

# St Peter's Hospice Strategic Plan 2016-21



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[www.stpetershospice.org](http://www.stpetershospice.org)



# St Peter's Hospice

## Strategic Plan 2016-21

### Introduction

This is the strategic plan for St Peter's Hospice to cover the period 2016-21. It is based on the 2013-18 Plan which has been comprehensively reviewed and revised, taking into account what has already been done and, acknowledging where the situation has changed, adapting accordingly. It is intended to give an overall view of our position during 2016-21 and reset the direction of travel. The St Peter's Hospice mission, vision and strategic goals have been revisited but not changed. As before, starting with the services we provide, which are our core purpose, the way ahead has been mapped with growth and development targets identified where appropriate. This plan follows a period of consultation with all of our different stakeholders including patients, families and carers, other health professionals, commissioners, as well as our own staff and volunteers. This has been led by the senior management team and discussed with the Board of Trustees in January 2016.

### Mission

To provide care and support for adult patients, families and carers in our community living with life limiting illnesses in order to improve the quality of their living and dying. We do this working closely with other health and social care providers, including the voluntary and 3<sup>rd</sup> Sector.

### Vision

St Peter's Hospice will play a leading role in the development and delivery of the best possible care and support services for adult patients, families, and carers living with life limiting illness in our community.

### Goals

- To be recognised as a centre of excellence for the delivery of compassionate palliative care.
- Continually improve access and equity of access to our services and be recognised as a valued community-based service.
- Effectively communicate the role of SPH to all, including health professionals and the wider public.
- Seek out and actively manage partnerships which will enhance our core purpose.
- To be recognised as a leading provider of education and training in palliative and End of Life Care.
- Be recognised as an employer of choice. Attract and retain high quality staff and volunteers, continue to grow our support base.
- Sustain statutory and charitable income streams to match demand for our services, which are to be free at the point of delivery.

- Preserve a clear charitable identity and be recognised as one of Bristol's leading charities.
- Ensure value for money and optimal use of all resources.
- Promote continuous improvement, encourage an innovative and creative environment, including preparedness to support wider research.

## **Background**

1. **Future Environment.** In planning for the next 5 years consideration was given to future trends which would have a direct impact on the hospice.

2. **Demographics.** The population in our community is not going to change radically in the next 5 years but the demographic projection over the next 20 years plus may cause other effects within the shorter time-span. Some key statistics:

- a. Currently 58% of deaths occur in NHS hospitals, and 18% at home. In the SPH catchment area (Bristol, N Somerset, South Gloucestershire and BANES) during 2008-10 21% of deaths occurred at home, 22% in care homes, 50% in hospitals and 4.5% in hospices.
- b. The number of deaths in England and Wales is likely to rise from c502k in 2012 to c.590k in 2030.
- c. If current trends continue c.90% of deaths in 2030 will occur in institutions, and deaths at home will drop to c.10%.
- d. It is assessed that 44% of those dying in 2030 will be aged over 85, an increase from 32% in 2004. <sup>1</sup> This trend is already evident. Alongside this multiple comorbidities and chronic conditions common in old age will also increase including cancer and dementia .
- e. The Bristol population is projected to increase by 95,700 (22%) between 2012-37. This is the third highest growth rate of all core cities (only Manchester and Nottingham are higher). <sup>2</sup>
- f. 16% of the Bristol population considers itself Black Minority Ethnic <sup>3</sup>. The percentage across our wider area is lower. Growing ethnic minorities are Somali and Polish. Bristol is however a relatively young population, and the ethnic mix varies considerably according to age groups. For example 28% of 0-15 year olds are BME<sup>4</sup>.

Deductions: Demands for services will keep growing. Notwithstanding the future increase in cancer deaths we must attend also to those with non-cancer life limiting illnesses. We must be accessible to all sections of the community and look for opportunity to make them aware of what we provide in a culturally sensitive way. Some of this may be long-lead activity. Community, PFS and Education teams can contribute to this area.

3. **Statutory funding.** SPH currently receives 27% of its funding from NHS (Report and Accounts 14/15). Commissioners have now agreed to a 3 year contract for

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<sup>1</sup> All statistics in para 2a,b,c,d from Department of Health End of Life Strategy.

<sup>2</sup> Office of National Statistics 2012-based Sub-national Population Projections.

<sup>3</sup> 2011 Census.

