

St Luke's Hospice

adding quality to life

Strategy

2006 - 2011



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Introduction

We are absolutely delighted to bring you our new strategy outlining the plans we hope to achieve over the next five years. This is the culmination of much consultation, discussion, observation, involvement and feedback and we hope it reflects the best possible way forward for St Luke's Hospice.

It is never easy to bring about change, particularly when an organisation has such an enviable reputation as St Luke's Hospice. However, the need to change is evident to ensure our survival in the years ahead, to allow us to grow and to allow us to do what we do best, caring for those needing our services. We also know that we need to be more inclusive, particularly involving patients and carers in our decision-making, and increasing accessibility and availability of all our services to those who need them the most.

Misconceptions about hospice care continue to abound and there are evident misunderstandings about how we are funded. This lack of understanding suggests that we need to do more work listening to and communicating with our supporters. Our strategy, therefore, looks at ways of overcoming these misconceptions.

Increasing costs, legislation, competition for funds, competition for staff and changes in practice mean that St Luke's Hospice has to work hard to stand still and even harder to make further progress. We need to consider the future of all our services in a constructive and logical way to ensure we are secure. In order to make difficult decisions, we need to be mindful of the funding we have available and the rigorous and objective review of the effectiveness and value of the services we provide.

However, the signs are good as we readjust to meet the needs of the 21st century. Our staff and volunteers continue to show the commitment they have given for many years. Our loyal supporters throughout Sheffield and beyond continue to pledge their time and money in the face of increasing demands on our resources.

Changing St Luke's Hospice to meet the demands of the next five years and beyond will be a challenge, but with the right financial support and the continued commitment and loyalty of our supporters, staff and volunteers, we will achieve this strategic plan.

Andrew Coombe
Chairman of the Board of Trustees

Steve Kirk
Chief Executive

Our heritage

For over 34 years, St Luke's Hospice has cared for people from the Sheffield region who have palliative care needs and terminal illnesses. It is based on the concept of the 'modern' hospice originated by Dame Cicely Saunders, which culminated in the opening of St Christopher's Hospice in London in 1967. Largely due to the vision and tenacity of our founder Professor Eric Wilkes, we subsequently opened as the UK's first provincial hospice on 1st October 1971.

Our base was our current site. Originally, the Hospice had 25 beds, reserved exclusively for extremely ill people needing immediate palliative care. We then opened the world's first ever day hospice - a model, subsequently, much-copied nationally and internationally - to provide specialist day-care, medical advice and support to patients living at home. The bereavement service began soon after, to support grieving families and friends.

Community support was always a key aim and, in 1975, we introduced a dedicated service, later named the Sheffield Macmillan Support Team in recognition of the partial funding by Macmillan Cancer Relief at that time. Latterly, known as St Luke's Hospice at Home team. The team consisted of specialist palliative care nurses who took our care into the wider Sheffield community, providing specialist nursing, medical advice and support to patients living at home.

As an important national centre for education and research into palliative care, we officially opened our Education Department in 1977, the year our palliative care course for qualified nurses was given professional recognition. This course played an important international role in introducing and establishing the education of specialist clinical professionals in palliative care, and subsequently led to degree and postgraduate level qualifications in the specialism.

We opened another day hospice at Beighton in 1993. Wheata Day Hospice, at Parson Cross, followed in 1995. The 24-hour helpline we introduced in 1997 enabled patients, their families and carers, GPs and other health professionals, who had serious worries or concerns, to access immediate advice and information. By 1998, having identified the need to provide beds for non-emergency patients in need of respite stays, we relocated the day hospice patients from the main building and established an eight-bed respite unit.

We were an undoubted pioneer in the hospice movement, and in working with the primary health care team throughout the whole of Sheffield.

The reasons for recent and future change

When the Hospice opened, it was revolutionary. It launched into a world which knew very little about the special care needs of the dying and those close to them. The government, and the medical and nursing professions, concentrated on the care of those who could be cured. Terminally ill patients, themselves, had no expectations. St Luke's Hospice and the other early hospices gradually made their impact, especially in the area of research and teaching, and moral argument.

Over the following three decades, the likes of Eric Wilkes, our founder and former Medical Director, influenced public opinion. World Interests and priorities moved on and developed, accepting palliative care as a necessity in a modern society.

By the 1980s Professor Wilkes was able to write:

'Centres of medical and nursing training should have available specialist units of a hospice type. I believe this is right. Only in this way can we maintain the teaching and research that over such a brief period of time has made the comparative neglect of the dying totally unacceptable today. In this I hope and believe St Luke's Hospice has had and will have both a local and an international role to play, and I am proud to have been associated with such a wonderful unit.'

But with success, St Luke's Hospice gradually acquired external and, later, internal pressures. Over time, those have increased, fuelled by a range of national and local developments and initiatives focussing, or impacting, on palliative care in a number of ways.

Clearly, the time is now ripe to review our operation and to build sound communication and working relationships internally and externally to fit us for the future.

We must clarify and promote our role as the established provider of free, expert, patient-centred palliative care for those people in our region who need it most, regardless of their social or cultural background, colour, location or income. And we must ensure that our unique position as Sheffield's Hospice is understood by health professions and general public alike, particularly our long-standing care of those who are in the advanced stages of any incurable illness, not just cancer.

We must work proactively with our NHS partners and others working in the same field, such as the Cavendish Centre, to develop palliative care provision and help GPs and hospital clinical teams ensure that all patients needing palliative care have access to it, regardless of the diagnosis. This should redress the traditional balance of bias towards cancer patients. And we need also to share our vast expertise by developing education and training programmes to increase palliative care skills and knowledge throughout our own team,

hospital teams and also in community-based services such as care homes, residential homes and primary health care teams.

National pressures

In the early 1990s, Virginia Bottomley, the then health minister, introduced the 'Hospice Grant' scheme which enabled hospices to be part-funded through contracts with the NHS. Prior to this St Luke's Hospice had been extremely fortunate to have received generous support from the former Sheffield Health Authority.

The Hospice Grant Scheme generated much needed additional resources for hospices around the country and started a trend where hospices worked increasingly in partnership with the NHS in return for partial funding.

In 2000, in addition to our long-standing responsibilities to The Charity Commission, the Healthcare Commission was given the responsibility for inspecting hospices - including St Luke's Hospice - to ensure that they were being managed professionally and effectively in fulfilling their roles as prime palliative care providers. At this time, our management and administrative structures, and operational procedures, had changed very little from the Hospice's early days.

In 2003, our Council of Trustees, (who were established at the original St Luke's Hospice inception), have overall legal responsibility for the running of the Hospice, received recommendations from The Charity Commission to update certain elements of its structure in line with current best practice. As a consequence, the Council decided in November 2005 to combine with the Hospice's Management Committee (previously named the House Committee), whose role had centred on more operational activities, to form a Board of Trustees, with two subcommittees, one entitled Clinical Governance, and the other Resource and Finance, which would support both the Board of Trustees and the Hospice's senior managers.

The Charity Commission review visit also resulted in a decision by the Trustees to review the Hospice's senior management structure and to move away from the triumvirate, shared leadership, model to the modern concept of leadership employing a Chief Executive.

The Chief Executive joined St Luke's Hospice in November 2004 and in May 2005, the Trustees and House Committee approved a new organisational structure to lead St Luke's Hospice through expected changes over the next five years. The aim of the new management team was to produce a medium to long-term strategy, for the period 2006 - 2011 and onwards, that would enable St Luke's Hospice to re-establish itself as the leader in the field of modern hospice care. The strategy would also enable staff, volunteers and supporters to understand the direction St Luke's Hospice must take in order to assure patients, and their families, of the high quality care that they have held so dear over the last 35 years.

In addition to the recommendations cited above a number of other influences need to be considered that will inform the way we develop. These are the NHS Plan (DOH 2000), the development of Cancer Networks, Improving Outcomes Guidance and the Supportive and Palliative Care Guidance as part of the NHS Cancer Plan (DOH 2000) and the recently published Standards for Better Health (DOH 2004).

The Hospice will also need to react to current changes within the NHS, specifically the decision to introduce practice-based commissioning and 'payment by results'. This decision by the government will result, not only in PCTs devolving substantial budgets to individual GP practices so that they can commission the services their patients need directly from the provider, but also enable particularly efficient and effective practices to commission long-term care for patients with long-term conditions.

While, in time, this decision should result in increased revenue for the Hospice, the amount is not guaranteed and may not be received for a number of years.

Funding which we are expecting to receive somewhat earlier is that resulting from the reorganisation of the NHS which, by reducing the number of PCTs and Strategic Health Authorities, will make substantial savings in administrative costs. Some of this money has already been pledged to extending cancer treatment and palliative care services, including those offered by St Luke's Hospice.

