Weldmar Hospicecare Trust
Caring for Dorset

Quality Account for 2012/2013

The Mission of Weldmar Hospicecare Trust

- To ensure all patients needing palliative care in Dorset have access to excellent services delivered when and where needed whether by Weldmar Hospicecare Trust, or by others supported by the Trust.
- To offer support to families and others affected by the patient's disease.
- To provide respite for patients with debilitating chronic conditions

Quality Account for 2012/2013

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Introduction
This is the third Quality Account of Weldmar Hospicecare Trust and is produced as a statutory requirement because Weldmar receives money from the NHS*, and also to help the users of our services and other stakeholders to see how we work to improve the service we give.

Our patients receive support from many different sources during their journey and the quality of the service theyexperience may be determined by the interaction of different providers as much as by any one provider alone. This report, on activity in 2012/13, covers areas where we alone are responsible and it follows the statutory requirements of the regulatory authority even though these are poorly matched to hospice operations. We hope it will be of interest to our community, our service users and commissioners.

More corporate information about Weldmar Hospicecare Trust, including our latest Annual Report and Accounts, can be found on our website www.weld-hospice.org.uk

**At Weldmar Hospicecare Trust, the NHS only commissions a third of our beds and some 30% of the day and community work carried out by the Trust, but this report covers the whole of our work, the rest being funded from charitable fundraising, retail operations and reserves. We do not have different standards for patients, depending on the source of funds for the service.*

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Patients, families and staff joined to welcome the Spring Equinox with a procession of lanterns made at workshops held in the previous weeks.

Report of the CEO

We ask the question "What is quality in End of Life care?" all the time and the answer – which is far from straightforward – takes us to the heart of what hospice care is all about. Forour patients, who we ask regularly, quality is about:

- valuing them as individuals and as people, not just patients
- seeing them in the context of their family and homes
- responding to their aspirations as well as their clinical needs -
- - but responding to changes in those needs rapidly, expertly and appropriately
- ensuring the consistency of care quality through time, and between organisations
- being helped to come to terms with what is happening to them and their families to allow a peaceful and dignified death

These very reasonable statements, which most readers of this report would probably ascribe to, do not lend themselves to easy measurement, and uniquely in End of Life care the patient cannot be asked a few months after the care episode to comment on their experience. Standards tend to be monitored by proxy measures and the final appendix to this report shows the 90 or soquarterly or monthly reports which we make to our commissioners, by which they attempt to see whether we are in fact providing safe, high quality care.

A further challenge in establishing a high quality service is the fact that our organisation only provides a fraction of the care which patients in their last year of life may depend on. By far the greatest burden is carried by family caregivers; primary care plays an enormous part at all stages and our colleagues in the local acute and community hospitals are also key contributors. A patient in receipt of excellent service should not need to worry about these organisational differences but be assured that coordination and communication is well handled, that all work with similar aspirations and philosophies of patient care and with sufficient expertise and resource in their area to deliver it.

In Dorset, as elsewhere, we cannot say that we have reached this point. Organisational differences do impact on patient care and while it is gratifying to be able to report this year great improvements in one of our relationships – with Dorset County Hospital – leading to improvements in care quality, the recent NHS reforms have frustrated our wish for similar developments elsewhere as people and organisations disappear. The reforms have also reduced momentum in some of the education and development work which addressed patient centred quality assessment, such as "Our Health" which were being promoted by the Strategic Health Authority and we look forward to the resumption of these initiatives.

We are acutely aware that if we do not optimise the experience of our patients and their families we will not have a second chance to put it right. More than 70% of our income comes from the general public – based on their appreciation of the quality of our service. If that falls so will our ability to fundraise and our long term future is threatened. But above all we are committed to quality as an organisation because that is why we have as individuals, staff and volunteers, elected to do what we do. We have in our hearts a commitment to making the last weeks and months of a person's life as good as they can be.

This report shows where we believe we are in making that goal a reality; we know that we still have a long way to go, and even more that we lack the tools which could tell us where we have got to. We would be interested to hear readers' views.

Alison Ryan Chief Executive

I would like to thank everyone that dealt with me for their kind and strong support. They have helped me to accept my illness and learn to live with it so that I can accept myself and move on from full time work to respecting myself as a person who is still useful and who can still have a purpose .

Comment on Reflections Form

Report from the Chairman on Assurance

The Board of Weldmar Hospicecare Trust takes its responsibilities,for ensuring the service we provide is of the best quality, very seriously. We have a rigorous clinical governance system committed to quality improvement and clinical effectiveness which generates the data reported in the next few pages. We work regularly with our NHS commissioning partners to share information and ensure that we meet their requirements for the standard of service offered. The Board receives information from all these sources on a regular basis.

