St Christopher’s Group Quality Account 2013-14

Part 1

Statement on quality from Barbara Monroe, Chief Executive

St Christopher’s sets out to provide the best possible care for people with life-limiting illnesses and those close to them, and all our staff and volunteers participate in this endeavour. Our mission is to promote and provide skilled and compassionate palliative care of the highest quality and we have a national and international reputation for providing care, delivering teaching and engaging in research. We are committed to continuously finding ways of improving our services to patients and families and we have a robust clinical governance framework that enables us to do this.

In the course of 2013-4 we have been committed to sustaining delivery of care despite the temporary closure of our inpatient beds while the unit was undergoing extensive refurbishment. We were fortunate in being able to rent a 14-bedded ward in a local hospital and, to support the most complex patients and mitigate the effects of lower bed capacity, we also deployed many of our ward clinical staff to look after patients at home as part of an intensive home ward service. We have been encouraged by the feedback from patients and carers that indicates that the quality of our care did not suffer, while our staff who found themselves working in an unfamiliar environment also gained in confidence and new knowledge, with some inpatient staff applying to work in the home care service to extend their community experience.

In recognition of the close relationship between health and social care we have continued to explore possibilities in this area of work. Working with one of our Clinical Commissioning Groups we have this year set up a pilot end of life health and social care coordination centre. This truly integrated service is a first point of contact for patients, families and professionals and aims to speed up and smooth any transfers of care from one organisation to another for people whose health and social care needs are changing fast. We are aiming to coordinate the care of a further 800 people with this service.

In Bromley, we have set up a project similar to the personal care project in LB Croydon that provides personal care to people thought to be in their last year of life. The Bromley project, for people believed to be in the last 6 months of life, also involves liaising closely with hospitals and assessing patients pre-discharge to ensure that they are provided with the most appropriate package of care so that unnecessary readmissions are prevented. In this document we report in more detail on the results from the Croydon project which has now been running for over a year.

St Christopher’s recognises the importance of training generalist and social care professionals as well as specialist colleagues. We have taken a lead in establishing links and potential partnerships with key organisations and
partners. We have been approved as an awarding centre by City and Guilds and have been awarded ROTO status (Register of Training Organisations) which enables us to be on the list of accredited government training centres delivering courses up to the value of £100,000. We are collaborating with St Giles Hospice to provide a platform for a national education consortium of hospices to deliver end of life care training which reflects a consistent and high standard across the country. This will initially focus on the delivery of QCF (qualifications credits framework) training for health and social support workers from all settings where people die. St Christopher’s and St Giles were successful in a joint workforce development bid submitted to Skills for Care to set up the following courses between us.

- Pre-employment programme
- Level 3 Award in End of Life Care
- Level 3 Certificate in Working in End of Life Care
- Level 5 Certificate in Leading and Managing Services to Support End of Life and Significant Life Events

In addition both St Giles and St Christopher’s delivered a government funded ‘Summer School’ for 16 to 19 year olds from local schools interested in a future career in health or social care in partnership with our local Further Education (FE) colleges. We were successful in a bid to the South London Local Education and Training Board (LETB) who have awarded us £40,000 to develop an accredited qualification in CBT and £125,000 over two years to develop in partnership with other employers, Skills Sector Councils and awarding organisations an integrated nationally accredited qualification in health and social care in end of life care and long term conditions. Together with 7 local hospices (including two children’s) that serve South London we have set up the South London Hospices Education Partnership which has submitted an expression of interest to the LETB to become a Community Education Provider Network (CEPN). We continue to deliver academically accredited palliative and end of life care modules and programmes from diploma to Masters level in partnership with Local Higher Education Institutions (HEIs).

Our Care Home Project Team (see dedicated pages on the St Christopher’s Hospice website: [www.stchristophers.org.uk/care-homes](http://www.stchristophers.org.uk/care-homes) ) has continued working with local care homes (nursing and residential) across five local CCGs, and the team are actively involved in research to improve care and provide an evidence base for activities such as advance care planning and to disseminate learning from projects like the Namaste programme for people with very advanced dementia.