Local pressures

Over the years, St Luke's Hospice was joined in its specialist care of the terminally ill, by specialist palliative care teams based at all the Sheffield Hospitals and, in 2002, by the Macmillan Palliative Care Unit on the Northern General Hospital site.

In 1997, the City of Sheffield examined how local people with palliative care needs were supported and produced a planning document entitled 'A Palliative Care Strategy'. For the first time, the palliative care needs of the people of Sheffield and the co-ordination of their specialist providers was examined as a whole, with the aim of planning and co-ordinating a seamless, comprehensive service to best meet their users' needs.

Since the Department of Health's recent investment in palliative care and the publication of the NICE Guidance for Supportive and Palliative Care in 2004, this strategy was subsequently revised and extended in 2005 as the 'Sheffield Supportive and Palliative Care Strategy'. St Luke's Hospice features as an important part of that strategy and it is vital for the future of our work that, from now on, we work in close partnership with other palliative, health and social care providers to ensure that all palliative care patients, and their carers, have a full range of services from diagnosis to death, and that their families are supported throughout this time and into bereavement. But, rather than simply state this intention, we now must modernise and update our culture and organisational structure to make such collaboration effective and fruitful.

Financial pressures

In the pursuit of constantly improving and developing our services, with rising building and staff costs and other operational overheads, our current annual running costs are almost £6million. The NHS provides £2million towards this amount. Consequently, in 2006, St Luke's Hospice itself needs to raise £4million. This situation will be further compounded in subsequent years by rises in inflation, the need to be guided by the NHS in reviewing our staff terms and conditions of service, and competition for charity funding.

With reserves which would keep the Hospice open and operational for only six months, should all contributions and support from the general public cease, we now need to put effective plans into place which will provide more financial security for the future.

Physical pressures

The site for St Luke's Hospice was given by British Steel with a covenant restricting the use of the site to a nursing home. In 1971, the Hospice was built, based on the model of a 1960s hospital. It is now bordered on all sides by residential housing.

The operational demands we now place on the building and the site, and the volume of both the people we care for and the staff who provide or support that care, expose it as inadequate for the needs of a 21st century hospice.

Operational pressures

The Hospice has traditionally operated with a small administrative infrastructure. There is an urgent need to develop internal departments dedicated to clinical and patient and family/carer services, personnel management, finance, IT and management information, buildings and estates, fundraising, PR and communication – and we must establish a consistent, corporate visual identity as a priority.

A questionnaire completed by 300 staff and volunteers in 2005, identified a number of operational areas which were in urgent need of review. This strategy will address their concerns and positive suggestions.

Our purpose and philosophy

We work hard to enhance quality of life for our patients and their families near the end of life, when it can be especially precious.

The type of care we provide is defined as palliative. This treats and eases serious, and often distressing and debilitating, symptoms of terminal illness without actually curing it. Our care is also fundamentally holistic, treating the person as a whole because life-threatening illness unsettles the mind as much as the body. Here, at St Luke's Hospice, doctors and nurses and other professionals interweave their expertise to provide multi-faceted treatments to meet the differing needs of each patient and his or her family. That care is more than just physical. It also concerns psychological, emotional and spiritual well-being.

The following statement is a guide for everyone in the St Luke's Hospice community, including staff, volunteers, patients and their family and friends

St Luke's Hospice exists to give free, expert care to local people aged 18 and over who have active, progressive and advanced, life-threatening illnesses.

Our team of nurses, doctors, therapists, counsellors and social workers are all specialist-trained and experienced in the type of intensive care that such people need. Together with our dedicated volunteers, and catering, domestic and maintenance staff, our aim is to care for each patient, body and soul, heart and mind. They also support and advise the patient's close family and friends throughout the illness and beyond.

Peace of mind, contentment and freedom from pain and other symptoms are central to everything we try to do for those in our care. We work hard to improve the quality of life for everyone at St Luke's Hospice, whatever his or her personal circumstances, needs or role may be. Everyone should know St Luke's Hospice as a place where each person really matters.

In all our work we are guided by the desire to treat everyone fairly, equally and honestly. Our staff and volunteers respect and support each other and our patients, their families and friends throughout the illness and beyond, regardless of race, social or cultural background or belief. We believe that communicating constantly, clearly and sensitively is the key to mutual understanding and acceptance.

In the future, as now, we shall work closely with local hospitals, care homes, council departments and the NHS to further develop exactly the range of care and support services, which all people with life-threatening illnesses need and deserve.

Our guiding principles, all equally important, are that:

1. we respect and try to meet every person's specific needs whether he or she is a patient, relative or friend, member of staff or volunteer
2. our staff and volunteers work as a team, providing care in line with the latest research and evidence

3. maximising quality of life is paramount in the care and support we provide
4. the close partnership between our staff and volunteers, and those in our care, is fundamental to our work
5. we are sensitive to each person's thoughts and feelings and protect confidential information at all times
6. everyone should be able to express his or her thoughts, opinions and emotions, providing these are not offensive to others.
7. we work hard to meet the medical, nursing, emotional, spiritual, psychological, therapeutic and social needs of everyone in our care
8. we accept that everyone is entitled to dignity, respect, courtesy, consideration and privacy
9. staff and volunteers are supportive and encouraging, empathetic, fair, objective and non-judgmental when dealing with those in their care, and each other
10. we share freely the reasons for our actions and decisions with those they affect directly and try to include them in our decision-making
11. we recognise a person's right to see any information concerning them
12. sensitivity, honesty and respect govern all verbal and written communication involving staff, volunteers and the people in our care
13. the information we provide, and the language we use, is tailored to the needs of those receiving it
14. we encourage the development of the knowledge and skills of our staff and volunteers in line with the Hospice's vision for the future
15. we continually review and develop policies and procedures which ensure high quality care for all
16. we encourage a positive attitude to any changes which improve our services
17. we encourage users of our services to give us constructive feedback
18. no-one working for the Hospice is anonymous

Above all, we treat each person equally, respecting his or her individual wishes, personal beliefs, religion, sensitivities and culture, and valuing every one as a whole, unique person, regardless of his or her social and economic background, race, abilities, sexuality, or mental and physical needs.

The way ahead: our vision for the future

We know our strengths*. They are our dedicated, passionate and committed staff and volunteers, the high quality care that our multi-professional teams provide, our 35-year track-record of providing excellent palliative care, and the love of the Sheffield community, which holds St Luke's Hospice in high esteem.

We also have weaknesses*, which mean that our future success, indeed our future existence, is not guaranteed. However, we have the necessary skills, experience and expertise to make us excellent in our field, to return us to the vanguard of modern hospice care and to secure our future.

In order to succeed, staff, volunteers and our supporters need to work together as an effective team, starting now and over the next five years and beyond. Our prime purpose is to provide the best patient-centred palliative care we possibly can to the people who need it the most.

*** see appendix 2**

Summary of strategic aims

1. Putting patients first

To be guided, at all times, by our prime purpose of providing free, expert, patient-centred, specialist palliative care and support to the people in our region who need it most, regardless of their social or cultural background, colour, location, income or special needs.

2. A guide for us all

To apply our purpose and philosophy to our dealings with each other and the wider community, and to all areas of our work

3. Planning for the future

To set strategic aims for our future work and its development

4. Building our infrastructure

To build a technical and managerial infrastructure that befits a modern, efficient organisation

5. Good business practices

To adopt accepted good business practices for our administrative and financial accounting systems

6. Guided by policy

To devise and regularly review a comprehensive set of rigorous policies and procedures which govern our work

7. Building relationships

To build relationships and establish good communications, both internally and externally

8. Securing our finances

To address the issue of our financial security by establishing an efficient and effective fundraising and marketing strategy to increase our sources of regular income.

9. Premises fit for our purpose

To ensure we operate from premises best suited to our planned level and range of service

10. Research

To work to regain our research status

11. Education and training for those who work at St Luke's Hospice

To develop a comprehensive education and training programme for staff and volunteers

12. Changing our culture

To establish a culture which is supportive, inclusive and open to change, with staff and volunteers committed to providing the highest quality of care to those who put their trust in us

Executive Summary

Core Objectives

1 All departments

- 1.2 As a matter of priority, every department will organise group discussions and practical workshops which will enable **all staff and volunteers** to contribute to shaping new procedures covering all areas of their work in line with our purpose and philosophy and its guiding principles.

2 Bereavement

- 2.2 We need to develop a strategy for bereavement care looking at elements of volunteer support and the provision of counselling, and other areas such as children's grief, complex grief and the use of explicit referral systems.

3 Buildings and Estates

- 3.19 Accepting the restrictions imposed by the size, location and geography of the site, and in the interests of our patients, families, staff, volunteers and immediate neighbours, we have decided to sell the current site and rebuild on a site chosen to meet the needs of the Hospice unless we meet obstacles which make such an intention impossible.
- 3.20 We shall also need to take a number of short term building measures to improve the internal layout prior to any relocation. This will be to improve accessibility, efficiency and improve the building during the three years or more it will take to plan, fund and build a new hospice.
- 3.21 We shall develop and launch a capital appeal to support the building of the new hospice.
- 3.22 We shall work with other partners eg Passenger Transport Executive, South Yorkshire ambulance etc to try and improve transport to and from the hospice for patients, visitors, staff and volunteers.

