“The scale of the challenge ahead is dramatic and will require hospices to significantly increase the extent and scope of end of life services”.
(Hospice UK Commission, January 2013)

“How we care for the dying is an indicator of how we care for all sick and vulnerable people”.
(National End of Life Care Strategy, 2008)

“One chance to get it right”.
(The Leadership Alliance for the Care of Dying People, June 2014)
St Luke’s Hospice Plymouth has been likened to a huge ship, whose crew work tirelessly to keep her safe and steer her in the right direction. It takes a while for such a large vessel to build up speed or turn and it is only by looking back at the wake that one can see how far we have come. As I come to the end of ten years as a Trustee and the seven year tenure of my Chairmanship, I look back on what we have achieved together.

The hospice has come a long way in the 35 years that is has been delivering exceptional care. While the quality of the care we provide has remained constant, the ways in which we provide that care have changed with the needs of the community we serve.

From the humble beginnings of our first inpatient unit, we now have teams in the hospital and community delivering care to more people in a variety of settings. Our ‘Hospice without Walls’ is now reaching further with a crisis team able to offer high quality care to people wherever they may be. Everything we do must be in pursuit of our vision of “a community where no person has to die alone, in pain or in distress.” By constantly evolving to meet demand and deliver that vision we ensure that St Luke’s is sustainable and here to help people for many years to come.

We cannot do this alone so we must work in partnership with others to further our vision; whether by sharing best practice, educating other professionals, signposting to more appropriate providers or joining together with other organisations to deliver more comprehensive and joined-up services. We are partnering with fellow hospices and other healthcare organisations in a spirit of selfless cooperation like never before.

I know the new Chair, the Board of Trustees and the Senior Management Team of St Luke’s Hospice Plymouth are united in their determination to continue our mission to work in partnership with others to achieve dignity, comfort and choice for people affected by a life-limiting illness.

I don’t know what the next 35 years will bring, but the plan for the next few years is what this strategic plan sets out. It has been a pleasure, privilege and honour to be a part of the journey with you.

Stuart Elford, CMgr FCMI, Chair
As we celebrate our many achievements over the last 35 years, we acknowledge the significant challenges facing us which are unprecedented with a rapidly ageing population who are living longer with increasingly complex needs at the end of their life. This changing demographic is set against the economic realities facing our country and our health care services and how services will be delivered in the future. [1, 2, 3]

These challenges require a brave response; we feel therefore that our plans over the next year are ambitious, stretching and innovative, to ensure that we not only meet the current challenges, but we continue to thrive, adapt and lead.

We will further develop the concept of ‘Hospice without Walls’ (see appendix A for definition of Hospice without Walls) and build partnerships. In working with others we can find new ways to innovate, influence, speak up and share our expertise, to encourage and ensure the delivery of high-quality palliative and end of life care by ourselves and other health and social care providers. We know that the future will make significant demands on the hospice workforce. Providing more and different care will require a better use of all the people that work and volunteer for St Luke’s. [4,5] However, we cannot and must not work alone; we will continue to work in partnership with many other organisations. I also acknowledge the support we obtain from our local community who trust us and give generously in order for us to deliver excellent care to patients and their carers/families.

*Steve Statham, Chief Executive*
“A community where no person has to die alone, in pain or in distress”.

Our vision is a far-reaching aim towards which everyone involved in end of life care should strive. St Luke’s vision provides an underlying service of purpose for staff, volunteers and stakeholders. In order to realise our vision we have clarified our mission, and how we aim to progress towards it.
St Luke’s Mission

“St Luke’s Hospice Plymouth works within our community in partnership with others to achieve dignity, comfort and choice for people affected by a life-limiting illness, by delivering and influencing exceptional care”.

Our mission sets out what St Luke’s role will be in helping to enable our vision to be realised. This mission gives greater prominence to not just the direct delivery of end of life care, but also exerting even more influence upon others involved in end of life care by bringing our experience and expertise to the work of health and social care professionals.
St Luke's Hospice Plymouth is registered as a company limited by guarantee at Companies House and is also registered with the Charity Commission.

Our services are delivered free to those with life-limiting illnesses. To do this we have an income generation team and a retail operation consisting of 30 shops who between them need to raise over £4.5m each year to assist in maintaining and developing our services. Around 30% of our income comes from the NHS. All our actions are governed by the knowledge that we have a duty to manage our resources wisely and cost effectively.

The care we provide may be for those with either malignant disease or non-malignant life-limiting illness (e.g. motor neurone disease, end stage heart and lung disease). We cover an approximate population of 450,000 and see people in St Luke's premises, their own homes, care homes and in the hospitals within the catchment area. The integrated service offers support and care for patients facing an incurable life-limiting condition in particular for: management and monitoring of persistent symptoms, management of complex emotional/psychological issues, management of complex family/social issues and end of life care.