<sup>4</sup> ONS 2013.

the period 2015-18 and so this headline figure is unlikely to change before April 2018. There is, however, potential opportunity for additional funding, for example for the Advice Line. We still have to negotiate with 4 Clinical Commissioning Groups (CCG), and the potential for disparity between different geographical areas in both funding and service requirement remains. To date the predicted significant time investment in building and maintaining relationships with commissioners has not materialised and we have nevertheless retained the same level of statutory funding. We have a realistic ambition to increase the level of statutory funding to support new or enhanced services, particularly where these contribute to wider NHS targets e.g. reduction in hospital admissions. The NHS 5 Year Forward View is explicit in a section titled "*Stronger partnerships with charitable and voluntary sector organisations*", which states "When funding is tight, NHS, local authority and central government support for charities and voluntary organisations is put under pressure. However these voluntary organisations often have an impact well beyond what statutory services alone can achieve.... these organisations provide a rich range of activities, including information, advice, advocacy and they deliver vital services with paid expert staff. Often they are better able to reach underserved groups, and are a source of advice for commissioners on particular needs. So in addition to other steps the NHS will take, we will seek to reduce the time and complexity associated with securing local NHS funding by developing a short national alternative to the standard NHS contract where grant funding may be more appropriate than burdensome contracts, and by encouraging funders to commit to multiyear funding wherever possible".<sup>5</sup> It is worth noting that while the cost of patient care has risen on average by 7.5% per annum since 2009 (partly due to discretionary enhancements and partly to health sector inflation), statutory funding has only risen by 1.5% per annum.

Deductions: Commissioners will increasingly look for value and efficiency in all areas. We can expect them to continue to seek ways of avoiding hospital admissions at end of life. We must continue to engage CCG decision-makers early in our plan with aim of "meshing". The requirement for formal bids is likely to increase, will require an internal ability to produce these, which may be by using external consultants. We must maintain and analyse necessary management information so that we can respond appropriately to statutory, charitable and other funders. This may require a review of staffing related to the introduction of EMIS.

4. **Competition.** Although the past 3 years has not seen it, there remains a strong likelihood of additional competition for NHS contracts, from private, public and charity sectors. In any event statutory funding will remain subject to tight financial constraints.

Deductions: we must remain prepared to construct rigorous bids, which may require additional appropriately qualified staff, probably on a consultancy basis. We may need to enter into partnerships or collaborations with existing providers and new entrants. There is already early evidence that we are an attractive partner because of St Peter's clinical reputation. When we are against private

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<sup>5</sup> NHS England 5 Year Forward View Chap 2.

and public competition we must constantly stress the added value of our charitable funding.<sup>6</sup>

5. **Community Roles.** As predicted we have seen increasing discussion about the “compassionate community” and the role hospices could play. We have established Hospice Neighbours in response to this. The requirement for respite care is growing, carers are themselves older and more infirm. Loneliness is identified as an issue which has a direct impact on health, if only because lonely patients present more frequently.

Deduction: We must continue to increase our community-based activity, to contribute to our overall patient care provision while still recognising the importance of the in-patient care. This will be met with an appropriate combination of paid staff and volunteers.

6. **Public attitudes.** Patients are increasingly encouraged to make choices.<sup>7</sup> St Peter’s enjoys an excellent reputation for care, with a strong local community element. We must ensure we are clear about what we are able to offer, to avoid raising expectations which cannot be met.

Deduction: We should use public support to reinforce the benefit to NHS of St Peter’s. We must always make it clear to patients/families/community that St Peter’s is primarily funded by charitable donations. At the same time we must ensure our messaging is consistent from all areas of the hospice, especially clinical and fundraising.

## Services

7. **General.** To support our mission and charitable purpose, St Peter’s Hospice provides a range of clinical services to its patients with life-limiting illnesses. These include specialist palliative care, generalist end of life care and what might be termed “light touch” care (See Fig 1). There are no strict boundaries between these and it is essential that patients are able to access any or all services as appropriate. While our services are currently delivered to a high standard and meet a number of defined needs we have an ambition to expand and develop our overall level of service. In particular we want to place greater emphasis on the integration of our services, and their delivery in the community, and improve accessibility by all parts of the population by engaging more with social, religious

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<sup>6</sup> “Promote a very local area approach. Bring together health providers and stakeholders at a very local level to tailor services in areas that have distinct and persistent health related and life limiting problems – also in partnership with schools, police and landlord services, VCS (voluntary and community sector)” Bristol Health & Wellbeing Board Paper for Stakeholders 3 Oct 12.