We also have a comprehensive Assurance Framework which maps every area of the Trust's activities and links these into mechanisms for providing assurance to the Board that all is as is reported to us and how it should be. This framework extends over all areas as the quality of the patient experience will be as much conditioned by the recruitment, management and training of staff, for instance, as it will be by the medication we give. The accuracy of the reports received at Board meetings, and the information in this Report, is checked by a rigorous independent internal audit staff and their processes which identify shortcomings in procedures and risk management.

We are fortunate to have the services of an Advisory Council which acts as the eyes and ears of the community and provides direct evidence to the Board of issues which are concerning local people and stakeholders. The Council mans a regular series of inspection visits to all our services which include confidential interviews with staff, patients and families and physical inspection of aspects of each facility. Reports of each visit are made available to the Care Quality Commission (CQC) with whom we are registered. CQC also conduct their own unannounced inspections and the Board was pleased to note that for the last three unannounced inspections the Trust was found to be completely compliant for each standard inspected, with some very positive comments made as well.

Following the Francis Report the Council discussed and reviewed the many initiatives which the Trust had instigated as the findings of this investigation had become clear since the initial report in 2010. One of the strengths of their inspections is that they give patients, families and staff the opportunity to raise concerns should they arise, in an informal but honest way. This was a clear omission at Mid Staffordshire hospital. It was suggested that these visits should extend beyond the day and in patient hospice services to those we offer at people's homes. This is now being put into practice.

Dr Geoffrey Guy MB BS
Chairman of the Board of Trustees

Liverpool Care Pathway and the Keogh report

As this Account was being finalised, two reports about the quality of care in the NHS were issued. The first of these was Rabbi Julia Neuberger's report on the operation of the Liverpool Care Pathway for people in the last days of life; the second was Professor Sir Bruce Keogh's report on standards of care in hospitals with "excess mortality" indicators. Weldmar's Board took swift action to review our own quality performance and monitoring in the light of both reports.

The Liverpool Care Pathway (LCP) was originally developed for use in hospitals as a tool for optimising the care and support given to patients and their loved ones in the final few days of life. The aim was to raise standards to those practiced in hospices and to avoid patients being continually subjected to inappropriate hospital interventions. It was reviewed, following adverse press comment, by Rabbi Julia Neuberger and because of its relevance to our work her findings were considered at a Clinical Governance Meeting on July 15th and a Board meeting on July 18th.

In general terms the report was about practice in hospitals not hospices and we were content that we could demonstrate that we already follow its recommendations. We do not therefore intend changing what we do. We have however stopped using the words "Liverpool Care Pathway", and have withdrawn our patient information leaflet on the subject so that patients and families do not become unnecessarily alarmed. We continue to do end of life planning on a one to one basis with patients and share and communicate our plans regularly with them and their families.

The report does not cast doubt on the potential efficacy of the LCP; it recommends that it is abandoned in acute hospitals and elsewhere because of the opportunity it gives, where there is poor nursing care or poor care planning, for it to be used as a proxy for both, leading to very poor outcomes for patients and families. It is to be hoped that without the pathway's guidance these shortcomings can somehow be made up to ensure that End of Life Care does not actually get worse as a result of its withdrawal. We will work with our colleagues in the NHS to support and educate them to try and ensure that this does not happen.

Similar findings on care standards are the result of the investigation by **Professor Sir Bruce Keogh.** His report felt that it was impossible to enumerate excess deaths in the hospitals investigated but that nursing standards and clinical leadership were significantly lacking in each hospital – leading to unacceptable levels of care of the sort that Francis had uncovered at Mid Staffs hospital. Again we reviewed our own staffing levels, and the way we elicit and handle feedback – both positive and negative – and felt that, as we try to demonstrate in this report, the Keogh findings gave us no cause to change our existing practice.

We have concerns in both cases however that the welcome emphasis on care standards and the quality of clinical care in acute hospitals which are the focus of all these reports, takes no account of the move to nurse patients in their own homes. In particular where a patient expresses a wish to be cared for and die in their own homes, we are expected to facilitate that desire. Such patients should be confident that the care they are given there is as good as it would be in an acute or community hospital - yet the Francis, Neuberger and Keogh reports are all silent on this point. The innovation we report later in this Account on accessing real time patient experience at home, is our means of trying to ensure that the focus on care quality is retained wherever the patient is to be found.

Quality improvement work in 2012/13

General

Reconfiguration.

As explained last year, with the aim of providing a service which is more responsive to patients choices about the place and nature of their care, and also the, sometimes rapid, changes in their needs and which is also robust enough to cope with a forecast 30% increase in demand in the next five years, we have undertaken a reconfiguration exercise. This is a longer term exercise but the key improvements we were able to achieve during the year were:

- providing a much more flexible day service in some areas
- being able to send a wider variety of staff and volunteers to patients' homes to support them as they need, when they need it
- having one Multidisciplinary Team meeting for each geographical operational area so that our response is integrated, timely and efficient
- Because of these flexibilities starting to be more responsive to different types of patients.