In addition to providing advice, support and care to patients, their carers and other healthcare professionals, St Luke's also provides palliative care education and specialist training for medical students, doctors, nurses and other health and social care professionals. In order to achieve the vision of a community where no person has to die alone in pain or in distress, St Luke's strategy is to develop wider support from the local community through education and community engagement, raising awareness and empowering the community to support itself. (See appendix B for details of the management of St Luke's.)
The service we deliver is covered by the following three integrated pillars:

**VISION**
“Our vision is a community where no person has to die alone, in pain or in distress”

**OUR MISSION**
We work within our community, in partnership with others to achieve dignity, comfort and choice for people affected by a life-limiting illness, through delivering and influencing exceptional care.

**PRINCIPLES**
Innovative, Evidence-based, Individualised, In Partnership

**VALUES**
Professionalism, Respect, Compassion, Integrity
**Specialist Care**

At the core of what we do is the provision of specialist care services. The focus of these services is on complex symptom control/terminal care. The service we provide includes:

- Inpatient care service
- Community based specialist advisory service
- Hospital based specialist advisory service
- Medical outpatients and domiciliary visits
- Crisis intervention service
- Telephone advice and support

**Supportive Care**

- Domiciliary care service
- Lymphoedema (under a separate agreement)
- Lymphoedema service for cancer related and non-cancer related
- Bereavement/befriending service
- Services delivered by St Luke's Care to complement and enhance those services provided in a person's home
- Supporting and signposting carers to access relevant services
- Volunteers to support patients at end of life

**Education and Community Engagement**

- Proactive education of professionals
- Development and support of end of life care champions
- Driving excellence across care homes in end of life care
- Driving partnership working to coordinate and make the most of services
- Raising awareness about death, dying and caring for people in the last days of life in our community
- Working in partnership with existing care groups to empower individuals, groups and the wider community to care for people living and dying with a terminal illness
- Promoting and growing the concept of advanced care planning to help address people's future care needs and wishes, to achieve a good death
- Signposting to other support groups
During 2016/17 St Luke’s supported approximately:

- **250** Inpatients
- **1500** Community patients
- **700** Outpatients
- **1100** Hospital patients

Total of approximately 3550 patients
Our Values

Professionalism, Respect, Compassion, Integrity

At St Luke’s we are proud of, and passionate about our history and the care we provide. This has been achieved by the hard work, dedication and commitment of all the staff and volunteers who have made St Luke’s what it is today. Our values are at the core of all our services. They inspire us and drive us to ensure we provide the best possible care to as many local people as we can reach who are living and dying with a terminal illness.

Professionalism

- Striving for excellence in everything we do
- Setting high standards and challenging ourselves to do our best
- Having the courage of our convictions
- Inspiring creativity, passion, optimism and fun

Integrity

- Being positive and realistic about our abilities
- Keeping our promises
- Communicating information honestly, openly and straightforwardly
- Having the personal courage to make the right tough decisions

Respect

- Taking time to say “thank you”
- Being fair and treating everyone with respect
- Embracing diversity; respecting the breadth of cultures, values and traditions
- Welcoming the opinions and ideas of all people

Compassion

- Giving time to listen
- Giving time to care
- Offering hope, comfort and support when required
- Understanding a position from others’ perspective

Our Principles

We aim for excellence and have agreed a number of principles which guide our strategy and our action plans. We will be innovative and our services will be evidence based. Our staff will have the skills and knowledge to deliver excellent services, the motivation and passion to make a difference and the processes and structures that allow them to work in an integrated way. We will ensure that our services are individualised (based on need not diagnosis and delivered where patients need them) and we will work in partnership with others; involving all stakeholders in decisions and avoiding duplicating services. We will deliver care but we will also provide education and support to those caring for patients at the end of life.
We will develop new and existing positive collaborative relationships with key stakeholders and partners in order to secure a more joined-up approach to the provision of end of life care and in doing so maximise the use of our expertise to influence the care that others give.

We will embed the National Ambitions for Palliative & End of Life Care framework into the delivery of our services to ensure the needs of people who are living with dying, death and bereavement are met, and that their priorities, preferences and wishes are taken into account at all times.

We will ensure that our workforce is fit for the future by continually investing in the effective recruitment, development and motivation of staff and volunteers.

We will focus on enhancing the well being and resilience of our staff and volunteers through training, communication and the further development of attitudes, beliefs and values to preserve and reinforce our positive culture.

A community where no person has to
We will develop new and existing positive collaborative relationships with key stakeholders and partners in order to secure a more joined-up approach to the provision of end of life care and in doing so maximise the use of our expertise to influence the care that others give.

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We will focus on enhancing the well-being and resilience of our staff and volunteers through training, communication and the further development of attitudes, beliefs and values to preserve and reinforce our positive culture.