<sup>7</sup> “A review is underway in Bristol (as nationally) about how to provide services that centre on personal choice and control and that meet people’s needs while retaining individual dignity. Older people are now choosing more ‘extra care’ housing or opting to stay in their own homes. Adults are now more in control of the services they use through personalised budgets and many people who use day services want to take part in activities that support them in the community. Prevention, early intervention and integration of social care and NHS services will remain vital elements in future social care provision.” Bristol Joint Strategic Needs Assessment 2012.

or ethnic minority groups. We recognise our part as a provider amongst others and acknowledge that some patients may require different services more appropriately delivered by others; for example it may be best to keep some patients out of hospital while, for others, hospital may offer the most appropriate care and support. We will co-operate with other agencies (e.g. acute hospitals, GPs, social care) to achieve this balance. In particular in this period we seek to improve EOLC provision and increase availability of appropriately resourced beds for EOLC, thus relieving pressure on specialist care services such as the IPU. This may be by establishing specific beds in locations other than Brentry, possibly in partnership with other providers, or by assisting other providers, e.g. nursing and care homes, to improve and enhance their services. We aim to contribute to existing work in this area which is already supported by commissioners. While recognising the importance of ensuring that our community services are integrated and coherent between themselves and taking account of those delivered by others, we assess the opportunities for current services as follows.

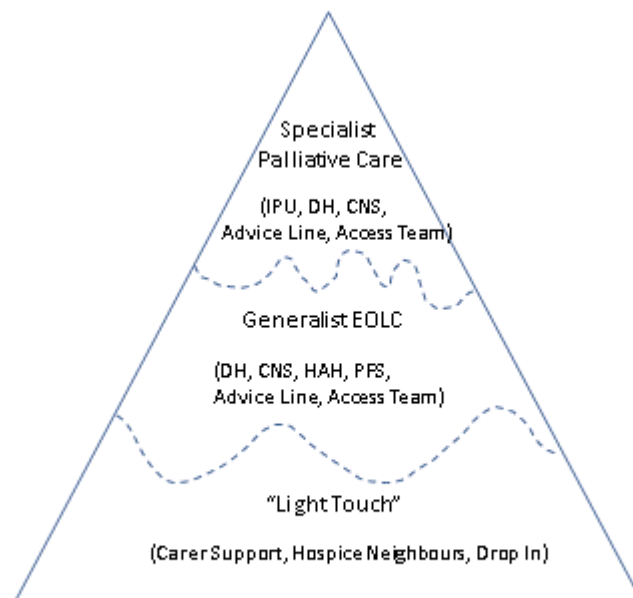


Fig 1

8. **In Patient Unit (IPU).** Develop. The IPU's purpose is to provide inpatient care for patients who need a short period of intensive and specialist intervention from the multi-professional team, which could be at various stages during an illness including the end of life. Considerable work has been done in the past 3 years to review the IPU, including a very comprehensive report by an external team from Marie Curie. We have also done significant work to study options for the redevelopment of the physical structure of the IPU. The IPU is assessed to be operating at correct capacity – to increase the number of beds would be very costly at a time of uncertain funding. But it would also result in undesirable second order effects e.g. additional pressure on staff, unmanageable numbers of distressed and bereaved relatives, increased levels of activity causing loss of ambiance and potentially reducing quality of care. There is also the real issue of recruiting and maintaining the high level of RN's needed to support an expanding unit. Recent work has also analysed the effect of switching to a unit of fewer beds but all single rooms; this has shown that reduction to 15 beds would

increase bed occupancy overall by virtue of the greater efficiency and flexibility offered by single rooms. This will now be taken as a planning assumption for the IPU refurbishment. The IPU must be prepared for a temporary relocation to enable the necessary rebuilding work to be done. This will not occur before 2017. Criteria for admission have been subject to a separate study.

**By 2021:** the IPU will be physically refurbished and reconfigured as necessary, with a fully integrated multi-disciplinary team of appropriately qualified personnel following any reorganisation resulting from review; it will have achieved all mandatory quality standards.

9. **Day Hospice (DH).** Develop. Day Hospice's purpose is to provide a therapeutic environment for patients who are well enough to attend in order to increase a sense of confidence and empowerment in living with illness. DH will continue to enhance its successful 12 week programme using a wider multi-disciplinary team model including greater integration with PFS and complementary therapies, to provide a responsive and adaptable model to meet changing patient need. We wish to expand complementary therapy. Drop-in sessions will be piloted and a new "therapeutic or well-being day" redesigned for one of the current days, to meet patients with different needs and maybe include their carers. Part of this process will involve a review of the current levels of medical input, to ensure we are using resources as effectively as possible. It will continue to provide blood transfusions.