In addition our new clinical base in Sturminster Newton provides an excellent place for patients in the North of the county to visit for complementary therapies and counselling and out patients appointments and we were pleased to play host to North Dorset GPs during the year where we discussed the future, as well as providing an update to them on aspects of End of Life Care.

Education

During the year our Education Team was brought to full strength and have introduced a needs led programme of in house education for clinical staff based on statutory requirements, those areas when Adverse Incident Reports (AIRs) indicate there is a problem, and where the Nurse Education Facilitator working in the In-patient Unit sees there is a need. (There is a similarly rigorous approach to non clinical education.)

We have seen in the year significant reductions in AIRs resulting from medication errors, in particular syringe driver misuse which can be attribute to the improvement in skills of the care team.

We have also looked outside the organisation to raise the skills levels of our colleagues in nursing homes, primary care and other community services with328 people attending our training courses.

Bereavement support – although bereavement support is not deemed, under the terms of the palliative care funding review, to be an appropriate use of NHS funds except in very extreme cases, we believe it has a role to play for those who request it in alleviation of unnecessary anxieties about grief responses and enabling family members to move on safely, possibly reducing further psychological distress later in life. A counsellor was appointed at the beginning of the year to develop this work and a team of "emotional support volunteers " – lay people who with appropriate training and supervision are extremely effective in supporting individuals when their suffering is most acute – was identified, trained

'I've just finished these sessions of aromatherapy - it was just so beneficial after my bereavement - I have never really done anything much for me - so it did seem especially for my benefit - X was such a good listener and I was able to talk about my grief as she was massaging in the oil. After the shock of such a short illness and coming to terms with the reality of my life as I know it's changed forever - having a regular treat and such a friendly face meant such a lot, so thank you.

Comment on Reflections Form

The coffee morning for bereaved people and the emotional support volunteers allow relationships to be developed without strain.

Carers Service – a common response of hospices to the support of carers is to see them as people who will be or have been bereaved – hence the development above. Carers are however also the principal source of support for patients living at home; they have expertise and views to share with us and they also need to be able to manage the impact that caring has on their lives.During the year we have significantly developed our approach to carers, recognising that they are our partners in care and supporting them in this role as much as we can.

The picture shows the Christmas dinner family support staff laid on for them – giving a night out (transport laid on), a chance to talk to other carers and knowing that their family member was being looked after by a volunteer. The evening was hugely appreciated.

Feedback from previous Quality Accounts

Very useful feedback was received from readers of last year's accounts who pointed out that while we reported the numbers of different types of incident in our electronic AIRS (Adverse Incident Reporting System) report , we did not discriminate between those which caused no, some or significant harm to patients. This was really useful feedback and we have started to introduce this categorisation using the following criteria, in all our reports. The following gives an example of how we apply the criteria – which match those in the National Reporting and Learning System (NRLS) - to falls. In our case we are also concerned about the impact of incidents on families.

Term	Definition adapted to falls	Examples from reports to the NRLS/at Weldmar
No harm and Near Misses	Where no harm came to the patient. Where incident observed before patient involved; action can be taken to prevent reoccurrence.	"No apparent harm." "No complaints of pain, no visible bruising." "I noticed that the Wanderguard plug had been dislodged when the bed was moved; this often happens"
Low harm	Where the fall resulted in harm that required first aid, minor treatment, extra observation or medication, or psychological upset.	"Shaken and upset." "…graze on right hand." "Small cut on finger." "Patient was upset by her reduced independence"
Moderate harm	Where the fall resulted in harm that was likely to require outpatient treatment, admission to hospital, surgery or a longer stay in hospital.	"Sustained fracture to left wrist." "…one inch laceration over left eye, taken to A&E for suturing."
Severe harm	Where permanent harm, such as brain damage or disability, was likely to result from the fall.	"….following an x-ray, a fractured neck of femur was confirmed." Note: up to 90 per cent of older patients who fracture their neck of femur fail to recover their level ofmobility
Death	Where death was the direct result of the fall.	"Patient heard to fall from commode hitting her head on the floor as she fell…bleeding from back of head... Coma Scale lowered ...patient intubated and sedated and transferred to intensive care unit (ICU) following scan. Patient died later the same day."