In this, our fourth Quality Account, we identify our priorities for quality improvement for 2014-5, and review our performance against the quality indicators we selected last year. I and my team of senior managers have been closely involved in this review and in developing these measures, which have been endorsed by the Board of Trustees. I am able to confirm that the information in this Quality Account is, to the best of my knowledge, accurate.
Part 2

Priorities for improvement

We have identified three areas for improvement in the coming year, under each of the domains of quality set out in the Department of Health Report *High Quality Care for All*: patient safety, clinical effectiveness and patient experience.

1. **Patient safety**

   In recent years increasing numbers of patients with tracheostomies have been admitted to the inpatient unit.

   **What are we aiming to achieve?**
   During 2014-5, we will deliver training in tracheostomy care to between 45 and 50 registered inpatient nurses (depending on vacancies).

   **How will we know whether the training has been effective?**
   We will develop competency-based workbooks that will be used to evaluate the learning of nurses who have participated in the training. The workbooks are still being developed so we will report on the % of nurses trained, and the % that have had their learning assessed.

2. **Patient experience**

   **What are we aiming to achieve?**
   The hospice is keen to implement a more individualised and flexible approach to the provision of meals and has extended the time during which meals can be ordered, and have introduced an à la carte menu. Training of volunteers has continued to take place to support patients with eating and drinking. We want to know what our patients think of these changes.

   A recent audit of patient records found that although patients’ nutritional needs were being assessed and acted upon, staff were not always completing the nutritional assessment on admission. We want to make sure that assessments are recorded for all patients.

   **How will we know whether we have achieved this?**
   We will survey patients in the course of the year to find out what they think of the quality and variety of food, and whether they have found they are able to eat at times that suit them.
We will be carrying out regular audits to make sure that nutritional assessments are being recorded on the patient notes. We will report our results to commissioners.

3. Clinical effectiveness

What are we aiming to achieve?
Coordinate My Care (CMC) is a patient consented networked palliative care information system which assists shared decision making, particularly out of hours. We are aiming that every new patient at home or due to be discharged home should be entered onto this record, so that all the healthcare professionals who may be involved in the care of a person is aware of their wishes and of the other professionals involved in their care. During 2013-4 we trained staff to use the system and start implementing it and our target is to maintain or exceed our target of entering the details and wishes of 90% of new patients onto CMC by 31st March 2015.

How will we know whether we have achieved this?

We will audit our records quarterly and report the results to our commissioners.

We will review progress in relation to each of these 3 priority areas at Board meetings twice a year.
Review of indicators for 2013-4

Patient safety

Last year we said we would improve our inpatient environment through the large-scale refurbishment of our inpatient unit, with replacement of pipes, electrical cabling and windows, installation of doors to the sluices and of more hand wash sinks. On reopening, we said we would review the responses in our bereaved carer survey that relate to the inpatient unit. We would continue to carry out regular infection control audits and monitor outcomes.

What we did:
We opened our 4 wards incrementally, and by April 2014 all four were operating at full capacity. All the planned work has been carried out. We will be analyzing the feedback from our bereaved carer survey over the first six months of 2014-5.
Our programme of infection control audits continued throughout the year and has been effective in demonstrating competent infection prevention practices. Audits of cleanliness of clinical / non clinical areas have generally taken place every 1-2 weeks. The main problems highlighted recently have been cleaning of the glass in the Anniversary Centre, which is now a daily task and the replacement and re-labelling of some bins in the ward areas. Hand hygiene audits have taken place monthly and have highlighted the need for non-clinical staff to be reminded about hand hygiene. Extra training has been provided for volunteers and individual staff concerned. Hand hygiene remains an important part of annual update for all departments.

Clinical effectiveness

Last year we said we would carry out an evaluation of the personal care pilot service that we were delivering in LB Croydon to people in their last year of life. We hoped to be able to use the results of the evaluation to extend this work into other geographical areas.