4 Clinical Quality

- 4.10 A representative Clinical Quality Group will be established and led by the Director of Medicine and Clinical Governance, to report to the Clinical Governance subcommittee of the Board of Trustees.
- 4.11 We shall develop a strategy for an integrated multi-disciplinary team, including medicine, nursing, therapies and social work, which will

provide clear direction, strong leadership, support for staff, consistency and development.

- 4.12 Therapy services will be reviewed and based on need, prioritised accordingly and managed through a formal referral system which ensures that those making decisions about referral have adequate knowledge of the therapies on offer and their effects and benefits. To help this process, we will define a therapeutic model and therapeutic practice.
- 4.13 We will review medical staffing needs to ensure that we can provide both senior and junior medical support to all services at all times.
- 4.14 Patients and carers will be represented on the Board and on Clinical Governance groups and we shall introduce a patients' and carers' user group which will meet regularly and feed back views on all aspect of the Hospice's care.
- 4.15 Clinical services, will be guided by the development of their own long term plans linked to this strategy ensuring the development of advanced practice and including new roles of advanced practitioners and consultant therapists (nurses / Allied Health Professionals).
- 4.16 We shall involve clinical staff in sharing expertise, practice development and raising standards in the sector by, for instance, writing for professional journals, publishing research or taking part in sector-specific events.
- 4.17 We shall develop our systems for collecting data on complaints, incidents, and near misses to ensure it is comprehensive throughout all areas of the Hospice, learning from them and using them to shape future direction.
- 4.18 We shall follow the agreed Sheffield eligibility criteria for referral for palliative care and, as such, will care for anyone in need of palliative care, regardless of diagnosis. These criteria will also guide our review procedures.
- 4.19 With the aim of redressing the imbalance in the cancer: non-cancer ratio of our patients, our clinical team will work proactively with GPs and hospital clinical teams to increase the percentage of referrals for non-cancer patients in need of palliative care and to promote the range and benefits of hospice care specifically.
- 4.20 We shall work closely with the new Sheffield Primary Care Trust and GP practices to maximise opportunities provided by practice-based commissioning and 'payment by results' and in identifying, reviewing and improving, where necessary, patient pathways to palliative care. Linked to this, we shall support further the promotion and adoption of evidence-based protocols for specific illnesses and symptoms.

- 4.21 While monitoring referral procedures and statistics to ensure that our services reach those most in need, we shall routinely compare the cultural and social profiles of our patients to that of Sheffield as a whole. Should they not be proportionate, will investigate and identify the reason for this with the aim of overcoming any possible barriers to access.

5 Community Service

- 5.4 As far as financial resources will allow, we want to work jointly with those who also provide and/or support palliative care in Sheffield, such as the Cavendish Centre, the Weston Park Cancer Information & Support Centre, Intensive Home Nursing Service and the Macmillan Palliative Care Unit at the Northern General Hospital, to develop for patients with palliative care needs and their families a co-ordinated and comprehensive 24 hour service wherever the patient would like to be.

We would welcome working with the Macmillan Palliative Care Unit, Intensive Home Nursing Service and primary care services to develop further the 24-hour helpline and face to face advice to ensure all those who need access to a palliative care professional with primary care experience, have that access.

- 5.5 We intend to undertake a formal review of all services in the community, looking at staffing levels, referral systems, eligibility criteria, prioritising systems and resources, and benchmark these against other organisations.
- 5.6 If, following the formal review of a patient's needs, care at home is clearly the best option, we shall work with our partners in the community, such as the Intensive Home Nursing Service and district/community nurses, to give as much home support for that patient as our financial resources and staffing levels will allow.

6 Day Hospices

- 6.13 We shall relocate the day hospices to the main building and merge them with the rehabilitation department and rename as the Therapies and Rehabilitation Centre, providing support for up to 20 patients a day. This will enable us to increase the services available to our day patients and to ensure our staff and volunteers are supported and up-dated continually. It will enable those of our multi-disciplinary team who routinely commute between the main site and the day hospices to see patients during the time they would otherwise have spent travelling, and enable the full multi-disciplinary team to fully assess each patient, at least every ten weeks, in line with agreed eligibility criteria for Sheffield for palliative care. This will ensure that our specialist services are received by those who need them the most, and that the limited

services currently available to day patients is extended to the full service we offer to our in-patients.

- 6.14 We will develop flexible working and cross cover/sickness cover throughout clinical areas, provide more opportunity for education and training for staff and students, integrate patients' views into research which informs the development of our services, and enable better supervision of staff and care, in line with agreed standards.
- 6.15 We shall offer a full therapeutic range of services on a menu basis and ensure regular medical involvement through a minimum of twice weekly sessions, and as required.
- 6.16 We shall regularly review patients attending, and prioritise referrals, to ensure we are offering therapies and rehabilitation to those most in need.
- 6.17 We will work with other providers of day therapy and rehabilitation services to ensure economic use of resources and prevent duplication.

7 Clinical Learning, Education, Audit & Research

- 7.10 We shall base the Clinical Learning, Education, Audit and Research Institute (CLEAR) in a state-of-the-art Conference and Education Centre to provide both a centre of excellence in clinical education and a source of income. The new building will be located at the Hospice to maximise access to specialist palliative care professionals and to minimise cost.
- 7.11 We shall ensure that practice development, i.e. the development of excellence in clinical skills, is a key role of the CLEAR Institute through the development of a strategy and structure that underpins all clinical education and training at the hospice.
- 7.12 We shall appoint a lead person for the CLEAR Institute, who will, with support from the Sheffield Universities, raise the profile of research and audit as part of the CLEAR Institute's role. We shall consider joint appointments with the universities to facilitate the link between theory and practice and provide succession opportunities.
- 7.13 We shall work towards combining the facilities of the TPCC and the St Luke's Wilkes Education and Resource Centre, into a state of the art Conference and Education Centre, making both more efficient and economic as well as maximising resources for palliative care education in Sheffield.
- 7.14 The CLEAR Institute will work in partnership with the Trent Palliative Care Centre to ensure the Conference and Education Centre meets the needs of both organisations, if that is possible.

- 7.15 We shall comprehensively review the role of academic education at the Hospice as part of the development of an education and training strategy, to ensure the availability of the highest quality of education, and assess its affordability and value-for-money.
- 7.16 We shall also give further consideration to developing the audit and research agenda through the appointment of a lead in that area as part of the CLEAR Institute.
- 7.17 We shall assess the need within community-based services such as care homes for palliative care training/education and develop a programme to meet that need.
- 7.18 We shall maintain and strengthen our relationships with the Sheffield universities and with the School of Medicine and any other institutions involved in clinical training.

8 Finance

- 8.11 We shall review, implement and maintain effective accounting systems to provide a seamless financial framework for the whole organisation.
- 8.12 We shall provide a responsive information system of relevant, accurate and timely information to aid the management and control of the organisation.
- 8.13 We shall strive for organisational effectiveness and efficiencies, eliminating duplication, implement costs control initiatives and maximising all our resources.
- 8.14 We shall secure income streams to provide continuity for long term planning of Hospice Services.
- 8.15 We shall implement performance measures to guide day to day activities and assess the organisation against its objectives.
- 8.16 We shall provide departmental accounting and budgets, to provide accountability by HOD's and individuals.

9 Hotel Services

- 9.7 Hotel and hospitality services are developed in such a way that they clearly meet the needs of each area and are focused on the individual needs of patients i.e. individualised plated meal service offered through a hospitality department.

- 9.8 Domestic and laundry staff will join together to provide a new, well co-ordinated housekeeping department.

10 Income Generation/Marketing/PR and Communication

- 10.9 We must ensure our main message is that we are guided, at all times, by our prime purpose of providing free, expert, patient-centred, specialist palliative care and support to the people in our region who need it most, regardless of their social or cultural background, colour, location or income.
- 10.10 We must establish a strategy that will increase annual income to £8 million by 2011 with the focus on sustainability. Initial priority areas are likely to be community and local business fundraising, legacy development and fundraising from trusts and community foundations.
- 10.11 We must develop a comprehensive strategy to grow the retail network, increasing the net income by increasing the number of shops, through purchasing or leasing, to a minimum of 15 over the next five years (i.e. one to two shops per year) and then review again, ensuring a new shops strategy provides the right personnel support.
- 10.12 We must set up a capital appeal to raise at least £14million by 2009 to support the redevelopment of the Hospice.
- 10.13 We must develop a fundraising strategy to raise our annual revenue spend, as well as any capital commitments over the next five years.
- 10.14 We must better communicate what St Luke's Hospice stands for, as well as what it does, ensuring all communications (including corporate publications, the web-site, signage, correspondence and promotional material) are consistent and reflect the spirit of the Hospice.
- 10.15 We need to review the St Luke's Hospice visual corporate identity to determine whether it projects the image and message we want it to project and to act accordingly if it does not.
- 10.16 We need to carry out market research to identify and understand the needs of St Luke's Hospice key audiences and to measure how far it meets these needs.
- 10.17 We need to develop specific plans to market St Luke's Hospice services to professional audiences including specialist palliative care services.