We will develop further our Information technology (IT) systems to achieve wider connectivity with our external Health and Social Care partners so that up to date vital key patient information is available across different clinical settings at all times.

We will adopt the core principles of Information Governance throughout the organisation and by working in collaboration with the NHS achieve the correct level of accreditation to enable us to share information.

We will continually adapt and take every opportunity to improve how effectively and efficiently we work, in order to respond to the increasing needs and growing complexity of the care required. We will achieve this by continuing to standardise and simplify all our systems and processes.

We will achieve financial stability to enable us to continue to develop our services to meet the growing needs of those we serve, through developing new approaches to fundraising and by investing in innovative and sustainable sources of new income.

We will review all our business and support areas to look at reducing our overhead costs, through partnerships or collaboration with other organisations to generate new economies of scale.

A community where no person has to die alone, in pain or in distress.
As we work towards realising our vision, we face a number of challenges and opportunities. We will need to adapt to the changing environment or we will cease to be effective, or even relevant, to those who need us. These challenges and opportunities, both local and national, will influence our growth and direction, both now and in the future and these have been considered during the development of our strategy.

As more people are living into old age and patterns of disease in the last years of life are changing, a greater proportion of our population will be living with and dying from chronic illness. There has been a growing realisation that people dying from progressive non-malignant diseases have similar symptom control problems, communication issues and unrelieved palliative needs to those with cancer. [7] Research suggests that most people would like to die at home, while mortality data suggests that the majority of people do not die in their preferred place of choice. [8,9] There are other providers who are willing and able to provide care that reflects the principles and practice of traditional hospices.

The key challenges and opportunities are:

• We will need to find innovative ways of raising revenue, of making our limited resources stretch further, and re-focusing resources on new and significant needs

• The future will make significant demands on our workforce as we face the challenge of changing working patterns, greater flexibility of roles, new educational and skills requirements, and a shortage of skilled workers [4,5]

• Significant shifts in demography and disease which are likely to challenge end of life care [2,10]

• Constant reform of health and social care

• Competition and the development of an emerging market in end of life care

• The inability of care institutions to provide consistent, effective and compassionate care

• Constrained and uncertain future income from public bodies [11]

• Increasing competition of fundraising and the need to strengthen our relationship with supporters/donors against a background of a general mistrust of charities

• Our society is ageing and the consequences are significant. More than 1 in 5 people in north, east and west Devon are over the age of 65 and this will be almost 1 in 4 by 2021.

• By 2035 there will be 3.5 million deaths in the
UK in the over 85s which will represent half of all deaths in the UK \[1, 2, 3\]

- The complexity of care facing us in the future is a consequence of the chronic nature of conditions from which people will be dying and the fact that many individuals will be living with multiple illnesses \[12\]

- Under New Devon's success regime, it is estimated that local health and social organisations are facing a financial shortfall of £442million by 2020/21 if nothing changes

- Increased number of people with dementia. It is projected that the number of people with dementia will rise from its current level of 800,000 people to 1,700,000 in 2051. \[13\]

To arrive at our priorities we have considered all the available national policy and guidance, as well as facts and projections in relation to local palliative care requirements over the next five years.

Our key reference document and the framework for the development of our services for 2017/18 is based on the National Palliative and End of Life Care Partnership national framework document, Ambitions for Palliative and End of Life Care. \[6\]

This document not only drives St Luke's actions and commitments to improve care, but local leaders in every community, including Clinical Commissioning Groups (CCGs), and local authorities, are expected to use the framework to plan and act in order to create far more integrated care and so ensure a better response from society to sudden, unpredictable or very gradual dying.

We have mapped our services against the Ambitions for Palliative and End of Life Care and stated publicly our commitment to the community using this framework so that these ambitions can be brought into reality. (Appendix C).
Underpinning the strategy of St Luke’s are a number of detailed departmental and functional strategies including Education, Social Care, Training and Development, Hospital Services, Income Generation, HR, Clinical Services, Retail and IT. In addition, detailed aims and action plans are prepared by each Head of Department, agreed with the responsible Director, and are regularly monitored by the Senior Leadership Team.

St Luke’s has developed a clear vision and plan for 2017/18 to take our long-term strategy into account. Our priority is to provide specialist care in the last days of life for those who have the greatest need. We also aspire to ensure that everyone has access to appropriate care and support at the end of life, and we therefore provide education, general support services and advice to patients, professionals and carers. We are committed to equality of opportunity and access to services and we aim to provide a service that is tailored to the needs of the individual. We recognise that we cannot deliver intensive end of life care to everyone and we therefore allocate resources to ensure that we can empower others to support local people at the end of life.
Key Strategic Objectives
2017/18

End of Life Coordination Centre

i. As identified in the End of Life Strategy for England (2008), critical to delivering effective care is the importance of a central coordinating facility that provides a single point of access through which all services can be coordinated.