National Patients Safety Agency: The third report from the Patient Safety Observatory, Slips, trips and falls in hospital PSO/03 (2007)

In addition we benchmark our performance on Falls, Medication errors and Decubitus ulcers against the hospices inthe Southwest using Hospice specific criteria for assessing severity

2012/13 AIRS REPORT of patient incidents / near misses at Weldmar Hospicecare Trust

	Severity (Patient Harm)				
	1	**2**	**3**	**4**	**5**
Medication	32	0	0	0	0
Accident	1	0	0	0	0
Fall	30	12	0	1	0
Patient Care	0	1	0	0	0
Patient Welfare	0	2	0	0	0
Untoward Incident	0	0	0	1	0
Total	63	15	0	2	0

Key:
Severity level of harm
1 = no harm (includes reports of Near Misses)
2 = low harm
3 = moderate harm
4 = severe harm
5 = death as a result of incident

Details: Severity 4

1) **Fall** Fracture neck of femur. Patient walking with aid of walking frame to the toilet –she had been advised not to walk on her own, but to call for help

2) **Untoward incident** Spontaneous fracture due to disease progression

2012/13 Priorities for Improvement

1. General
Our long term programme of reconfiguration, enhancing the strength and flexibility of our response to community based patients required changes in some procedures and practice to maintain or improve patient experiences. These were the priorities we set out last year.

1.1 Triage

Because:	We neededa new tool so we could safely implement our vision of matching the capacity we have to provide support (ranging from lay volunteers befriending to senior clinicians providing complex treatment) to the needs of the patient as they change.
Covering:	A set of new referral, assessment and triage procedures
Output:	A more personalised, flexible and responsive comprehensive service to patients providing the right person at the right time with the right skills in the right place.
Timescale:	Beginning Autumn 2012; will not be fully rolled out until 2015.

Progress: Since April 2013 we have been holding daily multidisciplinary meetings to review new referrals to the service. The objective is to prioritise need and to ensure we have the right person to make an initial assessment of the patient and/or carer. This may be a community nurse, doctor or other professional according to the presented needs. In the past most new patients were seen in the community by the community nurses. The process was reviewed in June and this is still the case, although more patients have been seen by other professionals than before.

1.2 Governance between organisations
The most worrying failures in patient care have been where care is transferred between parties. We worked with our partners in Dorset County Hospital and Dorset Healthcare University NHS Foundation Trust to see how we could improve the care of patients as they move from once care setting to another. Most progress was made with the hospital where meetings were held at CEO/CEO level identifying the issues. The hospital appointed a senior member of staff to champion improvements, which was very helpful, and they worked with both doctors and nursing staff to improve care and the continuity care for all End of Life patients.

The 'transfer of care' window on our electronic records has also improved speed and quality of information from the acute setting to the hospice. A change in the role of the inpatient admin team means they will be proactively seeking information before a patient is transferred from any setting. In addition we provided training of End of Life Champions in the hospital to embed the attitudes and skills needed to make sure the needs of this particular group of patients were not overlooked.
Since this work has been taking place there have been no incidents of really poor discharges of people at the end of life.

In addition where there are problems between the two organisations, such as making referrals without adequate information, we have a more streamlined system for recording concerns and getting a timely response.

1.3 Pilot data collection
As part of the Department of Health Palliative Care Funding Pilot covering the whole of Dorset over the next 2 years, we have started to use tools for measuring and categorising some aspects of care. Definitions of datasets required by the Department were very late being delivered so there is insufficient information collected at present to allow us to report on learning this year. A report will be included in 2014 Quality Account, although by a recent prohibition by the Department of Health detailed data is no longer to be put in the public domain.

2 Specific new areas for investigation and development :

2.1. Benchmarking audit with South West on admission of our patients to an acute hospital at the end of life
One of the End of Life Care quality markers is to reduce unnecessary deaths in acute hospitals. Some admissions to hospital at the end of life could be appropriate, others are because of services in the community not being available or there is no bed available in a hospice or community hospital. We aimed to find out what happened to patients within our service (across daycare, hospice and the community)if they had an unplanned admission to an acute hospital setting to see if they were they admitted appropriately.

It has proved extremely difficult to get reliable and useful data on this. Our patients may go to any of five community and three acute hospitals which serve the area we cover and getting information fromthem, which is numerically consistent with ours, and which has insufficient details for us to be able to make an assessment of the appropriateness of an admission to an acute hospital has not proved adequately possible to draw any conclusion.

We are looking for other ways of getting the same insights - but this is an issue the whole health economy should be looking at – not just Weldmar.

2.2. **Accessing Real time patient experience especially at home.**
Finding out what patients think about our services is relatively easy when they attend day or in-patient facilities. The building defines the service and there is a team of people upon whom to comment. It is far more difficult when the patient is at home and when their principal link with us is through one individual Community Nurse Specialist. Whatever they may think patients are even more reluctant to tell us. In addition a patient at home is receiving possibly a multitude of service from District nurses, domiciliary care and reablement support as well as Weldmar nurses. Patients may not know who to tell about which part of the service they receive.