11 Information, Communications & Technology

- 11.6 We shall establish an Information, Communications and Technology department to lead the support and development of services, particularly focusing on developing IT skills, capturing information, improving efficiency and reducing cost throughout all departments. In addition the role can contribute to the Staff Development Unit education and training strategy led by the Director of Personnel & Volunteers.
- 11.7 We shall develop integrated databases for patient care, finance, donors and personnel to enable analysis and information to be provided in an efficient and timely way.

12 Inpatient Unit

- 12.8 We shall reduce bed numbers to 30, in line with actual median usage and within national recommendations, (this may include an additional two beds to cope with occasional peaks in demand).
- 12.9 We shall continue to provide and further enhance our ability to offer admission to beds 24 hours/seven days a week.
- 12.10 Although the Hospice is renowned for providing high quality nursing and clinical care, we shall work further towards clinical excellence as a top priority.
- 12.11 We will work with the Sheffield Primary Care Trust, Sheffield Social Services, and any other service with an interest, in ensuring the city caters for the needs of those individuals with long term neurological conditions, and / or long terms disorders of younger people (under 65) whose illness, ultimately, will be terminal, by developing a system of access to planned and pre-bookable holiday relief beds

13 Personnel and Volunteers

- 13.8 We shall establish and develop the personnel department to enable them to fully support the Hospice in applying best management practices by providing clear and comprehensive personnel policies and procedures. These will support a professional recruitment process and a fair and equitable management approach.
- 13.9 An overall review of the roles and responsibilities of volunteers will be undertaken with Heads of Departments to develop these to meet the changing needs of the Hospice.
- 13.10 We shall develop a non-clinical education and training strategy in parallel with the CLEAR Institute and look at partnership with other organisations, such as the NHS and higher education institutions.

- 13.11 We shall review all terms and conditions of service and including pension provision through the development of a job evaluation and pay review system taking into account the issues around attracting and keeping high calibre staff and the implications of the NHS Agenda for Change.

14. Psychological and Spiritual Care

- 14.6 A strategic review to be undertaken to establish the range, level and availability of psychological services required in the hospice. The review to recommend those essential services and those that could be made available dependent on additional resources being secured.
- 14.7 Spiritual care to be highlighted as a key service that is made available to all patients and carers 24 hours a day seven days a week. Therefore a review of the lead role is essential to ensure this role provides leadership and support to the patients and carers, staff and volunteers and ensures the hospice provides in excess of the minimum standards for hospice chaplaincy (6).

15 Trustees

- 15.4 We need to raise the profile of the Board of Trustees, which has now superseded the Council and the Management Committee, through regular visits of their members to the Hospice, including presentations from individual departments.
- 15.5 The membership of the Board of Trustees needs to include representatives from patients / carers, volunteers and from black and minority ethnic groups where practical.
- 15.6 We shall also establish a patients' and carers' user group whose views about our services, accommodation and communication, and all policies and procedures affecting these, will feed back via those representatives mentioned in point 15.5 to the Clinical Governance subcommittee of the Board of Trustees and the Board of Trustees.

Core objectives

1 All departments

- 1.1 Every department within St Luke's Hospice needs to review the planning and operation of its service in line with this strategy and its implications for them and to ensure cost savings and seeking more efficient working practices where possible.

Objective

- 1.2 As a matter of priority, every department will organise group discussions and practical workshops which will enable **all staff and volunteers** to contribute to shaping new procedures covering all areas of their work in line with our purpose and philosophy and its guiding principles.

2 Bereavement

- 2.1 The bereavement service has recently been established as a separate department in recognition of the importance of this service to the work of St Luke's Hospice. The service consists of a strong team of volunteers supervised by the bereavement service co-ordinator. It offers one-to-one and group support and is beginning to integrate counselling into the service.

Objective

- 2.2 We need to develop a strategy for bereavement care looking at elements of volunteer support and the provision of counselling, and other areas such as children's grief, complex grief and the use of explicit referral systems.

3 Buildings and Estates

- 3.1 The site for St Luke's Hospice was given by British Steel and is under a covenant restricting the use of the site to a nursing home. It is also in a residential area.
- 3.2 The St Luke's Hospice design is based on an early 1960s hospital model. However, the majority of hospices since the early seventies have moved away from this style to one that reflects a more informal and homely feel. In addition, the age of the building is showing, as is the wear and tear of over thirty years of constant use.
- 3.3 The Hospice was built on a sloping site. Since then, we have added a number of extensions and space is now at a premium.
- 3.4 We also provide accommodation for the Trent Palliative Care Centre (TPCC), which is not part of the Hospice.
- 3.5 **The main ward** is on a level above our medium-sized, well-kept garden, offering lovely views but making accessibility difficult for many patients and their families. There is also a shortage of therapy/interview rooms for use by our therapists, social workers and the bereavement service.
- 3.6 The ward area has 33 beds of which 28 are in six shared rooms, four are single rooms and one is a family room. Evidence exists to show that patients receiving our type of care preferred individual rooms (1).

- 3.7 The Hospice cannot offer a satisfactory standard of **overnight accommodation** to patient's relatives/carers, or provide them with a hot meal at a time best suited to them.
- 3.8 **The mortuary and viewing room** are on a separate level, located at a distance from the main ward. This causes a number of problems with practicality, privacy and dignity. Also, the main mortuary fridges need replacing.
- 3.9 **The reception area** is pleasant, but the main doors are difficult to use, particularly for the disabled, the elderly and parents with young children.
- 3.10 The reception desk and switchboard are located too far apart.
- 3.11 **The main refreshment area** (called the 'Day Room') is currently used by staff, volunteers, patients and relatives as a rest and refreshment area. It splits the main inpatient ward area in half and the entrance to the refreshment area cuts through the ward main corridor.
- 3.12 A conservatory linked to the day room is reserved for patient smoking, and smoke drifts into the day room when it is in use. The current trend is away from smoking provision and a review carried out in 2005 shows that the smoking room is little used.
- 3.13 Clinical staff, often, must use the main reception area for their breaks. Not only does this alter the use and ambiance of the Hospice's foyer, it does not respect staff needs for a private area where they can relax.
- 3.14 **Parking** is extremely limited with the main car park, which provides space for up to 87 vehicles, being full on most weekdays. Many people now park on the road and our neighbours, increasingly, inform the Hospice of associated problems.
- 3.15 A recent audit gave guidance on the best uses of available space within the Hospice, but also showed it insufficient for the services we now need.
- 3.16 An architectural review completed in 2004 concluded that limited additional space for our work could be provided on the current site although there would be implications for the TPCC and the on-site crèche.
- 3.17 It needs a significant financial commitment to create a 21st century building with the space to provide all the support and facilities for one of the largest hospices in the country. Specifically, these facilities need to include homely accommodation, more single rooms, overnight accommodation for all relatives, and an even larger therapeutic garden than we already have, which patients could view from their

beds and access easily. The strategy needs to ensure the Hospice's buildings and estate complements our future vision.

- 3.18 The current state of the building and the need for imminent repairs will result in a cost of over £2million just to keep the building in good condition and structurally sound.

Following the drawing up in 2006 of architectural designs which would give us the 6000 square meterage we need (currently we have 3300 square metres; other hospices providing equivalent services to us have a minimum of 5500) it was clear that, in addition to several years of disruption, noise, mess, inconvenience and loss of peace and quiet for our patients, families, neighbours, staff and volunteers, such a major rebuilding project on our present site would also rob us of our gardens which are so precious to those in our care.

A new tailor-made build elsewhere in a location which would give easier access to people travelling by public transport and from all parts of the city, and more car-parking than we currently have, will cost £14 million plus cost of land (with sufficient space for a substantial garden) but no VAT. These figures are purely indicative at this stage.

Objectives

- 3.19 Accepting the restrictions imposed by the size, location and geography of the site, and in the interests of our patients, families, staff, volunteers and immediate neighbours, we have decided to sell the current site and rebuild on a site chosen to meet the needs of the Hospice unless we meet obstacles which make such an intention impossible.
- 3.20 We shall also need to take a number of short term building measures to improve the internal layout prior to any relocation. This will be to improve accessibility, efficiency and improve the building during the three years or more it will take to plan, fund and build a new hospice.
- 3.21 We shall develop and launch a capital appeal to support the building of the new hospice.
- 3.22 We shall work with other partners e.g. Passenger Transport Executive, South Yorkshire ambulance etc to try and improve transport to and from the hospice for patients, visitors, staff and volunteers.