What we found:
Considerable energy was devoted to selecting and training a mature and committed workforce keen to deliver high quality care. Service management by a nurse care manager with experience in end of life care enhanced the model by enabling conversations to take place with clients and families at assessment to establish the preferred place of death. Where relevant the care manager was also able to discuss with them who to contact in an emergency (with the encouragement to ring the service first) and their wishes in relation to DNACPR (Do not attempt cardio pulmonary resuscitation) to prevent unwanted hospital admissions. She was able to identify clients who were entering the dying phase, support clients and their families through this time.
and ensure GPs were aware and that district nursing was mobilised at the right time.

In the first 12 months St Christopher’s social care project delivered care to 83 clients who were thought to be in the last year of life. More than half of the service users were between 71 and 90 years. 65% of clients had a malignant diagnosis and 35% non-malignancy. The average length of stay on the service was 9 weeks, with a range of 1-326 days. Eight four per cent (84%) used the service for less than 6 months indicating that clients were being appropriately selected for the service.

Forty three clients died and of these 30 (70%) died at home, as they wished. We found that 91% of clients expressed a preference to die at home, and we achieved this in 70% of cases. A further 7% expressed a preference to die in a hospice and 100% achieved this. Of the 23% who died in hospital, none had originally expressed a preference to die there but all agreed to the admission for an acute event, such as a perforated abdomen or haemoptysis, or because they wanted further treatment. A further 12% were discharged to a care home and died there. All had initially expressed a preference to die at home but changed their minds due to their circumstances.

The project benefitted from the ‘in kind’ contribution of a volunteer support component which delivered a total of 63 support visits with an average duration of 2.5 hours for each visit.

Clients expressed high levels of satisfaction with the service and all quality indicators were exceeded.

The service has been commissioned for another year ending May 2014.

Patient experience

Last year we said that we wanted to assess how well we had succeeded in offering patients and their families excellent care, regardless of the setting, whether on NHS premises or at home with our intensive nursing service for patients who might otherwise have been admitted to the inpatient unit.

What we did:
We collected feedback from bereaved carers whose relatives had had an admission to Linden ward (our ward in an NHS acute trust) and surveyed patients who were well enough to respond. Patients admitted to this ward tended to have very complex and challenging needs nonetheless overall satisfaction with care was high.

There was some evidence that the lack of private space on the ward and consequent difficulty in holding family meetings detracted from the perceived support for families.

- 71% of patients (sample n=60) said that their main concern had improved since admission and 73% said that the service had made a difference to how things were going for them
- Around half of bereaved carers (sample n=40) said that the care the patient had received was ‘exceptional’
We also collected feedback from patients and bereaved carers and about the intensive home ward service:

- 96% of bereaved carers said that the overall care was exceptional or excellent (sample n=24).

- 81% of patients (sample n=47) said that the service had made a difference to how things were going for them to a very great or great extent.
Participation in clinical audits

As an independent hospice, St Christopher’s does not participate in the national NHS clinical audit programme that covers subjects that do not apply at the hospice. However, we regularly undertake audits which we select according to network, local or internal priorities. Audits we have carried out in 2013-4:

<table>
<thead>
<tr>
<th>Subject matter</th>
<th>Implication for practice/outcomes of audit</th>
<th>Follow-up actions</th>
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<tbody>
<tr>
<td>Review of admissions December 2013 to March 2014</td>
<td>This audit aimed to assess efficiency in the early weeks of the inpatient unit reopening following refurbishment. During the audit period 79% of all requests met our rigorous waiting time target. Of 66 emergency requests only 7 were not admitted on the same day.</td>
<td>Audit regularly</td>
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<td>Mattress audit</td>
<td>Mattresses are serviced annually. Monthly audits identify any actions that may be required between services. For example any stained mattresses are cleaned and sent for decontamination.</td>
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<td>Consent to interventional pain procedures</td>
<td>A retrospective audit of records of all patients undergoing interventional pain procedures over 12 months (2011-2) showed good documentation of discussions about the proposed procedure and of consent.</td>
<td>Recommendations have been made in relation to using the correct consent form consistently and fully completing patient demographics on it.</td>
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<td>Recording of patient consent and reported problems following urinary catheterisation</td>
<td>This audit showed that 60 out of the 61 patients (98.5%) had a recorded indication for catheterisation. Blocked catheters and urinary tract infections were the most commonly occurring problems in 16% of patients.</td>
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<td>Site waste audit</td>
<td>Recommendations have been made in relation to bin stickering and bin tagging. A shortage of small clinical waste bags has been remedied, and staff are being reminded not to include domestic waste in the offensive waste.</td>
<td>Reaudit annually</td>
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<tr>
<td>Cleaning and infection control audits</td>
<td>High standards of cleanliness were found in all clinical areas. Fabric upholstery has been replaced to facilitate cleaning, and sinks on the wards have been replaced. Sluice doors have been installed</td>
<td>Regular audit</td>
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<tr>
<td>Audit Type</td>
<td>Description</td>
<td>Action</td>
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<td>Hand hygiene</td>
<td>These audits occur monthly and have highlighted the need for non-clinical staff to be reminded about hand hygiene. Additional annual training has been provided for volunteers, orderlies and stewards.</td>
<td>Continue to audit</td>
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<tr>
<td>Audit of patient falls</td>
<td>Evidenced that falls risk assessments were taking place and that staff were using a range of strategies for preventing falls in patients who were assessed as being at high risk of doing so. Between October 2013 and March 2014, 68 patient falls occurred, one of which resulted in a fracture and 8 required first aid. Falls occurring in the first 3 months of 2014 have been benchmarked against those in other large participating hospices. Our results show that we had 18.5 falls per 1000 occupied bed days compared with the category average of 10.2, however 100% resulted in no or low harm.</td>
<td>Continue to audit</td>
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<tr>
<td>Audit of documentation of diagnosis on electronic patient records</td>
<td>Ninety percent of patients (n=54) had a correct diagnosis recorded on their electronic record. Of those who did not this was usually because the information provided on the referral was unclear. Four of 6 incorrect diagnoses were similar to the correct ones.</td>
<td>Institute checking of diagnoses against medical letters by multidisciplinary team</td>
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<td>Audit of care home deaths</td>
<td>The project team working in collaboration with local care homes is undertaking a long-term programme to reduce the number of inappropriate deaths in hospital of care home residents. Rates of death in care homes continue to increase, as does the use of end of life care tools such as advance care planning. In 2012-3 the % of care home deaths across 72 nursing care homes was 77% (compared with 57% across 19 nursing care homes in 2007-8).</td>
<td>Continue to audit</td>
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<tr>
<td>Pressure sore audit</td>
<td>The first 3 months of pressure ulcers occurring in the inpatient unit in 2014 have been benchmarked against those occurring in other large</td>
<td>Continue to audit</td>
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<td>Participating Hospices</td>
<td>Our results show that we had 2.9 pressure sores per 1000 occupied bed days compared with the category average of 6.0. 100% of sores were assessed as unavoidable.</td>
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<td>Medical Discharge summaries April 2013 to March 2014</td>
<td>100% of all medical discharge summaries were completed. 98% were sent within the standard of 3 working days. This is a regular annual audit to monitor the consistency and timeliness of medical team communication with GPs and District Nurses.</td>
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<td>Heart failure audit</td>
<td>This audit of patient records sought to identify what items relating to two heart failure assessment tools formed part of the data routinely collected on heart failure patients receiving palliative care and to consider whether either tool was suited to such patients. The audit confirmed that neither was ideally suited to a palliative care population.</td>
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Participation in clinical research

St Christopher’s has been involved in conducting several clinical research studies, either alone or in partnership with others.

1. The Namaste study investigating the benefits of intensive sensory stimulation for people with advanced dementia has produced encouraging results. The findings have now resulted in a programme of teaching workshops for Care Homes, supported by a Handbook and Toolkit. One paper has already been published, a second has been accepted for publication and two others are in preparation.

2. Our AHP lead in collaboration with a colleague from King’s College, London, completed an evaluation of the Gym Rehabilitation Programme, which is being published in the April edition of Progress in Palliative Care. The study will also be shared at the EACP Scientific Congress as a poster presentation.