**By 2021:** year 1 develop a wider MDT model including integrated complementary therapies, introduce a drop-in session and scope a new therapeutic day. Year 2: pilot new therapeutic day, integrate more closely with PFS, develop carers lead with PFS. Years 3 onwards consolidate revised service in accordance with lessons learned.

10. **Community Nurse Specialists (CNS).** Expand. The purpose of CNS teams is to provide advice and support to patients and their families in the community, where this is of benefit over and above the care provided by professionals such as GPs and District Nurses. CNS capacity was increased during 2013-15 to attend to unpredicted increases in referrals combined with evidence from benchmarking exercises which suggested the service was under-resourced compared with other hospices. This period has also shown that 7 day working by CNSs would answer a patient need and assist in improving the efficiency of the service. This is also in keeping with wider health sector aspirations<sup>8</sup>. CNS teams could also play a central part in helping to develop care/nursing homes to improve availability of EOLC beds.

**By 2021:** subject to affordability we aim to increase CNS staffing to enable 7 day working in Year 1. Care home support will be piloted and developed, probably in conjunction with Education, resulting in a sustainable and enduring model of support.

11. **Hospice at Home (HAH).** Expand. HAH purpose is to provide personal care to patients in their homes in the last weeks of life, and to provide respite to their families and/or carers, to enable patients to remain in their own homes when they

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<sup>8</sup> For example: The National Palliative and End of Life Care Partnership '*Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020*' [www.endoflifecareambitions.org.uk](http://www.endoflifecareambitions.org.uk)

wish. HAH remains a key enabler to discharging patients home to die, or allowing them to stay at home, and has the advantage of being under our control unlike other social services, thus improving co-ordination. We will continue to work in coordination with the Bristol Care Coordination Centre and the newly developed South Gloucs Coordination Centre. HAH's ability to provide respite is also an important component in the care of carers, but EOLC has often taken priority and we seek to address this. Although we have increased care hours by 30% in 2 years, demand for HAH regularly exceeds our current capacity. The model of using HCAs supported by roving RNs has proved successful when sufficient levels of RN support are provided and enables more hours of appropriate care to be delivered. Recognising the demands on HAH HCAs we seek to develop HCA competency in this period. We must therefore continue to increase the number of HAH hours, and this remains the highest priority for additional resources.

**By 2021:** Continue to increase HAH care hours by 10% per annum, with target of 30,000 hours in 2021. As part of this develop specifically resourced respite care. Train HCA staff to Band 3 competency level

**12. Psycho/Social/Spiritual Team to be renamed as Patient and Family Support (PFS)** . Develop/expand. Much has been learned from the first 4 years of the PSS Team about how the team can be better configured, enabling single discipline teams to function as part of a coordinated structure. Patient and Family Support is an umbrella term for the small teams (social workers, psychological therapists (Level 3) , a Spiritual Care Lead and Bereavement Care Coordinators) that offer individual and group support to patients and their families in relation to their psychological, social or spiritual needs. Both Spiritual and Bereavement Care are actively supported by a trained volunteer workforce. Physiotherapy and Occupational Therapy have been reallocated to this team, due to their close working with the social workers to support discharge plans and/ or enable independence to remain at home, and we aim to reinforce this team. We have recently introduced a Social Work assistant to support the increased demand on our social work team. Not least because of recent staff movement Patient and Family Support needs a period of rebuilding in year 1, to include the addition of Social Work and Therapy Leads. In years 2 onwards we seek to expand and enhance services provided by Patient and Family Support, and consider the inclusion in Patient and Family Support of Day Hospice as part of its revised therapeutic approach . We also aim to have increased availability of social work support for community patients.

**By 2021:** in year 1 subject to affordability Patient and Family Support will reconfigure and expand to include recruitment of two new Band 7 posts as Social Work and Therapy leads, and a Band 3 post in the Physiotherapy and Occupational Therapy Team. In Year 2 and beyond Patient and Family Support will expand its work with Day Hospice, increase group working with young people and develop the lead for carer support. The need for Level 4 psychologist support will be scoped, volunteer roles further developed and a benefits support implemented.