4 Clinical Quality and Development

- 4.1 St Luke's Hospice has always offered an exceptional level of high quality patient care supported by regular feedback from patients and their families and other health care professionals. Historically the leadership of clinical care has been split between the Medical Director and Matron. Accredited training in palliative medicine was not approved until 1986 and therefore the Medical Director could not have been a consultant until after that date. Since St Luke's Hospice opened, the medical lead

has been held by a GP, albeit one with special interest in, and experience of, palliative care. The new organisational structure clearly puts the lead role with a Director of Medicine & Clinical Governance who has accredited specialist training.

- 4.2 Carers have not traditionally been involved with the development or review of clinical services at the Hospice although surveys have shown a general high level of satisfaction with the current services.
- 4.3 There is a lack of coordination of clinical standards throughout the Hospice with little consistency regarding the standard or level of service or development goals we should be offering.
- 4.4 Each clinical department is responsible for setting and delivering its own standards of care with no group having overall responsibility for leading on clinical quality.
- 4.5 There is currently no designated lead nurse / Allied Health Professionals considering advanced nursing / therapy practice and how nursing / therapy practice is consistently maintained and developed throughout all services.
- 4.6 Therapies are offered to patients in some instances based on location rather than on need. Referral systems are frequently informal with no recording system in place. The therapy services feel undervalued and, at times, unsupported.
- 4.7 There is insufficient consultant sessional time available in the main hospice. The number of sessions needed for a hospice the size of St Luke's Hospice is a minimum of 20 programmed activities (formerly known as sessions).
- 4.8 Systems for managing incidents, accidents and near misses involving patients are inadequate, poorly evaluated and a lack of detailed action plans may compromise quality of care.
- 4.9 Most healthcare employers face significant workforce development issues e.g. skill mix, advanced roles, consultant therapists (nurses, allied health professionals) and career progression for staff and we are not exempt from those challenges.

Objectives

- 4.10 A representative Clinical Quality Group will be established and led by the Director of Medicine and Clinical Governance, to report to the Clinical Governance subcommittee of the Board of Trustees.
- 4.11 We shall develop a strategy for an integrated multi-disciplinary team, including medicine, nursing, therapies and social work, which will

provide clear direction, strong leadership, support for staff, consistency and development.

- 4.12 Therapy services will be reviewed and based on need, prioritised accordingly and managed through a formal referral system which ensures that those making decisions about referral have adequate knowledge of the therapies on offer and their effects and benefits. To help this process, we will define a therapeutic model and therapeutic practice.
- 4.13 We will review medical staffing needs to ensure that we can provide both senior and junior medical support to all services at all times.
- 4.14 Patients and carers will be represented on the Board and on Clinical Governance groups and we shall introduce a patients' and carers' user group which will meet regularly and feed back views on all aspect of the Hospice's care.
- 4.15 Clinical services, will be guided by the development of their own long term plans linked to this strategy ensuring the development of advanced practice and including new roles of advanced practitioners and consultant therapists (nurses / Allied Health Professionals).
- 4.16 We shall involve clinical staff in sharing expertise, practice development and raising standards in the sector by, for instance, writing for professional journals, publishing research or taking part in sector-specific events.
- 4.17 We shall develop our systems for collecting data on complaints, incidents, and near misses to ensure it is comprehensive throughout all areas of the Hospice, learning from them and using them to shape future direction.
- 4.18 We shall follow the agreed Sheffield eligibility criteria for referral for palliative care and, as such, will care for anyone in need of palliative care, regardless of diagnosis. These criteria will also guide our review procedures.
- 4.19 With the aim of redressing the imbalance in the cancer: non-cancer ratio of our patients, our clinical team will work proactively with GPs and hospital clinical teams to increase the percentage of referrals for non-cancer patients in need of palliative care and to promote the range and benefits of hospice care specifically.
- 4.20 We shall work closely with the new Sheffield Primary Care Trust and GP practices to maximise opportunities provided by practice-based commissioning and 'payment by results' and in identifying, reviewing and improving, where necessary, patient pathways to palliative care. Linked to this, we shall support further the promotion and adoption of evidence-based protocols for specific illnesses and symptoms.

- 4.21 While monitoring referral procedures and statistics to ensure that our services reach those most in need, we shall routinely compare the cultural and social profiles of our patients to that of Sheffield as a whole. Should they not be proportionate, will investigate and identify the reason for this with the aim of overcoming any possible barriers to access.

5 Community Service

- 5.1 The community team provides support across the whole of Sheffield to people living at home. The specialist nurses carry out each patient's initial assessment and then refer him or her, as necessary, to other specialists, such as doctors, therapists, social workers, or to the day hospice or inpatient unit. There are 10.6 whole time equivalent nurses led by a senior nurse. The team also provides support through a 24-hour help-line staffed by the community team during the day and by ward nursing staff at night and is involved in the education, training and support of primary health care teams across Sheffield.
- 5.2 Referral by the community nursing team to other therapies is inconsistent and therapies are being provided that may be the responsibility of other services in the community. Staff are rarely supervised in practice and no formal systems are in place for supervision or coaching.
- 5.3 There seems to be a shortage of nursing staff in the team compared to other community specialist teams, although no formal workload analysis or benchmarking has been undertaken.

Objectives

- 5.4 As far as financial resources will allow, we want to work jointly with those who also provide and/or support palliative care in Sheffield, such as the Cavendish Centre, the Weston Park Cancer Information & Support Centre, Intensive Home Nursing Service and the Macmillan Palliative Care Unit at the Northern General Hospital, to develop for patients with palliative care needs and their families a co-ordinated and comprehensive 24 hour service wherever the patient would like to be.

We would welcome working with the Macmillan Palliative Care Unit, Intensive Home Nursing Service and primary care services to develop further the 24-hour helpline and face to face advice to ensure all those who need access to a palliative care professional with primary care experience, have that access.

- 5.5 We intend to undertake a formal review of all services in the community, looking at staffing levels, referral systems, eligibility criteria, prioritising

systems and resources, and benchmark these against other organisations.

- 5.6 If, following the formal review of a patient's needs, care at home is clearly the best option, we shall work with our partners in the community, such as the Intensive Home Nursing Service and district/community nurses, to give as much home support for that patient as our financial resources and staffing levels will allow.

6 Day Hospices

- 6.1 We have two day hospices. **Wheata** is located in the middle of a residential setting and shares the building with a community dental service. **Beighton** is located at the Beighton Community Hospital next to a residential area and a trading estate. Both buildings are leased from the Sheffield Care Trust at a total cost of £46k per annum in 2005. The funding which supports this lease ceases on the date the lease expires.
- 6.2 Each has places for 15 patients per day, five days a week. There are two day hospice coordinators based at each day hospice. They work different days and rarely have the opportunity to meet. There is no lead person providing overall co-ordination of service, hence the day hospices have no clear direction or vision and services are provided in different ways at both locations.
- 6.3 The day hospices share the majority of their nursing staff with the main hospice ward, but each has its own dedicated secretarial support and a transport manager/handyman.
- 6.4 At monthly multidisciplinary meetings, the nursing staff lead individual reviews of patients. However, formal individual medical reviews of each patient rarely take place more frequently than every five to six months and there is a lack of senior specialist palliative care medical involvement.
- 6.5 **Day treatments** such as blood transfusions, intravenous infusions and pain blocks cannot be delivered in peripheral day hospices such as ours due to lack of medical supervision and facilities.
- 6.6 There is limited and inconsistent availability of other therapeutic activities (such as occupational therapy, physiotherapy, complementary therapy, and psychological therapies), which are not always available to patients most in need or available every day.
- 6.7 Day hospice staff are not involved in **the referral process** to the day hospice and do not visit patients prior to accepting referrals.
- 6.8 Day hospice services are, usually, a way of gently introducing patients to the main hospice so that, should admission be necessary, they are

already aware of the Hospice's culture and environment, where it is, and the help, treatment and care it can give. The distance separating our day hospices from the main building prohibit this fundamental function widely endorsed by other hospices providing facilities on a main site.

- 6.9 The total running costs of both day hospices is £452k per annum and the overall costs of running two peripheral day hospices **may** be higher than running one based on a main site.
- 6.10 **The transport service** limits access to the day hospices. Patients usually attend on the days the transport picks up from their area. Until recently it was difficult to attend more than one day a week. Urgent support is, consequently, more difficult to provide to those most in need.
- 6.11 A significantly high proportion of patients currently attending both day hospices have no specialist palliative care needs and have not been formally reviewed as to whether this service is right for them. Many have neurological diagnoses such as Multiple Sclerosis and Parkinson's Disease with unchanging and stable needs. For them, hospice care may not be the most appropriate service to offer: their needs could be met through other types of day services.
- 6.12 The future of current day hospice provision, palliative care rehabilitation and other similar day therapy provision such as the Cavendish Centre needs citywide coordination to ensure economic operation and prevent unnecessary duplication.