> 'I have nothing but praise for my Community Nurse Specialist who visited us during the later stages of my husband's cancer. She was so kind and caring as she gently led my husband towards some difficult decisions. We also appreciated the OT and Physio input.
>
> ***Comment on Reflections form***

In due course we hope to use technology – such as Real Time Monitoring - to find out what patients think and the new Healthwatch in Dorset has indicated they are interested in this. Such a development should really be one which all agencies unite in using. However for Weldmar Hospicecare Trust's own purposes we are now introducing domiciliary "Provider

Visits" by trained trustees and council members who currently inspect our buildings based services. With patients' permission they will visit to have the kind of informal interview about how services are meeting needs which they currently do with patients and family members in the in-patient and Day hospices.

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Weldmar joined the National Hospice Care Week theme "I am hospice care" celebrating the contribution of staff and volunteers

2013/14 priorities for improvement

1. Providing continuous 1:1 volunteer contact/ support if wanted from the time of referral

Because: Patients and families may leave our clinical care several times during the course of their illness because they no longer need that level of input. Sometimes this is when theyare discharged from the in-patient unit following a phase of symptom control. They report feeling "abandoned" at such a time as they no longer have contact with us, nor have confidence that we know what is happening to them and can pick up our caring responsibilities immediately they relapse. Also any problems occurring within the family may go unnoticed at this time.

Covering:

While dedicating scarce clinical resources to maintaining contact with such patients is not feasible, we do have a large volunteer body and will, for those who wish it, appoint one volunteer to "buddy" a patientand their family, making regular phone calls or visits just to keep in touch with them throughout. While unable to provide advice, they will of course act as a conduit toclinical staff if they perceive concerns.

Output **:** maintained contact with patients and families. Reassurance and faster response to change.

2. Multidisciplinary Team (MDT) meeting development

Because: MDTs are resource intensive but vital meetings which determine the care plan for individuals. These plans needto be integrated across all parts of our service.

Covering: Currently the MDT for the In-patient unit is separate. This means that patients who may have been covered by, say, the North area MDT while using our day or community services there are reviewed , when they are In-patients, by a team which does not know them. The care plan loses integrity thereby. The new system will review all patients geographically. To communicate efficiently across a widespread geographic area we have installed good video conferencing capacity in Joseph Weld hospice and Sturminster Newton to facilitate this, and ensure that where input is required from distant bases it can be obtained effectively and efficiently.

Output; Improved continuity of care planning. Less repetition and better use of resources.

3. Improving up to date evidence based practice throughout the organisation

Because: it is difficult to maintain up to date standards in a rural community with staff working on their own who may become isolated in their work

Covering; the strengthening of the existing Clinical Practice Group to identify areas of service development where improved learning and skills could make a difference, particularly in the challenge of very elderly people, and those with non malignant diagnosis and to set standards of care through audit

Output: Better informed and higher quality care.

4. Further Triage development

Because: referrals often arrive too late and we wish to be able to handle safely patients with a wide variety of support needs, using our rich array of support services.

Covering: the development of our new triage system which allows much more patient centred allocation of resources to care, to handle patients whose needs are social or which can be managed by volunteers, ensuringthat change is rapidly picked up on and the process is safe.

Output: More open to referrals of patients earlier in their journey.

5. Improvement of facilities at Joseph Weld Hospice

Because: public areas and the ward pantry have not been altered since they were built in 1993

Covering: improved relaxing, eating and meeting areas and a better pantry.

Output; a more pleasant environment for patients, families, visitors and staff.

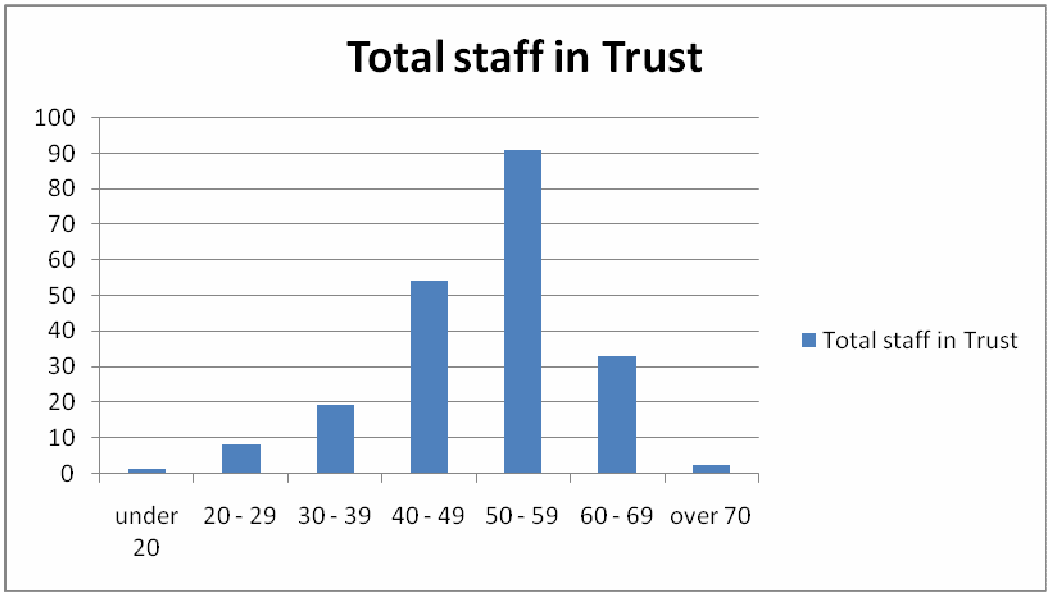
Staff

The Key performance indicators for our staff are:

- Turnover
- Sickness Absence
- Staff Satisfaction Survey

This report covers the twelve months ending 31st March 2013 and analyses the numbers of joiners and leavers for the period. The total number of full and part time permanent staff employed at 31st March 2013 was 201; there were 26 joiners and 21 leavers over the twelve months, giving an annual staff turnover rate of 10.45%. For comparative purposes, the staff turnover rate for 2011/12 was 8.54%.

Of the 21 leavers, there were 6 age retirements. The remaining 15 leavers moved on for a variety of reasons. If age retirements were removed from the figures, the staff turnover rate for the twelve months would be 7.46%. The age profile for staff at 1 April 2013 is:



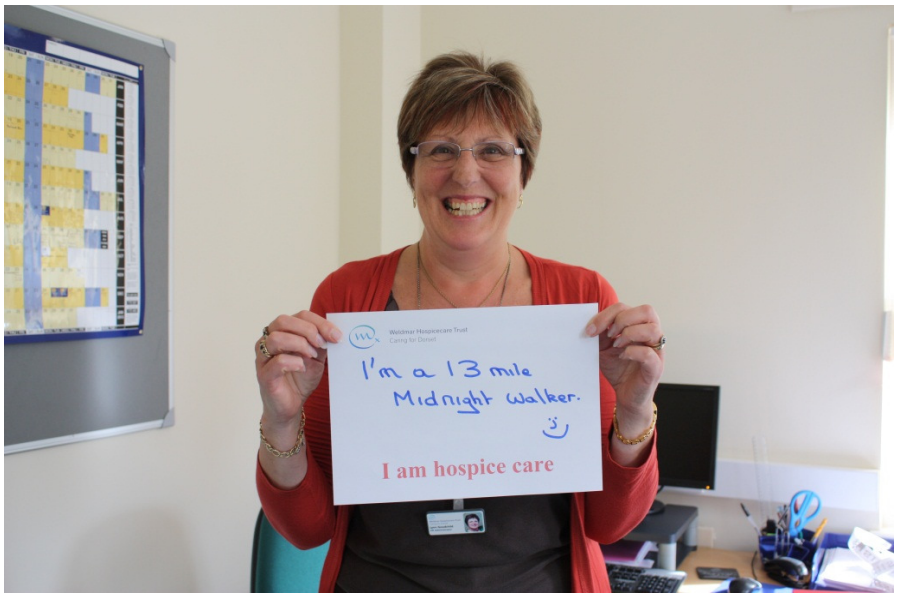
SICKNESS ABSENCE

The sickness/absence rate for 2012/13 was 4.84% (% hours lost against contracted hours). If long term sickness/absence is excluded, the rate falls to 2.53%.

The comparable rate for 2011/12 was 4.14% for all sickness/absence. If long term sickness/absence is excluded, the rate falls to 2.89%.Long term sickness absence was responsible for the year on year increase in the overall sickness/absence rate during 2012/13.

STAFF SATISFACTION SURVEY

73 members of staff filled in the 2013 survey. Of the 33 areas explored, 24 showed improved scores. Those indicating deterioration were focussed around the perceived quality of line management and the Trust has embarked on an extensive programme of development and master-classes for new and existing line managers to try and improve this vital area.



Volunteers

Without volunteers not only could we not do the amount of work we manage but the nature of it would be different. Volunteers are there because they want to be, not because they are paid and that makes patients feel more like people. Volunteer recruitment, matching to tasks, training and support is taken as seriously as it is for staff and their performance is monitored through our clinical governance structures.

During the year volunteers performed the following:

Community:	**Tasks (no.)**	**Hours**	**Average hours**
Transport incl prescriptions	216	432	2 hrs
Sitting	31	1,488	2 hrs for 24 wks
Befriending	8	576	3 hrs for 24 weeks
Shopping	9	216	1 hr for 24 wks
Dog Walking	3	72	1 hr for 24 wks
Gardening	0	0	3 hrs
HH Reception & Admin duties	473	946	2 hrs
Social Group (3 groups)	1,175	4,700	4 hrs
Jam Che	8	24	1 hr for 3 wks
Family Support - adult bereavement	3	216	3 hrs for 24 wks
Complementary Therapy	115	230	2 hrs
Refreshments	27	54	2 hrs
Day Hospice: (on rota)			
Daycare Help	205	615	3 hrs
Transport (own car)	382	764	2 hrs
Transport (minibus)	55	110	2 hrs
Beautician (hair dressing, nails & hand care)	50	100	2 hrs
Creative Therapy	100	200	2 hrs
Jam Che	250	500	2 hrs
Art Therapy	27	54	2 hrs
Chaplaincy	67	134	2 hrs
Reception (John Greener)	79	237	3 hrs
Handyman & Gardening	50	100	2 hrs