**13. Access Team/Advice Line.** Develop. The purpose of the Access Team is to triage every referral to the organisation and run the Advice Line service 7 days a week in normal hours. Building on the development of the Access Team since 2012, we will continue to enhance its operation in parallel with other services. We will be alive to potential benefits arising from the introduction of EMIS and scope the use of other technology. We will develop a patient information support role to ensure we



have robust and coherent processes regarding the information clinical staff offer patients and families. The 24/7 Advice Line will be maintained, and we will continue to seek NHS funding for it.

**By 2021:** subject to affordability in Year 1 appoint a Band 7 Lead and increase service hours to 2200 daily, working alongside expanded CNS hours. In years 2 onwards create a patient information role.

**14. Carer Support.** In this period we will develop our concepts of carer support through a variety of mechanisms such as information, support groups, respite and innovative use of technology. This will span all services and so we will scope how best to design, coordinate and manage this activity.

**15. Outreach.** Develop. Several existing and proposed lines of activity such as working with care homes, providing a drop-in service in Day Hospice, Hospice Neighbours, CNS working with the homeless and prison population, constitute a significant element of outreach. We will continue to scope this, particularly drawing on experience gained from new aspects of this plan.

**By 2018:** we will have researched and resourced an outreach programme designed to penetrate an increasingly complex demographic.

**16. Education.** Sustain. The education department is a service not an income stream but it should when appropriate cover all the costs of courses/training for external attendees, and seek opportunity to use spare capacity for revenue. In all cases, however, the prime purpose of the education delivered must be in keeping with the hospice's mission. The department need to remain responsive to the development needs of both the external and internal workforce. Priorities for the education department are, in order:

- a. Internal education, training and professional development. Based on the existing training needs analysis, and in close consultation with hospice management, this is to develop alongside and thus match the needs of the hospice. This should also be seen as a major contributor to staff recruiting and retention.
- b. Education, training and professional development for external agencies e.g. NHS, higher education health courses, care homes, nursing homes. In some of these aspects the education department will work in tandem with other services e.g. CNS teams.
- c. Wider education in the community about, for example, the hospice, death and dying. This should link directly to the objective above to improve access to services. This is engagement with a longer-term view e.g. schools and community groups to develop earlier awareness of EOLC in order to prepare people better for end of life issues. The education department is a valuable resource to gain greater engagement with minority groups. It could also be used as an internal research tool to understand cultural factors. It is accepted that as the lowest priority there will often be insufficient capacity for this.

**17. Research.** We will look for opportunities to participate in research activity. Acknowledging our limited resources in this respect we should aim to make ourselves "research ready", by developing an investigative culture for example using audits as opportunity for evaluation.

## Commercial

18. **General.** Develop. We are still about 80% dependent on our charitable income to support our services, which have had an average net increase cost of 7.5% pa over the past 5 years. Future NHS income is uncertain. We aspire to provide more services. The Commercial Director is thus to review all commercial activities with a target of a net increase in income of 3% per annum over the 5 year period. Over the past 3 years the Hospice Awareness Programme has enabled us to use every shop as an information point, stressing the relationship between all our fundraising, our patient services and the community we serve.

19. **Retail.** St Peter's shops remain a vitally important income stream which must be sustained; retail Gift Aid and rag prices have helped considerably in recent years but the latter in particular has proved very volatile, and income from it has dropped significantly as the price per kilo has halved over the past 3 years. While new retail income sources have already been established to offset the underlying decline in shop income which is common to the whole charity sector, the impending increases to minimum wage, henceforth the national living wage, will have a major cost impact on shops from 2016. Retail development over the next 5 years will include:

- a. New shops in areas not currently covered. Clearance shops have helped to offset rag price decline and those functioning from pop-up shops have proved particularly profitable. This is an area for growth. We should particularly seek new shops in areas where we seek wider engagement, e.g Stapleton Road.
- b. The "space release" programme in existing shops should continue guided by experience from previous such development.
- c. The opening of a warehouse has already enabled Ebay to expand and shop stock and fittings to be managed more efficiently. It will also enable us to operate a house clearance operation once a suitable furniture store has been found.
- d. Shop paid staff levels are to be validated.
- e. Other costs, especially lease renewals, are to be continually scrutinised.

20. **Fundraising.** Fundraising has been very successful since 2012 in most areas, and legacies in particular have exceeded budgeted income. This has served to offset the reduction in retail income over the same period. It is now clear that FR will be subjected to additional regulation in the coming year, which is likely to have a major impact on our ability to communicate with donors and supporters.