Objectives

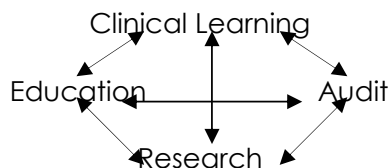
- 6.13 We shall relocate the day hospices to the main building and merge them with the rehabilitation department and rename as the Therapies and Rehabilitation Centre, providing support for up to 20 patients a day. This will enable us to increase the services available to our day patients and to ensure our staff and volunteers are supported and up-dated continually. It will enable those of our multi-disciplinary team who routinely commute between the main site and the day hospices to see patients during the time they would otherwise have spent travelling, and enable the full multi-disciplinary team to fully assess each patient, at least every ten weeks, in line with agreed eligibility criteria for Sheffield for palliative care. This will ensure that our specialist services are received by those who need them the most, and that the limited services currently available to day patients is extended to the full service we offer to our in-patients.
- 6.14 We will develop flexible working and cross cover/sickness cover throughout clinical areas, provide more opportunity for education and training for staff and students, integrate patients' views into research which informs the development of our services, and enable better supervision of staff and care, in line with agreed standards.

- 6.15 We shall offer a full therapeutic range of services on a menu basis and ensure regular medical involvement through a minimum of twice weekly sessions, and as required.
- 6.16 We shall regularly review patients attending, and prioritise referrals, to ensure we are offering therapies and rehabilitation to those most in need.
- 6.17 We will work with other providers of day therapy and rehabilitation services to ensure economic use of resources and prevent duplication.

7 Clinical Learning, Education, Audit & Research

- 7.1 The Hospice has provided formal education through its education department (latterly renamed the **Wilkes Education and Resource Centre**) since 1977. The Centre's main focus has been on providing formal palliative care education to nurses through, initially, the English National Board for Nurses. Since 1991, Sheffield Hallam University has validated all courses which have been open to all those in the allied health professions. The Centre currently offers two undergraduate degrees and a postgraduate diploma in palliative care. It is also involved in the training of medical students.
- 7.2 The Hospice also employs staff to lead on **clinical practice development** and **audit/research** including a number of other training courses such as mandatory training, nursing auxiliary training and medical students training. The two services have historically been managed and operated separately.
- 7.3 In addition, the Hospice also provides placements for students in nursing, medicine, physiotherapy, occupational therapy, counselling and social work. We also employ training grade doctors and, therefore, must comply with standards set by the university's dean of the medical school and specialist palliative care training committee.
- 7.4 **There is a need to bring clinical practice, education, audit and research together** to ensure each informs and enhances the other. The organisational structure has recently been reviewed at St Luke's Hospice and we have developed a new unit, CLEAR (Clinical Learning, Education, Audit and Research Institute), to take over the role of these areas.
- 7.5 **Clinical staff need to review practice** using the best possible audit systems and available evidence. They also need education to ensure knowledge; skills and information are shared and developed.

C.L.E.A.R. Wheel



- 7.6 Our Wilkes Education and Resource Centre has a departmental office, another office, seminar rooms, a lecture theatre and a specialist palliative care library. The Trent Palliative Care Centre (TPCC) which rents accommodation from us and is based on our site, also has a departmental office, other staff offices and a library and seminar room. Historically, the TPCC and St Luke's Hospice have been separate entities.
- 7.7 A joint Conference and Education Centre involving the Hospice and the TPCC could provide facilities to raise income to meet the revenue commitment of education, with any surplus contributing to the funding of the Hospice.
- 7.8 It is extremely important that the Hospice continues to provide support to, and involvement with, academic training in palliative care. However, serious examination and analysis of our particular role in administering the courses at the St Luke's Hospice site should be considered. The cost of providing academic education currently stands at £119k with projected income at £76k. This expenditure only includes direct salary costs and no other associated costs of running the Education Centre.
- 7.9 We should undertake comparisons with other providers, and fully consider whether, or how, to continue supplying the universities with our specialist knowledge and skills in palliative care, and the use of our facilities as a base for learning.

Objectives

- 7.10 We shall base the Clinical Learning, Education, Audit and Research Institute (CLEAR) in a state-of-the-art Conference and Education Centre to provide both a centre of excellence in clinical education and a source of income. The new building will be located at the Hospice to maximise access to specialist palliative care professionals and to minimise cost.
- 7.11 We shall ensure that practice development, i.e. the development of excellence in clinical skills, is a key role of the CLEAR Institute through the development of a strategy and structure that underpins all clinical education and training at the hospice.

- 7.12 We shall appoint a lead person for the CLEAR Institute, who will, with support from the Sheffield Universities, raise the profile of research and audit as part of the CLEAR Institute's role. We shall consider joint appointments with the universities to facilitate the link between theory and practice and provide succession opportunities.
- 7.13 We shall work towards combining the facilities of the TPCC and the St Luke's Wilkes Education and Resource Centre, into a state of the art Conference and Education Centre, making both more efficient and economic as well as maximising resources for palliative care education in Sheffield.
- 7.14 The CLEAR Institute will work in partnership with the Trent Palliative Care Centre to ensure the Conference and Education Centre meets the needs of both organisations, if that is possible.
- 7.15 We shall comprehensively review the role of academic education at the Hospice as part of the development of an education and training strategy, to ensure the availability of the highest quality of education, and assess its affordability and value-for-money.
- 7.16 We shall also give further consideration to developing the audit and research agenda through the appointment of a lead in that area as part of the CLEAR Institute.
- 7.17 We shall assess the need within community-based services such as care homes for palliative care training/education and develop a programme to meet that need.
- 7.18 We shall maintain and strengthen our relationships with the Sheffield universities and with the School of Medicine and any other institutions involved in clinical training.

8 Finance

- 8.1 The Hospice has always been well supported by the former Sheffield Health Authority, but the erosion of this support through inflationary rises which are never fully funded has contributed to the development of a negative financial position.
- 8.2 The Hospice is currently budgeting for a deficit of over £300k annually (i.e. this financial year it is expecting to spend £300k more than it expects to raise). The majority of expenditure (i.e. 76%) is on staff salaries and the rest is made up of non-pay costs such as utilities, mileage, insurance, repairs and renewals, equipment, etc. There is little opportunity for major savings other than reducing pay costs and therefore reducing services.

- 8.3 The inclusion of hospices in the Payment By Results (PBR) scheme, where hospices are fully funded by the NHS for clinical work they undertake, is likely to provide additional support to the Hospice. However, this cannot be relied on in the short-term as it is likely that hospices will not be included until 2008/9. However, taking the 2003 ScHARR (Sheffield School of Health And Related Research) benchmark inpatient costs as an example, and comparing them to our current NHS income, this shows that **we would expect to receive at least an additional £1 million income each year.**
- 8.4 A significant legacy left to the Hospice in 2004 enabled the Hospice to increase its legacy budget for two years to £900k. If the Hospice were to budget for the median legacy income received over the last 10 years it would be budgeting for £600k annually.
- 8.5 Assuming inflation at 3% in the next few years an additional £174k annually would be necessary to continue as we are.
- 8.6 Therefore, in total we are likely to require a further £874k annually if we wish to continue to provide the same services as we currently do.
- 8.7 The finance department can play a key role in ensuring that donations are tax effective, that we remain informed about current legislation and policy developments in tax effective giving and by putting in place the systems that make donations simple to administer. They also play a role in developing good income reporting systems, minimising duplication between departments, and benchmarking income generation.
- 8.8 We must review all areas of expenditure to examine whether efficiencies can be made and maximise income generation wherever possible
- 8.9 We shall develop and review the finance department to enable them to generate financial information that is timely, accurate and useable to all Heads of Department, the Leadership Team and the Board.
- 8.10 Everyone needs to have a personal interest and responsibility to ensure their working practice results in maximum efficiency and effectiveness, by taking ownership of their work and being accountable for their own personal effectiveness, being receptive to feedback, willing to learn and embrace continuous improvement.

Objectives

- 8.11 We shall review, implement and maintain effective accounting systems to provide a seamless financial framework for the whole organisation.
- 8.12 We shall provide a responsive information system of relevant, accurate and timely information to aid the management and control of the organisation.

- 8.13 We shall strive for organisational effectiveness and efficiencies, eliminating duplication, implement costs control initiatives and maximising all our resources.
- 8.14 We shall secure income streams to provide continuity for long term planning of Hospice Services.
- 8.15 We shall implement performance measures to guide day to day activities and assess the organisation against its objectives.
- 8.16 We shall provide departmental accounting and budgets, to provide accountability by HOD's and individuals.