We are ideally placed to be involved in coordination care for our local community and we will work towards becoming the key provider for the coordination and provision of End of Life Care (EOLC) across the western locality of NEW Devon CCG.

Under this new arrangement, we will involve bringing together other organisations, so that anyone needing end of life care will have one central point of contact to coordinate their care.
To deliver this end of life care model we will continue to develop formal partnerships with Livewell Southwest and Marie Curie. The pilot scheme will be evaluated during 2017/18. If it has proven to be successful we will make recommendations to the commissioners to make this a permanent arrangement.

Empowering the Community

iii. Workforce development is one of the essential factors to the future success of our strategy and its implementation. We are in a unique position to provide this education and have already seen the impact some of our education projects are having on the end of life care provided by other organisations, e.g. Six Steps programme. As part of the community in which we live, we will play a role in raising awareness and empowering the community to support itself. This will be achieved in a number of ways such as raising public awareness and working with community groups to enable them to better support people at end of life in their communities.

Develop IT Systems

iv. We know that in order to operate effectively with our NHS partners and other health care providers, we need to further develop our Information Technology (IT) systems. Shared patient information across the different clinical settings is critical to the success of any integration. We will therefore work towards achieving greater, wider connectivity with our external health and social care partners by achieving the correct level of accreditation with the NHS that will enable us to share and receive appropriate patient information.
Workforce Development

v. We know that in order to provide more and different care will require better use of all the people that work and volunteer for us. One of our key strategic priorities is how we develop our workforce to achieve flexibility and responsiveness required for the changing needs and preferences of our users. The development of our workforce is not just about the skills and knowledge but creating the right environment where all staff and volunteers feel valued, supported and motivated to succeed in their role.

Competitive Environment

viii. All this takes place within a changing and more competitive healthcare environment. There are other providers who are willing and able to provide care that reflects the principles and practice of traditional hospices. We need to demonstrate that we represent better value in terms of high-quality care and excellent outcomes. This will entail focusing on our core business and emphasising what we do best, while supporting others to plug the gaps.

Reducing Overhead Costs

vi. We will continually adapt and take every opportunity to improve how effectively and efficiently we work, and to reduce our overhead costs wherever possible. This will involve us simplifying our processes and looking at opportunities to work in partnership with other organisations to share costs and generate greater buying power.

Sustainable Sources of Income

vii. In order to develop our services to meet the growing needs of those we serve we need to find innovative ways of raising revenue. We will investigate and where appropriate invest in new sustainable sources of income. We will continue to strengthen our culture of fundraising. To reinforce it is the responsibility of all staff as well as positively engaging with all our supporters and donors to make them aware of how their donations make a difference to patients and families.
We have identified nine strategic objectives that will help us consolidate and move towards our mission and vision. The nine strategic objectives have been directed by three broad but far reaching strategic priorities: Hospice without Walls, workforce development and organisational awareness.

<table>
<thead>
<tr>
<th>Strategic Objective</th>
<th>What success will look like for 2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. HOSPICE WITHOUT WALLS</strong></td>
<td></td>
</tr>
<tr>
<td>1. We will develop new and existing positive collaborative relationships with key stakeholders and partners in order to secure a more joined-up approach to the provision of end of life care and in doing so maximise the use of our expertise to influence the care that others give.</td>
<td>St Luke’s will have representation on the Health and Well-being Board.</td>
</tr>
<tr>
<td>2. We will embed the National Ambitions for Palliative &amp; End of Life Care framework into the delivery of our services to ensure the needs of people who are living with dying, death and bereavement are met, and that their priorities, preferences and wishes are taken into account at all times.</td>
<td>Formal contract/grant agreed with appropriate commissioners for a three year period.</td>
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<td></td>
<td>St Luke’s alongside Livewell Southwest, Derriford and Marie Curie will have agreed a five year plan with the local commissioners on working collaboratively to improve end of life services in line with the local STP plan.</td>
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<td></td>
<td>The use of outcome measures will be embedded throughout clinical services.</td>
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<td></td>
<td>Successful completion of the End of Life co-ordination pilot project in June 2017 leading to the establishment of a permanent EOL hub with St Luke’s as the lead provider.</td>
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<td></td>
<td>In conjunction with Devon hospices, impact upon the provision of End of Life care within the Devon STP and ensure EOL pathway is contained within the integrated care work stream.</td>
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<td></td>
<td>A sustainable model of spiritual care is embedded in the organisation and staff will have attended awareness workshops.</td>
</tr>
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</table>
**Key Strategic Objectives 2017/18**