In the next 5 years FR will continue to develop:

- a. Regulation. We must analyse the implications of new fundraising regulation and take appropriate actions in a timely way to mitigate any adverse effects.
- b. Major capital fundraiser. IPU refurbishment may present a need or opportunity for a major capital project fundraiser and FR should scope options for this, including engagement with potential major donors.
- c. External Events. We must continue to engage with all major Bristol events e.g. Bristol Half Marathon. We have a plan in place to gain selection as the

charity for the Balloon Fiesta in 2017/18 to coincide with our respective 40<sup>th</sup> anniversaries.

- d. Internal Events. Midnight Walk has proved to have enduring appeal and so will continue but we must be alert to loss of popularity in future. Tour de Bristol has had an excellent start and promises growth potential so should be developed, aiming to attract 600 riders in 2017.
- e. Website and social media development. Social media and web-based means of raising funds have been developed considerably over the past 3 years. Future potential in this area will be analysed, in particular to scope the establishment of our own donation mechanism and thus avoid JustGiving costs.
- f. Lotto. We will continue to grow lotto membership using a 3<sup>rd</sup> party canvassing company, remaining vigilant for any adverse reputational impact. Single ticket sales via shops will be promoted.
- g. Legacies. Legacies will always be unpredictable. They had been declining during the period 2007-12 but have since exceeded budget by a significant margin. We must continue to consider new approaches, which must be sensitive and appropriate, to encourage legacies.
- h. Corporate. This is now considered an area of growth, having remained flat for some years. We will continue to engage actively with all Bristol-based businesses, especially those with a strong Bristol connection.
- i. Paid staff are to be encouraged to support hospice fundraising activities.

## **People**

**21. Paid Staff.** We have experienced difficulty 2012-15 in attracting sufficient numbers of qualified clinical staff of the right quality, which has led to new ways of approaching recruitment. In order to recruit and retain high quality staff St Peter's must demonstrate a commitment to the welfare and development of its staff and be innovative in our approach. The following measures are to be taken:

- a. We have adopted a pro-active recruitment approach to attract the best clinical staff, especially RNs and this must be developed. Different media will be used especially social media to publicise our employment offers, and a programme of open events is to be maintained to encourage potential employees to gain a better understanding of the hospice. We will review the number of student nurses we can support post IPU refurbishment and whether we can support preceptorship nurses. We must be more direct about the benefits enjoyed by SPH staff relative to NHS.
- b. A formal annual pay review process has now been in place since 2013 and is to be maintained. The Governance Committee continues to review SMT salaries, while Resources Committee is required to approve any overall annual increase recommended by Executive. The Executive considers Line Managers' recommendations for specific individual pay awards.
- c. Personal development plans are to be maintained for all personnel; training and education needs are to be coherently identified organisationally. A Training Panel has been created to consider and authorise applications for training or education funding where these carry significant cost to the hospice.

A central training budget has been created to support these applications. Internal training opportunities e.g. Retail Development Programme and Leadership Course are to be sustained. Such opportunities for staff should be used to support recruiting and retention.

- d. Individual Performance Review (IPR). All paid staff are to receive mid-year and end of year IPRs annually. The IPR process is now embedded in SPH and revisions have recently been made to simplify that process for shop staff and improve the IPR format. Clinical supervision for all staff directly involved in patient care has been successfully implemented and will be maintained.
- e. Biennial staff survey. A staff survey is now held biennially. Using the same question set each time, trend analysis is becoming more valuable.

22. **Professional Advisors.** We will regularly review our professional advice to ensure it provides the necessary expertise combined with understanding of the hospice and its work at a cost which is reasonable and offers value for money.

### 23. **Volunteers**

- a. Recruitment programme. We remain well supported by a generally active volunteer body. We recruit successfully, but we should continue to seek volunteers from all elements of the community we serve. Head of Volunteer Services has now taken responsibility for all aspects of SPH volunteers, including shops, in order to improve volunteer recruitment, encourage a single sense of SPH volunteer identity and ensure consistency of volunteer policy.
- b. Wider use. Volunteer Resources will research the wider use of volunteers across all areas of the hospice, especially clinical, in conjunction with relevant managers, in order to improve services and minimise costs.
- c. Trustees. We recognise the role and responsibilities of the Trustee Group and will ensure that they hold appropriate experience and skills to oversee the development of the hospice. We will continue to pay attention to their development and plan succession.

24. **Supporters.** Community support groups. These groups are to be fully supported and helped to develop, especially to find new (and younger) members. Innovative ways must be found to support virtual community support groups when they are created on-line.