3. The Bromley Research Project in Palliative Care for Heart Failure has now been granted Research Ethics Approval.

4. The hospice has participated in a number of multi-site studies originating elsewhere including a University of Leicester study on the experiences of families of people with Motor Neurone Disease who had requested cessation of their non-invasive ventilation; the InSpirit International Study on Spiritual Care in Palliative Care led from the Cicely Saunders Institute; a University of Greenwich MSc study on the impact on counsellors’ practice of their personal experience of loss and grief.

Research Publications in the past year


Goals agreed with commissioners

Use of the CQUIN framework

A proportion of St Christopher’s income during 2013-4 was conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework. Each of these was achieved as follows:

**CQUIN1:** To report on and achieve incremental percentage targets of patients assessed for SKIPP (the St Christopher’s Index of Patient Priorities).

**CQUIN2:** To develop guidance for the completion of Coordinate My Care (CMC), a patient consented electronic record which assists shared decision making. To train nurses in the use of CMC. To achieve a percentage target of patients whose details and wishes are recorded on CMC.
What others say about St Christopher’s

St Christopher’s is registered with the Care Quality Commission (CQC) and is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury
- Personal care - application to Care Quality Commission in hand to register this as a separate service
- Diagnostic and screening procedures
- Transport services, triage and medical advice provided remotely

The CQC has not taken enforcement action against St Christopher’s during 2013-4.

St Christopher’s is subject to periodic reviews by the Care Quality Commission, the last of which was in December 2013. The CQC’s assessed the hospice as being compliant with all the outcomes inspected.

St Christopher’s has not participated in any special reviews or investigations by the CQC during the reporting period.

Data quality

St Christopher’s is not required to submit records to the Secondary Uses service for inclusion in the Hospital Episode Statistics. In accordance with the Department of Health, it submits a National Minimum Dataset (MDS) to the National Council for Palliative Care.

The hospice regularly quality assures the data provided to CCGs (patient demographics, inpatient, day care and home care activity summaries, place of death etc.) All reported errors of entries made on the electronic patient records are recorded and scrutinised quarterly by the Information Governance Committee.

Information Governance Toolkit attainment levels

St Christopher’s is an NHS business partner and therefore is required to meet 29 of the Information Governance toolkit requirements. We have completed the IG requirements to level 2.

Clinical coding error rate

St Christopher’s was not subject to the Payment by Results clinical coding audit during 2013-4 by the Audit Commission.
Part 3

Review of quality performance

We review all our services regularly and our clinical governance scorecard is one of the ways in which we keep track of trends in relation to quality and patient safety (See page 17 for the scorecard covering the 12-month period to March 2013). This is evidence of the way in which we track critical areas of care. It also highlights that we have low rates of complaints, infection rates on our inpatient unit, and medication errors. We assess each patient on admission to the inpatient unit in order to put measures in place to reduce the likelihood of a fall while allowing them the freedom to move around as they wish. Our falls rate in the inpatient unit is 16 falls per 1000 occupied bed days, which is very similar to that of other hospices and palliative care units. During 2014-5 we will be participating in a national benchmarking exercise with other hospices in relation to pressure sores, patient falls and medication errors.

Our audit programme reviews the effectiveness of our clinical care as does feedback from patients and carers.

The result of the last 12 months to March 2014 of the SKIPP patient outcomes measure shows that of patients surveyed within 3 days of admission to the inpatient unit 77% (n= 128) said that in relation to the problem that was of greatest concern to them ‘things had got much better’ or ‘a little better’ since their admission. The hospice had made a ‘great’ or a ‘very great difference to how things are going at present’ to 39% (n=66) of those surveyed.

Eighty five percent (n=57) of bereaved carers surveyed said that care from the inpatient doctors was ‘exceptional’ or ‘excellent’, and 88% (n=59) of carers said the same of the inpatient nurses.

In home care, 72% (n=304) of patients surveyed within a month or so of initial contact said that in relation to the problem that was of greatest concern to them ‘things had got much better’ or things had got a little better since the nurse started visiting them. The home care team had made a ‘great’ or a ‘very great difference to how things are going at present’ to 60% (n=252) of those surveyed.