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<tr>
<th>Strategic Objective</th>
<th>What success will look like for 2017/18</th>
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<tr>
<td><strong>B. WORKFORCE DEVELOPMENT</strong></td>
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<tr>
<td>3. We will ensure that our workforce is fit for the future by continually investing in the effective recruitment, development and motivation of staff and volunteers.</td>
<td>All line managers within the organisation will have completed training in key areas of HR e.g. absence management, performance management and training in resilience building.</td>
</tr>
<tr>
<td>4. We will focus on enhancing the well-being and resilience of our staff and volunteers through training, communication and the further development of attitudes, beliefs and values to preserve and reinforce our positive culture.</td>
<td>360 degree appraisals completed for all of the SLT and OMG.</td>
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<td></td>
<td>Workforce planning model completed, along with succession plans for all areas completed by the SLT.</td>
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<td></td>
<td>Staff reporting that their well-being is supported by the organisation, through the implementation of a health and well-being strategy, and our health and well-being week becoming an annual central focal point for staff.</td>
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<td></td>
<td>Implementation of the findings of the pay review strategy being established in practice, with staff reporting back that a clear and fair process has been implemented.</td>
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<td></td>
<td>All staff will have completed the values workshops and our refreshed values will be in place throughout the organisation.</td>
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<td></td>
<td>A two year formal pathway for the development and assessment of newly appointed clinical nurse specialists will be embedded within the community specialist palliative care team.</td>
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</table>
## Key Strategic Objectives 2017/18

<table>
<thead>
<tr>
<th>Strategic Objective</th>
<th>What success will look like for 2017/18</th>
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<tbody>
<tr>
<td><strong>C. ORGANISATIONAL EFFECTIVENESS</strong></td>
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<tr>
<td>5. We will develop further our Information Technology (IT) systems to <strong>achieve wider connectivity with our external health and social care partners</strong> so that up to date vital key patient information is available across different clinical settings at all times.</td>
<td>Passing level 2 of the IG toolkit and the establishment of a Health and Social Care network.</td>
</tr>
<tr>
<td>6. We will <strong>adopt the core principles of Information Governance</strong> throughout the organisation and by working in collaboration with the NHS achieve the correct level of accreditation to enable us to share information.</td>
<td>Completion of a review of key support functions with recommendations regarding any opportunities for out-sourcing, collaboration or partnerships with other organisations for implementation during the 2018/2019 financial year.</td>
</tr>
<tr>
<td>7. We will continually adapt and take every opportunity to <strong>improve how effectively and efficiently we work</strong>, in order to respond to the increasing needs and growing complexity of the care required. We will achieve this by continuing to standardise and simplify all our systems and processes.</td>
<td>Attainment of overall budget for 2017/2018.</td>
</tr>
<tr>
<td>8. We will <strong>achieve financial stability</strong> to enable us to continue to develop our services to meet the growing needs of those we serve, through developing new approaches to fundraising and by investing in innovative and sustainable sources of new income.</td>
<td>Attainment of fundraising profitability for 2017/2018.</td>
</tr>
<tr>
<td>9. We will review all our business and support areas to look at <strong>reducing our overhead costs</strong>, through partnerships or in collaboration with other organisations to generate new economies of scale.</td>
<td>Identification of a new commercial venture to launch in April 2018 with a projected minimum net contribution of £40K to give us a sustainable new source of income.</td>
</tr>
<tr>
<td><strong>Further embed the principles of knowledge management meeting agreed critical success factors. Through employee surveys be able to demonstrate improvements in knowledge sharing across the organisation and a reduction in how much time staff spend in searching for information.</strong></td>
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<tr>
<td><strong>Improvement in internal customer service surveys.</strong></td>
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<tr>
<td><strong>Improved efficiencies across departments including overhead costs and processes.</strong></td>
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</table>
Financial Review, 2016/2017

The hospice has been running at a deficit over the last few years and the organisation has been driving towards achieving more financial sustainability in this time, by looking at new areas of income generation and through efficiency savings. The budget for 2016/17 was set with a small deficit, and current forecasts for the year end in March 2017 are still aiming to achieve this.

In the year, the Board of Trustees have reviewed the organisation’s reserves policy and, rather than setting it to achieve a minimum number of months of free reserves, has looked at it with a risk based approach. As a mature organisation with a variety of established income streams and predictable and well planned expenditure, it would be more appropriate for St Luke’s to operate a reserves policy centred on an analysis of the potential risks to the amounts of those income streams and of the potential risks of over expenditure. In the current year, the board has set its minimum risk reserve requirement at £2.2million, and currently the organisation has £2.7million in free reserves.

This year’s fundraising income has recovered somewhat from the previous year, still behind budget which is disappointing but not surprising in light of recruitment difficulties in the income generation team which have now largely been resolved. Retail income is continuing its trend and increasing its contributions to the charity. The lottery business however has seen a further drop in playing members, as we lost our canvassers to retirement. We have recently reviewed our approach to canvassing for members and are hopeful that we can rebuild our lottery membership to previous levels and even beyond. In the last year the crisis intervention services have been fully bedded in, and we have been seeing increasing numbers of patients this year.