## **Infrastructure**

25. **General.** Since 2013 the Commercial Team has been relocated in new office accommodation at Long Ashton, which also houses the South CNS Team. This has been very successful and there remains no intention to try to co-locate the Commercial Team at Brentry. The Garden Rooms at Brentry, built with Department of Health funding to provide dedicated therapy space, have been opened. We aim to make wider use of these, by both hospice and some selected non-hospice users. A car parking survey was conducted in 2014 at Brentry which confirmed that there was insufficient parking in the hospice car park at peak times, especially if external training events were being held, but there was always sufficient on-street parking

nearby which attracted no adverse local comment. Local business has always made their parking space available to us for major events. There was insufficient evidence to support any expansion of the existing car park.

**26. IPU refurbishment and development.** IPU development remains the most significant infrastructure issue. Since 2013 options for its refurbishment have been developed but the central difficulty has always been how to maintain the service while doing extensive building work. Opportunity has arisen which will be scoped in 2016. If a feasible option exists a project manager will be required to plan the necessary hospice activity to support the build.

**27. Environment/ Energy.** A hospice environmental plan is to be put in place in 2016. This is to include consideration of energy efficiency and installation of renewable energy sources, with a view to reducing energy costs in the medium term as well as lowering the hospice's carbon footprint. This work will be linked to any IPU rebuild.

## ICT

### ICT Strategy

**28. General.** ICT is to provide support for organisational change. We will use new capabilities, e.g. EMIS, to enable us to improve our services and we will look for other opportunities for technology, particularly ICT, to make all areas of the hospice more effective. The following are key factors:

- a. The adoption of EMIS Web by patient care services.
- b. Information governance.
- c. A need for better methods of system integration.
- d. The importance of enabling supporters to donate or communicate with the organisation digitally, using the channel of their choice, will increase.
- e. The trend of applications hosted by software providers is expected to continue. Where possible, SPH seek to take advantage of this change.
- f. Business continuity.
- g. The need to take advantage of the 'richer' data that is being captured, across the whole organisation, through more sophisticated data analysis.

### 29. Deductions:

- a. The core IT services will continue to be outsourced, but we aim to reduce both their scope and cost (in real terms) over the next 5 years. The contract is to be reviewed and tendered by 2018.
- b. There is a need for an internal IT Service Manager, to assume the ICT responsibilities currently held by FD.
- c. Where cost effective applications should move to being hosted externally.
- d. New application selection and implementation must ensure digital integration with connected systems.

**30. EMIS Web.** Release 1 of EMIS Web in April 2016 will bring significant change and benefit. Community focussed staff will take advantage of mobile computing. Data

sharing with GPs and District Nurses will drive data quality and standardisation. This increased capability will demand greater resource to enable it to be fully exploited, as follows:

- a. More mobile devices for IPU and community based teams will be needed.
- b. More support and management to and of the system, overseen by good governance, will be required, most likely in the form of an additional post in patient care.
- c. Release 2 will enable Healthcare Assistants (HCAs) to enter data on patient digital records (c. 50 additional users). This will have an impact on training, support and hardware requirements.

31. **ICT Infrastructure.** This includes: telecommunication system, computer hardware (servers, desktops, etc.), operating systems, data links. The move to an off-premise solution was anticipated in the 2012 Plan. For this reason the decision was made to manage with the existing physical server set-up. Physical servers will be >6 years old in 2016/17. The selection and introduction of EMIS Web allows the requirements for the local servers to be defined and purchased in 2016/17. The plan remains to continue to use a virtual server environment using VMware. This is still a more attractive option than using a physical server environment for a number of reasons including, improved business continuity capabilities and lower energy consumption.

32. **Business continuity.** Access to ICT services is organisationally critical, and so ICT business continuity plans must be robust. The SPH approach remains to run the majority of on-premise services from the Brentry site and for these servers to have built-in redundancy. In the event of a server failure that cannot be managed locally, IT services will “fail over” to servers at Estune that will continue to be replicated. This area must be regularly tested and subject to regular review. ICT support will be a vital part of any IPU relocation. This is potentially more complicated in an N3/EMIS Web environment.

33. **Information security.** Generally, ensuring the security of information has become increasingly complicated as the desire to share data conflicts with the rising concerns over the loss or misuse of data and the rise in cyber-attacks. Already required for the N3 connection, but highlighted by the introduction of EMIS Web, is the need to comply with Level 2 of the NHS Information Governance Toolkit.