9 Hotel Services

- 9.1 The support services which include catering, domestics, laundry, stewards and transport provide an **essential and highly valued service** supporting clinical staff in providing care to patients and their carers as well as supporting other departments in their functions such as raising money etc.
- 9.2 It is important that all support services provide the highest quality services to these areas and are able to reflect clearly their requirements.
- 9.3 Due to the way that support services tend to develop, they often provide a slightly different service from the needs of the department representing the patient or customer. It is essential that services are built around negotiated agreements with each department to reflect the real needs of users of the service.
- 9.4 **'Hospitality'** relates to the importance of **welcome and warmth** that is generated when departments are involved face to face with 'customers' (defined as patients and their visitors, customers to our shops and staff and volunteers using our services such as meals). Any department can be faced with a 'customer' but the main ones are predominantly the support services including staff and volunteers working in reception, admin / clerical and the switchboard.
- 9.5 There has been a clear lack of investment in support and training to all these areas and as a result they often feel less valued.
- 9.6 The provision of meals and refreshments in clinical areas is provided through nursing staff and volunteers. Nursing staff time needs freeing up to concentrate on clinical care and volunteers need a structured hospitality service to support them with the service to patients.

Objectives

- 9.7 Hotel and hospitality services are developed in such a way that they clearly meet the needs of each area and are focused on the individual

needs of patients i.e. individualised plated meal service offered through a hospitality department.

- 9.8 Domestic and laundry staff will join together to provide a new, well co-ordinated housekeeping department.

10 Income Generation/Marketing/PR and Communication

- 10.1 Historically the former Sheffield Health Authority supported us with 49% of our income. The Sheffield South West Primary Care Trust (on behalf of the other PCTs in the city) are our lead commissioners and provide just over a third (36%) of our overall income i.e. £2million. **In 2006, this will leave us with £4million to find ourselves.**
- 10.2 Since it opened its doors in 1971, the Hospice has always been extremely well supported by the generosity of the people of Sheffield.
- 10.3 Our Action Committee, which has worked tirelessly for ten years, has raised over £100,000 annually. Many volunteers, staff and other supporters raise significant amounts towards our annual revenue budget. In addition, legacies and grant making trusts are crucial to our survival and development. The Hospice shops and lottery raise, annually, over £750,000 (net) between them, but need further support and investment in the future to maximise their contribution. However, these areas are reliant on **voluntary** input and expertise.
- 10.4 There has been **no formal coordinated, fundraising, marketing or PR** structure at the Hospice, despite the appointment of a consultancy to support marketing in 2003.
- 10.5 When the Board approved our new organisational structure in May 2005, it included a paid fundraising team, including a Director of Fundraising and Communications and a small team of fundraising, marketing and PR staff, yet to be recruited. These are crucial initial steps to develop the fundraising structure at the Hospice.
- 10.6 The people of Sheffield are extremely supportive of the Hospice but many misconceptions still abound. Many supporters think the NHS/government finances us, that we are 'well off' and that we have significant income each year and a wealth of reserves. Some of these views relate to our location in the more affluent part of the city.
- 10.7 The Hospice owns six shops and is buying a seventh. **None of the shops are leased.** The shops department can only just manage the work it is currently undertaking and the area shops' manager spends all of her time covering absences as there are no deputy shop managers. In addition, a significant part of her day is spent organising drivers for pick-ups and working in the Crookes shop. There is little or no time to

investigate acquiring other shops, developing staff, looking at policy or strategy or monitoring the workload and performance of staff and shops. **There is the potential in Sheffield to at least double the shops we currently have, particularly if we look at leasing as well as purchasing.**

- 10.8 The Institute of Fundraising suggest that the costs of community fundraising are very high and it is often the case that many hospices will need to spend 50% of funds raised in order to secure long-term income streams. Any fundraising strategy needs to consider the best return on investment to ensure the security of the Hospice for the future.

Objectives

- 10.9 We must ensure our main message is that we are guided, at all times, by our prime purpose of providing free, expert, patient-centred, specialist palliative care and support to the people in our region who need it most, regardless of their social or cultural background, colour, location or income.
- 10.10 We must establish a strategy that will increase annual income to £8 million by 2011 with the focus on sustainability. Initial priority areas are likely to be community and local business fundraising, legacy development and fundraising from trusts and community foundations.
- 10.11 We must develop a comprehensive strategy to grow the retail network, increasing the net income by increasing the number of shops, through purchasing or leasing, to a minimum of 15 over the next five years (i.e. one to two shops per year) and then review again, ensuring a new shops strategy provides the right personnel support.
- 10.12 We must set up a capital appeal to raise at least £14million by 2009 to support the redevelopment of the Hospice.
- 10.13 We must develop a fundraising strategy to raise our annual revenue spend, as well as any capital commitments over the next five years.
- 10.14 We must better communicate what St Luke's Hospice stands for, as well as what it does, ensuring all communications (including corporate publications, the web-site, signage, correspondence and promotional material) are consistent and reflect the spirit of the Hospice.
- 10.15 We need to review the St Luke's Hospice visual corporate identity to determine whether it projects the image and message we want it to project and to act accordingly if it does not.
- 10.16 We need to carry out market research to identify and understand the needs of St Luke's Hospice key audiences and to measure how far it meets these needs.

- 10.17 We need to develop specific plans to market St Luke's Hospice services to professional audiences including specialist palliative care services.

11 Information, Communications & Technology

- 11.1 Historically, our administration and management has not been supported by integrated computer-based systems.
- 11.2 Three years ago, a citywide palliative care information project provided funding to upgrade the computers and servers at the Hospice. Until then, the Hospice had been well served with computers but there was a lack of coordination and planning in terms of developing the service. Consultancy support was extremely expensive and did not address the network-related problems.
- 11.3 There is **no electronic patient database** to capture information regarding the patient journey through our services, therefore, the collection and analysis of statistics to influence and improve patient care and to influence service development is limited.
- 11.4 The **clinical staff have limited access to IT hardware, software and expertise** that would support them in their role. There are no hand held/laptop machines to enable community staff to have immediate access to information on patients in their own homes. Excessive time is spent using manual systems where electronic services would be more timely, efficient and economic in the longer term.
- 11.5 There is **no formal lead for IT, for statistics or for data management** and **no training in computer skills**.

Objectives

- 11.6 We shall establish an Information, Communications and Technology department to lead the support and development of services, particularly focusing on developing IT skills, capturing information, improving efficiency and reducing cost throughout all departments. In addition the role can contribute to the Staff Development Unit education and training strategy led by the Director of Personnel & Volunteers.
- 11.7 We shall develop integrated databases for patient care, finance, donors and personnel to enable analysis and information to be provided in an efficient and timely way.

12 Inpatient Unit

- 12.1 The inpatient facility of 33 beds is based on a hospital model, which was 'state of the art' when completed in the early seventies. **By today's**

standards, it has inadequate and tired facilities. There is a lack of bathrooms and showers, no built-in hoists and no overnight accommodation for relatives. The floors' surfaces are tiled and, consequently, not conducive to peace and quiet. Access to audio-visual aids is difficult. We nurse most patients in shared rooms, although evidence suggests that patients who are feeling ill would prefer single rooms (1).

12.2 **Current thinking advocates providing private, comfortable facilities, with carpeted floors, as one would find in a person's own home.**

12.3 The median number of beds in use at St Luke's Hospice over the last five years is 28 following a detailed analysis of day-by-day bed usage. The National Council for Palliative Care in their publication 'Palliative Care 2000' (2) suggested 36 to 54 beds per million population for cancer patients and an additional 18 to 54 beds for non-cancer patients i.e. 54 to 108 beds. The Yorkshire Cancer Network strategy 2002 to 2005 (3) used an average of 69 beds per million as its benchmark. Sheffield currently has the equivalent of 93 beds per million.

12.4 Historically, the Hospice always had a waiting list for admission until the Macmillan Palliative Care Unit opened in 2002. Since then the waiting list has reduced considerably but, on occasions, acutely ill patients still wait for admission. The principle of admitting patients with only specialist palliative care needs and stopping advanced bookable holiday relief admissions was endorsed by the Board of Trustees in May 2005. Therefore, in November 2005 we combined the eight bookable beds with our existing 25 beds to make 33 beds available for specialist palliative care. Patients rarely need to wait for beds since this decision was made.

The removal of the planned bookable beds highlights the under provision of this type of support particularly for those people with long term illnesses i.e. neurological conditions e.g. multiple sclerosis and Parkinson's disease and for those under 65, an issue replicated in many large cities

12.5 A review of the inpatient nursing establishment in May 2005 shows we have approximately the right number of staff working on a 33 bed ward although we are slightly low on the qualified nurse skill-mix.

12.6 There is some evidence of individualised care for patients but a number of routines and systems currently in place need reviewing to develop this further. We introduced a modified system of Team Nursing in November 2005 to enhance individualised care and to provide further development for senior nursing staff on the ward.