In-Patient Unit: (on rota)			
Ward (incl feeding)	805	1,610	2 hrs
Ward Clerk	2	6	3 hrs
Sitting	74	148	2 hrs
Chaplaincy	64	128	2 hrs
Family Support - coffee morning	12	24	2 hrs
Beautician (nails & hand care)	26	52	2 hrs
Reception & Admin duties	712	2,136	3 hrs
Flower Arranging	259	518	2 hrs
Pets As Therapy (PAT)	52	52	1 hr
Jam-Che	104	208	2 hrs
Handyman & Gardening	2	4	2 hrs
	5,445	**16,654**	

Information Governance Toolkit

The Trust undertook a self assessment using the NHS Information Governance toolkit Version 10 with the following results. There is an Action Plan to bring those areas where the score is 2 up to standard 3.

Toolkit Requirement	**Descriptor**	**Level of self –assessment (L0=1 Hi=4)**
10 -114	Attribution of responsibility for Information Governance	**3**
10-115	New policy to be written and adopted	**3**
10-116	Inclusion of IG in all staff and 3rdparty contracts	**3**
10-117	Training requirement of IG to be incorporated into in house training policies and plans	**2/3**
10-202 and 10-214	Ensuring the rules around accessing and passing on confidential information are set out, known and reviewed	**2/3**
10-213	IG information for public	**3**
10-215	Ensuring new policies are in line with IG – Directors Group to check	**3**
10 -216	Confidentiality audits are carried out in all areas .	**2**
10-316 And 10-317	Information asset register /Unauthorised access prevented.	**2**
10-318	Safeguarding of mobile IT	**3**
10-319	Business continuity	**2**
10-320	Documentation of information governance incidents	**3**
10-321	Access to IT equipment /servers etc managed	**3**
10-325	Network security	**3**
10-412	Accuracy of clinical notes –Governance	**3**

STATUTORYSTATEMENT OF ASSURANCE FROM THE BOARD
The following are statements that all providers must include in their QualityAccount. Many of these statements are not directly applicable tospecialist palliative care providers, and therefore explanations of whatthese statements mean are also given.

Review of Services
During 2011/12 Weldmar Hospicecare Trust provided thefollowing services to the NHS:

- Inpatient Unit – 5 beds
- Day Hospice
- Community Specialist Palliative Care service
- Specialist Palliative care consultant and nursing service to Dorset County Hospital
- Occupational Therapy, Physiotherapy,
- Complementary and Creative Therapies
- Family, Carer and Psychological Support Services, including bereavementsupport

The Quality of these services, which represent some 30% of the patient care given by Weldmar Hospicecare Trust has been reviewed and is covered by these accounts.

What this means:
Weldmar Hospicecare Trust is funded through an NHS contract linked to activity through a Community Contract for 2011 -2012, and also fundraising and trading activity. The grant allocated by NHS Dorset represents approximately 25% of the Trust's total income. The remaining income is generated through fundraising, shops and lottery activity and investments.

Participation in National Clinical Audit
• During 2009/10 no national clinical audits or confidential enquiriescovered NHS services provided by Weldmar Hospicecare Trust
• During the period Weldmar Hospicecare Trust participated inno (0%) national clinical audits and no (0%) confidential enquiriesof the national clinical audits and national confidential enquiries itwas eligible to participate in.
• The national clinical audits and national confidential enquiries thatWeldmar Hospicecare Trust was eligible to participate induring 2009/10 are as follows: NONE
• The national clinical audits and national confidential enquiries thatWeldmar Hospicecare Trust participated in during 2009/10are as follows: NONE
• The national clinical audits and national confidential enquiries thatWeldmar Hospicecare Trust participated in and for which datacollection was completed during 2009/10 are listed below alongsidethe number of cases submitted to each audit or enquiry as apercentage of the number of registered cases required by the termsof that audit or enquiry.
• Weldmar Hospicecare Trust was not eligible in 2009/10 toparticipate in any national clinical audits or national confidentialenquiries and therefore there is no information to submit.

What this means:
As a provider of specialist palliative care Weldmar Hospicecare Trust Hospice is not eligible to participate in any of the national clinical audits or national confidential enquiries. This is because none of the 2011/12 audits or enquiries related to specialist palliative care.

The Hospice will also not be eligible to take part in any national audit or confidential enquiry in 2012/13 for the same reason.