Eighty five percent (n=247) of bereaved carers said that the care from the home care team was exceptional’ or ‘excellent’
### St Christopher’s summary clinical governance overview (April 2013- March 2014)

#### Written complaints
- Number received: 8 (2 upheld; 4 partly upheld)
- **Written complaints by 6-month period**
<table>
<thead>
<tr>
<th>April-Sept 2013</th>
<th>Oct 2013 -March 2014</th>
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<tr>
<td>3</td>
<td>5</td>
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</table>
- **Oral complaints** n= 3 (not upheld/not possible to substantiate)

#### Service User Experience
- **SKIPP** - in relation to their most pressing concern
  - IPU/Linden: Things have **got a little/much better** since admission = 77% (n=128)
  - HC: Things have **got a little/much better** since the nurse started visiting =72% (n=304)
- **VOICES-SCH**
  - 88% of carers (n=59) thought that the patient had received **exceptional** or **excellent** care from the ward nurses
  - 85% of carers (n=247) said that the care the patient received from the SCH/HH home care team was **exceptional** or **excellent**

#### Incidents

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<tr>
<td>Total clinical incidents:</td>
<td>81</td>
<td>54</td>
<td>77</td>
</tr>
<tr>
<td>Total health and safety incidents</td>
<td>17</td>
<td>24</td>
<td>22</td>
</tr>
<tr>
<td>Total medical device incidents:</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Total information security incidents</td>
<td>9</td>
<td>12</td>
<td>9</td>
</tr>
<tr>
<td>Total medicine-related incidents</td>
<td>44</td>
<td>35*</td>
<td>n/a</td>
</tr>
<tr>
<td>Total n of RIDDOR reports:</td>
<td>3</td>
<td>1</td>
<td>2</td>
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* Relate to Linden ward

#### Notifications to Care Quality Commission
- Serious untoward incident n=1
  - (pressure sores) n=2
  - Fracture n=1

#### Completed actions arising from incidents, alerts and risk assessments, and after event reviews:
- Requirement to report SUIs to CCG incorporated in incident reporting policy and review & revision of suicide policy
- Case study relating to a complaint included in training for clinical teams on assessing and caring for people with end stage dementia
- Reminders to staff about following procedures e.g. re faxing, printing and photocopying (re information security)
- Review of IT back-up systems at alternative site (SCH-Bromley) Patient safety training and root cause analysis training arranged for managers/senior managers
- Case study relating to a complaint included in clinical update training ‘when good care goes wrong’.
- Reminders issued to staff about timeliness of RIDDOR reporting

#### Alerts
- **Total alerts from CAS**
- **CAS alerts on which action required and taken**
- **Total MHRA drug alerts**
- **n. MHRA alerts on which action required and taken**

#### Infection control
- n patients during period who developed C Diff / MRSA while on Linden*
  - C Diff: 2
  - MRSA: 0

* = patients admitted with unknown infection status who develop symptoms 3 days or more after admission.
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Feedback from patients and carers

Feedback from patients and carers is one of the most important ways in which St Christopher’s measures the quality of the care we give. We receive many compliments and positive comments from patients and families. Here is a selection from the most recent surveys of patients and bereaved carers:

“I enjoyed meeting the team and working alongside them. I felt really empowered with all the knowledge I gained from them at the time when my mother was very poorly”
(Home ward patient’s daughter)

“Superb. We could not have enabled my father to die in peace and with dignity without the attentive sensitive care and support from the nurses”
(Inpatient’s son)

“I cannot speak highly enough of the team; they took time to explain everything very well and gave the family a lot of support.”
(Home care patient’s relative)

“Those who called on us were very caring and extremely helpful, particularly with practical matters like the Blue Badge and Disability Living Allowance”
(Relative of home care patient in receipt of support from St Christopher’s welfare officer advice and support)
“I’m alive because of St Christopher’s. The treatment has brought out qualities in me I didn’t know I had. The negative side of my life doesn’t exist, and because of what I’ve received here I can cope with it.”
(Day centre patient)