34. **New projects.** The following new projects are planned:

- a. The HR/Payroll system is to be reviewed in 2016/17 with replacement in 2017/18.
- b. The Finance and purchase order system are not integrated. This is to be reviewed in 2017/18.

## Finance

35. **Finance Team.** The planned departure of the current FD in July 2016 presents the opportunity to fully review the size and structure of the Finance Team which is to be determined in consultation with the incoming FD when appointed.

36. **Reserves.** The reserves policy has been fully re-assessed since 2013 and now centres on an analysis of risk to our income streams and the cumulative effects if such risks were realised, profiled over a realistic period during which SPH would have to make changes to manage such reduced income. It has been agreed that we should attempt to spend down our surplus reserves over the period of this plan.

37. **Investment Policy.** The SPH investment policy has been comprehensively reviewed in 2014 alongside an external review of our fund managers. Given the increased value of the SPH portfolio following the realisation of the value of Peg Hill land bequest, we must continue to review our investment policy. A fund manager review should be done in 2019.

38. **Procurement.** We must continue to seek more efficient procurement and to that effect have joined the Hospice Quality Partnership in 2015. This is still immature but has much potential and we should remain a member for the coming period, evaluating its benefits annually.

### **Communications and Marketing**

39. **General.** A separate communications plan is to be revised annually to identify target audiences and key messages and ensure all activity is coordinated.

40. **External.** Externally we must ensure we communicate consistently and effectively with all those who

- a. Influence our activity. This will include the NHS (especially but not limited to commissioners of services), policy makers and opinion formers (e.g. Health and Wellbeing Board, MPs, councillors), other hospices and providers, educational institutions.
- b. Could be of direct or indirect benefit such as the media, local businesses, major event organisers, influential individuals.
- c. Use our services. "Iwantgreatcare" and PLACE (Patient Led Assessment of the Care Environment) will be central to this for the patient and carer perspective. We will continue periodically to survey other health professionals. We will continue to communicate with patients and families via internet social media such as Facebook and Twitter, and to develop this channel.
- d. Potential service users. We will continue to seek channels to communicate with geographical areas and elements of our community which are under-represented amongst our referrals, for example minority ethnic groups and the homeless. These channels should span all areas of hospice activity, both clinical and non-clinical. Shops and fundraising can provide such opportunities to increase awareness of our work.

41. **Internal.** Our internal communications to ensure all members of staff, both paid and voluntary, are kept aware of developments and able to comment appropriately have improved but demand constant attention. The following measures will continue to be used:
- a. Routine cascade of information from Executive meetings using management structure.
  - b. Use of intranet to pass information; key to this will be to attract staff to look regularly at the "Communicate" pages.
  - c. Internal newsletter Connect.
  - d. Staff surveys.
  - e. Monthly informal CEO sessions open to all staff.
  - f. Periodic volunteer events organised by Head of Volunteer Services.
42. **Marketing.** We will build on our successful campaigns by advertising through various media including radio, poster sites, online, public transport and in print. We will continue to develop our own in-house design capability to reduce costs and improve product. With fundraising the marketing department will maintain a high level of activity on social media, ensuring we remain up to date with most recent developments in this arena.

### **Risks**

43. During the period of this plan the key risks to it are assessed as resource-based:
- a. **Affordability.** A combination of reduced or flat NHS Funding, reduced charitable income (most probably from retail) and increased costs arising from the new national living wage may limit our ambitions to expand in all the areas proposed.
  - b. **Staffing.** Recently the hospice has had difficulty recruiting into certain roles, notably RNs and shop managers. While we will attempt to overcome this through innovative recruiting, we may also have to tailor some developments, for example in patient services, accordingly.

### **Summary**

44. During the period 2016-21 St Peter's Hospice will continue to expand its services. We will make greater efforts to describe better the purpose of our services and thus to ensure clarity for everyone and coherence across those services to make best use of resources. We will continue to seek greater engagement with under-represented areas and elements of the community, in order to ensure equity of access to all our services. Recognising the complexity of the project it is still the intention to refurbish and modernise the IPU at Brentry. The Day Hospice programme will be developed. We will also seek to increase our effect in the community by enlarging HAH, moving CNS service to 7 day working and assisting care homes as well as scoping a carer support service. To support this activity we will continue to secure our income streams, where necessary by adaptation and innovation, and we will pursue the wider use of volunteers across all areas of the hospice.