12.7 A comprehensive multi-disciplinary service is offered to patients and their families and carers on the ward, providing emotional, practical, spiritual and social support including planning for discharge

Objectives

- 12.8 We shall reduce bed numbers to 30, in line with actual median usage and within national recommendations,(this may include an additional two beds to cope with occasional peaks in demand).
- 12.9 We shall continue to provide and further enhance our ability to offer admission to beds 24 hours/seven days a week.
- 12.10 Although the Hospice is renowned for providing high quality nursing and clinical care, we shall work further towards clinical excellence as a top priority.
- 12.11 We will work with the Sheffield Primary Care Trust, Sheffield Social Services, and any other service with an interest, in ensuring the city caters for the needs of those individuals with long term neurological conditions, and / or long terms disorders of younger people (under 65) whose illness, ultimately, will be terminal, by developing a system of access to planned and pre-bookable holiday relief beds

13 Personnel and Volunteers

- 13.1 Personnel management has become an area of specialism/expertise due to both the significant changes in employment law over the last decade and the increased expectations of employees for fair and equitable management practices. In addition, an organisation is now required to have policies and procedures which demonstrate how it applies good management practices and complies with statutory requirements.
- 13.2 St Luke's Hospice employs nearly 250 staff in a wide variety of roles and professions with differing terms and conditions of employment which are not equivalent to those in the external market place.
- 13.3 With nearly 600 Volunteers supporting St Luke's Hospice, they form a significant part of the workforce. Volunteers are now managed directly by the Head of Department (HOD) in the area in which they volunteer. However, there has been no overall review undertaken of the roles they perform and recruitment is currently carried out in an ad hoc manner.
- 13.4 There has also been little or no investment in non-clinical education and training and, in particular, management or supervisory skills training for the majority of managers within the Hospice. Other training should also be made available ie information technology, communication skills, customer service skills etc.

- 13.5 If we are to continue to provide education and training in all areas, a complete review of both clinical and non-clinical factors is necessary in the near future.
- 13.6 **Nursing salaries** are currently less than the NHS Whitley equivalent. There are also many anomalies within the pay and conditions at the Hospice. The Department of Health (DOH) National Partnership Group for Hospices has estimated that the potential additional cost of implementing the Agenda for Change proposals for a hospice could total between 15 - 20% of the current overall salary cost. Comparing St Luke's current salary scales to the new Agenda for Change scales shows an estimated shortfall of approximately £400k per annum. Foundation Hospital trusts are already looking to enhance their terms and conditions above Agenda for Change levels to increase their competitiveness for clinical staff. There is evidence showing a national shortage of high quality, experienced nursing staff particularly in specialist areas.
- 13.7 The Hospice provides a **stakeholder pension scheme**. In addition, staff who have previously been in the NHS pension scheme are allowed to continue in this scheme at the Hospice. In order to attract the highest calibre of non-NHS staff, the introduction of a pension scheme with employer's contributions should be seriously considered in the future.

Objectives

- 13.8 We shall establish and develop the personnel department to enable them to fully support the Hospice in applying best management practices by providing clear and comprehensive personnel policies and procedures. These will support a professional recruitment process and a fair and equitable management approach.
- 13.9 An overall review of the roles and responsibilities of volunteers will be undertaken with Heads of Departments to develop these to meet the changing needs of the Hospice.
- 13.10 We shall develop a non-clinical education and training strategy in parallel with the CLEAR Institute and look at partnership with other organisations, such as the NHS and higher education institutions.
- 13.11 We shall review all terms and conditions of service and including pension provision through the development of a job evaluation and pay review system taking into account the issues around attracting and keeping high calibre staff and the implications of the NHS Agenda for Change.

14 Psychological and Spiritual Care

- 14.1 A number of psychological services are available at the hospice including psychology, art psychotherapy, writing therapy, relationship psychotherapy. Historically most of these services have developed in an

ad hoc way and do not necessarily reflect the needs of the organisation or the patients and their carers.

- 14.2 Currently we are not aware of the requirement for each of these services and whether there are any other services that would be of benefit to our patients and their carers. The availability, accessibility and range of services has never been formally evaluated.
- 14.3 We are committed to providing psychological support based on need and acknowledge the value this has on the patient and carers experience of hospice care.
- 14.4 Holistic care, which encompasses the spiritual, has always been at the heart of Hospice and Palliative care and throughout the life of St Luke's Hospice, the spiritual aspect has been underpinned by the presence and work of the chaplain and the pastoral / spiritual care team
- 14.5 Spiritual care is an essential element of high quality holistic care. The need for a team approach to pastoral care that supports all faiths and none is fundamental to holistic spiritual care. The service also has a key role in providing staff support.

Objectives

- 14.6 A strategic review to be undertaken to establish the range, level and availability of psychological services required in the hospice. The review to recommend those essential services and those that could be made available dependent on additional resources being secured.
- 14.7 Spiritual care to be highlighted as a key service that is made available to all patients and carers 24 hours a day seven days a week. Therefore a review of the lead role is essential to ensure this role provides leadership and support to the patients and carers, staff and volunteers and ensures the hospice provides in excess of the minimum standards for hospice chaplaincy (6).

15 Trustees

- 15.1 The Trustees are the group of people who are responsible for the strategic management and direction of the Hospice. When meeting in formal session they are called the 'Board of Trustees' and they appoint the Chief Executive and, with him or her, the other Directors. The Trustees have a duty of care to ensure that the Hospice is properly managed and are personally liable for any loss if they are careless, negligent or act improperly. They are subject to periodic scrutiny by the Charity Commission.
- 15.2 Many staff and volunteers have been unaware of the existence of the either the former Council of Trustees or the House Committee (latterly called the Management Committee), and have little understanding of

their roles or membership. In addition, in line with the Charity Board recommendations, we are aware that the membership of the Board should reflect the makeup of society.

- 15.3 It may also be helpful to support our Trustees in being actively involved in fundraising activities, mobilising their contacts and expertise as well as being ambassadors for the Hospice by helping raise its standing within their own networks.

Objectives

- 15.4 We need to raise the profile of the Board of Trustees, which has now superseded the Council and the Management Committee, through regular visits of their members to the Hospice, including presentations from individual departments.
- 15.5 The membership of the Board of Trustees needs to include representatives from patients / carers, volunteers and from black and minority ethnic groups where practical.
- 15.6 We shall also establish a patients' and carers' user group whose views about our services, accommodation and communication, and all policies and procedures affecting these, will feed back via those representatives mentioned in point 15.5 to the Clinical Governance subcommittee of the Board of Trustees and the Board of Trustees.

Appendix 1

Consultation

This strategy was formulated after consultation with:-

Patients
Patients' relatives and carers
Council of Trustees
Management Committee
Staff and volunteers
Sheffield Primary Care Trusts
Sheffield Social Services
Sheffield Teaching Hospitals NHS Foundation Trust
Sheffield Care Trust
Sheffield MPs and councillors
Sheffield Cancer Services Advisory Group SCSAG
Sheffield Primary Care Teams i.e. GPs and District Nurses
Sheffield Chamber of Commerce
University of Sheffield
Sheffield Hallam University
Intensive Home Nursing Service
Cavendish Centre
Weston Park Hospital Cancer Information and Support Centre
MS Society
Parkinson's Disease Society
MND Society
St Luke's Hospice neighbours

Appendix 2

Swot Analysis

A SWOT (strengths/weaknesses/opportunities/threats) analysis of St Luke's Hospice was led by the House Committee in 2003 and resulted in the following summary:-

Strengths

- Superb patient care
- Perceptions
- Dependency
- Staff quality
- Education
- Fundraising in the community
- Reserves
- Sheffield's only hospice
- 'Goodwill'

Weaknesses

- Marketing
- Perceptions
- Dependency
- Staff difficulty with accepting change
- Restrictions of the sites
- Management organisation
- Inability to break even
- Uncertainty of legacy income

Opportunities

- Partnerships
- Management team re-structuring
- Other potential developments
- Clinical service
- Government funding
- Business - marketing
- Academic activity

Threats

- Lack of funding
- Dependency
- Isolation
- Loss of independence through bureaucracy
- Individual departmental objectives

References

1. The NHS Cancer Plan (2000), **A plan for investment, A plan for reform**
Department of Health
2. Standards for Better Health (2004), Department of Health
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4. P. Tebbit (1999), **Palliative Care 2000 - Commissioning Through Partnership** National Council for Hospice and Specialist Palliative Care Services
5. Yorkshire Cancer Network, (2000), **Network Palliative Care Strategy 2002-2005**
6. AHPCC (2003) **Standards for Hospice and Palliative Care Chaplaincy**. Association of Hospice and Palliative Care Chaplains, Help the Hospices, London. www.ahpcc.org.uk