“I’m not using a wheelchair now, I’m using a stick, which I didn’t have the confidence to do before. I’ve come on leaps and bounds.”
(Patient attending rehabilitation gym sessions)

“I love the social feeling, that there are people round you, the feeling that you are very welcome. I made myself come and it was worth the effort!”
(Day centre patient)

“All nurses were just so kind to me and gave me strength when it was so needed. Their strength & kindness couldn’t have been better.”
(relative of Inpatient)
Lewisham CCG recognise that the closure of the in-patient wards during 2013/14 has been very challenging for St Christopher’s staff. We applaud the way staff adapted to this change and worked alongside staff in the NHS to ensure that high quality care continued to be delivered to all patients.

As a Joint Commissioning Unit we particularly welcome St Christopher’s initiatives towards working with Social Care to deliver personal care to end of life patients and look forward to this venture developing and expanding.

(Corinne Moocarme, Associate Director, Physical Disability, NHS Lewisham Clinical Commissioning Group) Endorsed by Richard Croydon, Commissioning Manager & Continuing Healthcare Lead, NHS Lambeth Clinical Commissioning Group; Peter Lewis Senior Community Commissioning Manager, Bromley Clinical Commissioning Group; Kate Moriary-Baker, Head of Continuing Care and Safeguarding, Southwark Clinical Commissioning Group

Croydon CCG also applauds St Christopher’s for all the hard work given to the patients and also the support provided. We look forward to continued close engagement with St Christopher’s and our community and primary care teams to further improve experience and outcomes for patients, carers and relatives. We will also focus on aligning safeguarding reporting procedures.

Cynthia Abankwa, Commissioning Manager, Older Adults, Croydon Clinical Commissioning Group

Healthwatch Bromley commentary on St Christopher’s Group Quality Account 2013-14

Healthwatch Bromley welcomes the opportunity to comment on St Christopher’s Group Quality Account for 2013-14. From a Healthwatch Bromley perspective, this is a particularly positive and encouraging report which has a clear central focus on patients/people using St Christopher’s services and their carers (family/friends) through:

1. Service quality
2. Training and development of staff and volunteers
3. Service development to improve quality, respond to patient need and respond to patient and carer feedback. For example, there is a good pathway of recording end of life care wishes from patients/ families.
4. Partnership working at all levels
   • inter-organisational e.g. pilot projects with CCG’s, with Local Authorities and with Further Education
   • inter-professional e.g. academic researchers, care home staff, primary care
inter-personal e.g. patients, carers, volunteers

5. Research and evaluation to add to evidence base and support service development across the Group and with their partner providers.

The areas identified as priorities for improvement in the coming year: patient safety, patient experience and clinical effectiveness, maintain the focus on individualised patient care, learning and skill development and effective communication and information sharing. There is also a clear commitment to regular auditing and good use of innovative clinical research to support palliative care.

The review of 2013/14 indicators indicates a well-managed refurbishment programme and temporary ward and extended home care services. It would be useful to see the result of the bereaved carer survey to be completed mid-2014.

The evaluation of the personal care pilot programme in Croydon suggests a successful outcome with positive client feedback and it is encouraging to see that a further year was commissioned. In due course it would be helpful to know the outcome and when there will be more information about the pilot now running in Bromley. It is good to see that the evaluation of patient and carer experience was done across different service areas (in-patient at St C’s, NHS hospitals and at home).

The clinical audits appear comprehensive and include a number which indicate a very strong focus on improving patient experience (e.g. admission waiting times, patient consent to interventions, falls prevention, discharge and communication). It would be particularly useful to see more about the audit of care home deaths and the programme to reduce the number of inappropriate deaths in hospital of care home residents.

We look forward to working with St Christopher’s Group over the coming year to achieve the best possible patient experience.

Healthwatch Bromley, June 2014
Opportunities to give feedback on this quality account

We welcome feedback on this quality account. If you would like to do this, please email b.monroe@stchristophers.org.uk or write to:

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