St Luke’s has long relied on generous bequests to help run the service, and over the last five years, annual legacies (adjusted for outliers) have averaged just below £1million. For 2016/17 we budgeted for around £750,000 in legacies, we re-forecasted this amount to £850,000 and we are still on target to achieve this. Analysis indicates that most of our legacies average at around £15,000 and these add up to around £500,000 per annum.
Looking ahead, the business plan is assuming some growth in fundraising income and donations, with greater emphasis on major donor engagement and regular giving and donations. The retail business is also poised to grow, through the new white goods project launched in late 2016, as well as through additional sales of new goods. The retail group will be contributing £1.3million in profit to the charity with steady but challenging growth targets thereafter. The lottery contribution is also budgeted to grow with more canvassing along with second number ticket sales and alternative revenue sources.

In the pipeline at the start of the next financial year is around £350,000 for bequests, and we have set a budget legacy figure of £750,000. Going forward we have set our baseline target figure below £750,000 reducing to around £550,000 in the next five years. This should make for a more robust plan going forward, and reduce some of the risks associated with budgeting for large legacy amounts in our longer term plans for the business.

Overall, the five-year plan indicates that free reserves will range between £3million and £4.6million. We will be carrying out risk assessments on this every six months and feel confident that these levels will not only make us financially stable in the medium term, but also allow us to fund more innovative income generation initiatives. A planned major fundraising event in year three will help us to generate more income. Any spare reserves in excess of our minimum risk reserve requirement will be designated to develop new and improved services in line with the needs and preferences of patients living with and dying from advanced incurable illness.

The five year business plan also makes realistic assumptions around staff costs, and other costs. With these assumptions, we are confident that we will become more financially sustainable over the next five years, and spend our resources in the best ways possible.
# Income & Expenditure Account

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<tr>
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<tbody>
<tr>
<td>Charity Income</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Fundraising &amp; Donations</td>
<td>1,729</td>
<td>1,993</td>
<td>2,484 *</td>
<td>2,166</td>
<td>2,275</td>
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<tr>
<td>Bequests</td>
<td>750</td>
<td>600</td>
<td>550</td>
<td>550</td>
<td>550</td>
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<tr>
<td>NHS Grants</td>
<td>1,953</td>
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<td>1,953</td>
<td>1,953</td>
<td>1,953</td>
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<tr>
<td>Education Income</td>
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<td>99</td>
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<td>Food Receipts</td>
<td>50</td>
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<td>53</td>
<td>55</td>
<td>58</td>
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<td>Investment/Property</td>
<td>121</td>
<td>122</td>
<td>123</td>
<td>124</td>
<td>126</td>
</tr>
<tr>
<td>Crisis Contributions</td>
<td>150</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Other Income</td>
<td>472</td>
<td>471</td>
<td>471</td>
<td>471</td>
<td>471</td>
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<tr>
<td><strong>Total Charity Income</strong></td>
<td><strong>5,318</strong></td>
<td><strong>5,282</strong></td>
<td><strong>5,729</strong></td>
<td><strong>5,416</strong></td>
<td><strong>5,531</strong></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Charity Expenditure</th>
<th></th>
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<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Staff Costs</td>
<td>(5,390)</td>
<td>(5,402)</td>
<td>(5,591)</td>
<td>(5,787)</td>
<td>(5,989)</td>
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<td>Facilities Costs</td>
<td>(1,015)</td>
<td>(995)</td>
<td>(1,015)</td>
<td>(1,035)</td>
<td>(1,056)</td>
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<td>Motor &amp; Travel</td>
<td>(61)</td>
<td>(60)</td>
<td>(62)</td>
<td>(64)</td>
<td>(66)</td>
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<tr>
<td>Office Costs</td>
<td>(220)</td>
<td>(236)</td>
<td>(238)</td>
<td>(241)</td>
<td>(243)</td>
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<tr>
<td>Nursing Supplies</td>
<td>(203)</td>
<td>(199)</td>
<td>(203)</td>
<td>(207)</td>
<td>(211)</td>
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<tr>
<td>Fundraising Costs</td>
<td>(125)</td>
<td>(188)</td>
<td>(364)</td>
<td>(197)</td>
<td>(217)</td>
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<tr>
<td><strong>Total Expenditure</strong></td>
<td><strong>(7,014)</strong></td>
<td><strong>(7,080)</strong></td>
<td><strong>(7,473)</strong></td>
<td><strong>(7,530)</strong></td>
<td><strong>(7,782)</strong></td>
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<tr>
<td><strong>Total Charity Deficit</strong></td>
<td><strong>(1,696)</strong></td>
<td><strong>(1,798)</strong></td>
<td><strong>(1,745)</strong></td>
<td><strong>(2,114)</strong></td>
<td><strong>(2,251)</strong></td>
</tr>
</tbody>
</table>

