles for the water cooler. They can only be replaced once fully empty. We have a designated person who makes regular checks and replaces these when needed. However, if you do notice a bottle that needs replacing please inform a member of staff who will then contact our Grounds & Maintenance Co-ordinator or the Central Support Services Office to action.
December			NO SUGGESTIONS RECEIVED			

Appendix Three
Schedule of Audits 2019/2020

Audit Schedule Reviewed by: Head of Clinical Services Review date: 31/03/20																	2020			
Audit Tool	Frequency		LWC	IPU	CS	FST	2019	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	Notes
Patient Carer Experience	Monthly	Service Managers x4	GC	JMcC	LH	AT														
LWC/Day Hospice Admission	Quarterly	Service Manager LWV	GC								18/07/2019			29/10/2019			28/01/2020			
In-patient Admission	Quarterly	Service Managers		JMcC												03/12/2019			26/03/20	
Controlled drugs	Quarterly	Nurse Consultant	CW	CW			01/11/2018					06/08/2019			01/11/2019					

Medicine Management	Quarterly	Pharmacist	AB	AB						27/06/2019				04/10/2019					
Medicine Compliance	Weekly on same day	Link Practitioner	JOB	JOB															
Nutrition	Quarterly	Link Practitioner	JB	ET			Oct-17					19/08/2019							
Infection control	Quarterly	Service Manager	JM	JMcC															
Mattress & Seat Cushions	Monthly	Senior HCA		TA															
Pressure Ulcers	Quarterly	Staff Nurse		MMG			10/03/2019						01/09/2019		27/11/2019			24/02/20 20	
Bereavement	Twice year	Link Practitioner		AC		BM													

Falls (To develop)	Quarterly	Physiotherapist	MP																	Falls Improvement Group to develop an audit
LWC/Day patient pain	Quarterly	Staff Nurse									11/07/2019			29/10/2019			28/01/2020			
In patient pain	Quarterly	Staff Nurse					20/03/2018									03/12/2019			26/03/20	
INFECTION CONTROL AUDITS																				
Code of Practice	Twice year	Infection control group								27/06/2019										
Clinical Rooms - IPU	Twice year	Infection control group								27/06/2019										

Clinical Rooms - LWC	Twice year	Infection control group									11/07/2019									
Domestic Rooms	Twice year	Infection control group								27/06/2019										
Care of deceased	Twice year	Infection control group								27/06/2019										
Hand Hygiene - IPU	Twice year	Infection control group					24/09/2018						06/09/2019							
Hand Hygiene - LWC	Twice year	Infection control group											30/09/2019							
Patient areas - IPU	Twice year	Infection control group					18/10/2018						06/09/2019							
Patient areas - LWC	Twice year	Infection control group												26/10/2019						

Offices within patient areas - IPU	Twice year	Infection control group					24/09/2018						06/09/2019						
Offices within patient areas - LWC	Twice year	Infection control group												19/10/2019					
Sluice/Dirty Utility	Twice year	Infection control group													29/11/2019				
Sharps IPU	Twice year	Infection control group													29/11/2019				
Sharps LWC	Twice year	Infection control group															26/01/2020		
Toilets for Public Use - IPU	Twice year	Infection control group													29/11/2019				
Toilets for Public Use - LWC	Twice year	Infection control group															28/01/2020		

Kitchen Areas	Twice year	Infection control group																09/03/20	
Public Areas - IPU	Twice year	Infection control group																12/03/20	
Public Areas - LWC	Twice year	Infection control group						11/04/2019											
Patient Toilets - IPU	Twice year	Infection control group																11/03/20	
Patient Toilets - LWC	Twice year	Infection control group						11/04/2019											
Patient bathrooms - IPU	Twice year	Infection control group																11/03/20	
Patient bathrooms - LWC	Twice year	Infection control group						23/04/2019											

Appendix 4

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 4) with clarification provided.

Participation in Clinical Audits

During 2019-20 no national clinical audits and no national confidential enquiries covered NHS services provided by St Cuthbert's Hospice.

During 2019-20 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 2019-20 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 2019-20 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 2019-20 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.