## Trading

| Shops Profit                | 1,301        | 1,386        | 1,464        | 1,544        | 1,621        |
| Lottery Profit              | 380          | 551          | 576          | 633          | 669          |
| Dom Care Agency surplus/deficit | 38          | 12           | 15           | 20           | 25           |
| Gain on investments         |              |              |              |              |              |
| Trading Contribution        | 1,719        | 1,949        | 2,055        | 2,197        | 2,315        |
| **Group Surplus/Deficit**   | 23           | 151          | 310          | 83           | 64           |
| **Net movement in revenue reserves** | 298        | 426          | 585          | 358          | 325          |
| **Revenue reserve balance** | 2,648        | 2,946        | 3,372        | 3,957        | 4,315        |
| **Revaluation reserve balance** | 316        | 316          | 316          | 316          | 316          |
| **Total Revenue Reserves**  | **2,964**    | **3,262**    | **3,688**    | **4,273**    | **4,631**    |

*A planned major fundraising event in year three will help us to generate more income.*
We will continue to implement this strategic plan, reviewing our objectives at the annual planning and budget process throughout the life of the plan.

Additionally, through our Heads of Department and teams we will review activities and progress against a detailed action plan on a quarterly basis.

Measures are in place to check on progress including the use of key performance indicators and standards. Regular reports and updates will be made to the Board of Trustees.

We look forward to working with others to ensure that, by pursuing our strategic objectives, we can achieve our vision of no person having to die alone, in pain or in distress, and we achieve as much dignity and choice as possible for all people facing the end of life.
References


What is a Hospice without Walls?

When we talk about a hospice we are not referring to a physical building but a philosophy of care. Hospice without Walls is about providing services and support that would traditionally be found in a hospice building but delivering these services in people’s homes and in other healthcare settings.

A Hospice without Walls means:

- Supporting more people in the community to die at home when it is possible, working together with other agencies, families and carers to make this happen.
- Working in partnership with others to provide education, advice and support so they can care for people at end of life who do not require our specialist care to prevent crisis.
- Providing specialist care and advice for those with complex end of life needs by providing inpatient care in the specialist unit at Turnchapel.
- Providing hospice at home through a range of specialist palliative care services including nursing, occupational therapy and social work, to support people with complex needs to die at home.
- Providing specialist nursing and medical care and support by the hospice team based in Derriford, supporting hospital staff, patients and their families.
- Supporting those who are dying to express their spirituality and respecting their individuality and choices.
- Supporting those who are left behind by providing bereavement support.
- Developing compassionate communities by striving to ensure all sections of society recognise the importance of supporting those who are dying and their carer’s and families, so they do not feel isolated and alone.
- Ensuring society does not treat death as a ‘taboo’ subject and supporting people to have open and honest discussions about their end of life wishes so they are known by others and respected.
St Luke’s Hospice Plymouth is a registered charity, a company limited by guarantee, and is registered with the Care Quality Commission. It is governed by a Board of Trustees comprising up to 14 trustees/directors who meet six times a year and who also participate in a number of sub-committees and operational management groups. Day-to-day management is vested in a Chief Executive, who reports directly to the Chairman of the Trustees – Mr Stuart Elford. The Senior Management Team comprises:

- **Chief Executive, Steve Statham FCIPD, MA (Hospice Leadership)**
- **Medical Director, Dr Jeff Stephenson BA, MB, BChir, MSc, FRCP**
- **Director of Clinical Services, George Lillie RN, RMN, BSc, MSc**
- **Director of Finance, Kavita Sinnett, BA, part qualified in ACCA, Cert.ITM-PF**
- **Commercial Director, Mike Dukes**

The principal object of the charity, as defined in the Articles of Association, is to relieve sickness amongst people suffering from terminal illness, in particular in the City of Plymouth and the surrounding districts. St Luke’s core service is the provision of specialist palliative care for the population of Plymouth, South West Devon and East Cornwall and aspires to be a national leader. We work in partnership with others, delivering the education and support required to ensure the provision of excellent end of life care.

We aim to continually review our services to ensure that they are delivering what the patients, their loved ones and the other stakeholders need and want. We therefore aim to keep abreast of developments in palliative and end of life care and the research behind those developments. We have limited resources and we want to use them as effectively as possible. We therefore need to ensure that we have a culture which embraces change and which values innovation and lateral thinking.
We are committed to embedding the Ambitions for Palliative and End of Life Care national framework within our community to achieve the following overarching six ambitions:

Each person is seen as an individual

- We will renew our commitment to the vision of St Luke’s; that no-one has to die alone, in pain or distress. This means developing and innovating on the scope of our services; reaching new people, new places and continually striving to serve as advocates for new ideas that benefit the entire community.

- We will create a Volunteer Forum which gives these vital volunteers the opportunity to meet others and receive information about the hospice.

Each person gets fair access to care

- We will look at outcome measures that fit the needs of St Luke’s and fulfil any future national dataset requirements. Also on the agenda is to ensure that these clinical outcome measures are useful in the daily management of patient care.

- We will expand the contact hours provided by our domiciliary care team and grow our pool of professionals across Tavistock and Ivybridge to explore how their work can support the care provided by our Crisis Team.

Maximising comfort and wellbeing

- We will push for the people we serve to get their preferred place of death.

- We will promote carers’ rights via our Carers’ Strategy.

- We will advocate for bereavement support networks with strong roots across our area of work.

Care is coordinated

- We will focus on the need for shared data in our new ambitions and investigate opportunities for shared clinical records within our local health sector. This fits into the new agenda for healthcare laid out by the Government and will help ensure we are a key player in the coordination of care.

- We will seek opportunities to integrate and consolidate our services; and wherever possible, explore opportunities for partnership working within the NEW Devon CCG.

All staff are prepared to care

- We will develop a competency-based curriculum for our staff during the first few years in a specialist post to aid recruitment and retention. We will also look at the possibility of rotational posts across clinical departments.

- We will identify opportunities to improve the quality and effectiveness of the organisation. This includes thinking about how to improve succession planning, business skills identification, prioritisation and development.

- We will continue coaching, leadership development and succession planning to allow our staff to develop personally, alongside growth for the organisation.

- We will commit to supporting quality end of life education for teams across diverse disciplines, from care homes to hospital doctors to district nurses.

Each community is prepared to help

- We will foster better links with the communities that currently see little to no end of life care, such as the homeless.

- We will stand together with partner organisations, either locally or nationally, that improve comfort, well-being, information-sharing, care or support to anyone affected by a life-limiting illness.
Glossary of Terms

**Advance Care Planning**

Advance care planning is a process of discussion and reflection about goals, values and preferences for future treatment in the context of an anticipated deterioration in the patient’s condition with loss of capacity to make decisions and communicate these to others.

**Bereavement**

Bereavement is the total response to a loss and includes the process of ‘recovery’ or healing from the loss. Although there are similarities in people’s responses, there are also marked differences. Each person will grieve and ‘recover’ in their own way.

**Clinical Commissioning Groups (CCGs)**

CCGs were created following the Health and Social Care Act in 2012, and replaced Primary Care Trusts on 1 April 2013. CCGs are clinically led statutory NHS bodies responsible for the planning and commissioning of healthcare services for their local area.

**Compassionate Community**

A compassionate community is a community that provides support to someone who is dying. The community could be family, neighbours, local organisations, faith groups, local businesses etc. Palliative care professionals, such as doctors and care workers are vital as part of a compassionate community.

**End of Life Care (EOLC)**

End of life care is for people who are considered to be in the last year of life, but this timeframe can be difficult to predict. EOLC aims to help people live as well as possible and to die with dignity.

**Hospice Care**

Hospice care is a term that is often used to describe the care offered to patients when the disease process is at an advanced stage. The term may be used to describe either a place of care (i.e. institution) or a philosophy of care, which may be applied in a wide range of care settings.

**Hospice without Walls**

Hospice without Walls is about providing services and support that would traditionally be found in a hospice building, but now delivering these services in people’s homes and in other healthcare settings.

**Inpatient Unit (IPU)**

The inpatient unit (also referred to as a specialist unit) provides short term care for patients requiring more complex symptom control or terminal care. The unit is open 24 hours a day, 365 days a year.

**Lift-limiting Condition**

Life-limiting condition means a condition, illness or disease which:

- is progressive and fatal; and
- the progress of which cannot be reversed by treatment.

**Operation Management Group (OMG)**

A group consisting of St Luke’s team leaders and managers.

**Palliative Care**

Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of
suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

Palliative care is also the appropriate medical care of patients with active, progressive and advanced disease, for whom the prognosis is limited, and the focus of care is the quality of life. Palliative care includes consideration of the family’s needs before and after the patient’s death.

**Senior Leadership Team (SLT)**
A group consisting of St Luke’s head of departments and senior management that meet on a monthly basis to collectively focus on the strategic direction and priorities of the charity.

**Specialist Palliative Care**
Specialist palliative care services manage more complex patient care problems that cannot be dealt with by generalist services. The specialist teams will include palliative medicine consultants, nurse specialists together with a range of expertise provided by occupational therapists, physiotherapists, social workers and those able to give spiritual and psychological support.

**Supportive Care**
The goal of supportive care (also called palliative care, symptom management) is to prevent or treat as early as possible the symptoms of disease, side effects caused by treatment of the disease, and psychological, social and spiritual problems related to its disease or its treatment.

**Sustainability and Transformation Plan (STP)**
The purpose of Sustainability and Transformation Plans is to help ensure health and social care services in England are built around the needs of local populations.
St Luke’s Hospice Plymouth

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