Use of the CQUIN payment framework
Weldmar Hospicecare Trust income in 2012/13 was notconditional on achieving quality improvement and innovation goalsthrough the Commissioning for Quality and Innovation paymentframework.

Research
The number of patients receiving NHS services provided by Weldmar Hospicecare Trust in 2012/13 thatwere recruited during that period to participate in research approved by a research ethics committee was NONE.

Data Quality
Weldmar Hospicecare Trust did not submit records during2012/13 to the Secondary Users service for inclusion in theHospital Episode Statistics which are included in the latest published data.

This is because Weldmar Hospicecare Trust is not eligible to participate in this scheme.

2h. Clinical coding error rate
Weldmar Hospicecare Trust was not subject to the Paymentby results clinical coding audit during 2012/13 by the AuditCommission.

Statement from the Commissioners

NHS Dorset Clinical Commissioning Group is pleased to comment on the Quality Accounts for Weldmar Hospice care Trust.

From reviewing the Quality Accounts and from the ongoing monitoring of the trust throughout 2012/13, the CCG has seen a number of improvements in the provision of care, these are evidenced within the quality account and include the strengthening of daily multidisciplinary meetings to review new referrals to the service, ensuring the right staff member makes the initial assessment of the patient and/or carer and the development of the 'transfer of care' window using electronic records which has improved speed and quality of information shared between other health providers and the hospice.

Other particular areas of good practice are noted in the Staff Satisfaction Survey with 24 indicators showing areas of improvement response against previous survey. The CCG is pleased to note the Trust is responding to feedback from the staff by embarking on an extensive programme of development and master-classes for new and existing line managers to try and improve leadership within the service.

The CCG recognises the importance the Trust places on working within the community which is reflected in the development of volunteers in providing the service

The CCG has not been actively engaged in the development of the Quality Improvement Priorities that the Trust has set for 2013/4 but is in broad support of these priorities and looks forward to working with Weldmar Hospicecare Trust over the coming year.

Statement from the Care Quality Commission

Weldmar Hospicecare Trust is required to register with theCare Quality Commission and its current registration status isIndependent Hospital, Hospice for Adults. Weldmar Hospicecare Trusthas the following conditions on registration:

- The service may only be provided for persons aged 18 years orover
- A maximum of 18 patients may only be accommodatedovernight
- Notification in writing must be provided to the Care QualityCommission at least one month prior to providing treatment or services not detailed in our Statement of Purpose

Weldmar Hospicecare Trust is subject to periodic reviews bythe Care Quality Commission (CQC) and the last inspection was of Trimar Day Hospiceon10th January 2013.As last year the report indicate that Weldmar Hospicecare Trust was entirely compliant on the standards inspected.

Trimar

One person using the service told us "I'm absolutely delighted to be here. Although I'm not lonely at home coming here means I have got company which is important to me." One member of staff told us "I'm involved in running a clinic for carers and other people who don't come otherwise. It's important to give them some time for themselves."
One member of staff told us "I would always have a discussion about diagnosis, insight and prognosis. It automatically opens up the conversation and helps me with more advanced care planning."

One person using the service told us "The benefit for me is that I've got attention from expert staff who know what they're doing."

We were shown an audit of questionnaires returned between July and November 2012. During this period seventeen questionnaires had been sent to people using the service and fourteen of these had been completed and returned. Of these seven rated the service as 'excellent' and a further four as 'fantastic', 'great' or 'very good'.

One member of staff told us about ways they used to get people who used the service to express their views and become involved in making decisions about their care and treatment. They described how complementary therapies "would be good for people coming here. Lots of them are short of breath and that often shows as tight shoulders. I can help de-stress and relax them and give them a sense of well-being." This member of staff provided us with an explanatory leaflet, given to people before any therapy took place, which provided clear information about what was available and how this might help. "I go very slowly." the member of staff explained. "Most people take advantage, sometimes after they've seen me doing it with someone else." One person using the service told us "I wasn't very keen at first but when I saw how it helped others I thought I'd have a go and it was really good."

CQC Website
Extract from report on 10th January visit

Appendices:
MDS Appendix 1
The National Council for Palliative Care - Minimum Data Sets

Weldmar Hospicecare Trust 2012/2013	
In patient Unit	
Total number of patients	241
New patients	211
% Occupancy	80.5
% returning home	38.1
Average LOS	14.2
Day Hospice	
Total number of patients	136
Sessions held	302
Attendances	2205
Average length of care	225
Community Service	
Total number of patients	976
Total contacts : face to face	4850
telephone	10219
Average length of care	95.9
Hospital Support	
Total number of patients	436
Total contacts : face to face	2091
telephone	715
Average length of care	9.3
Family Support	
Total number of clients	181
Total contacts	1064
Average length of care	159.7
Out patients	149

Practice changed as a result of Audit April 12- April13

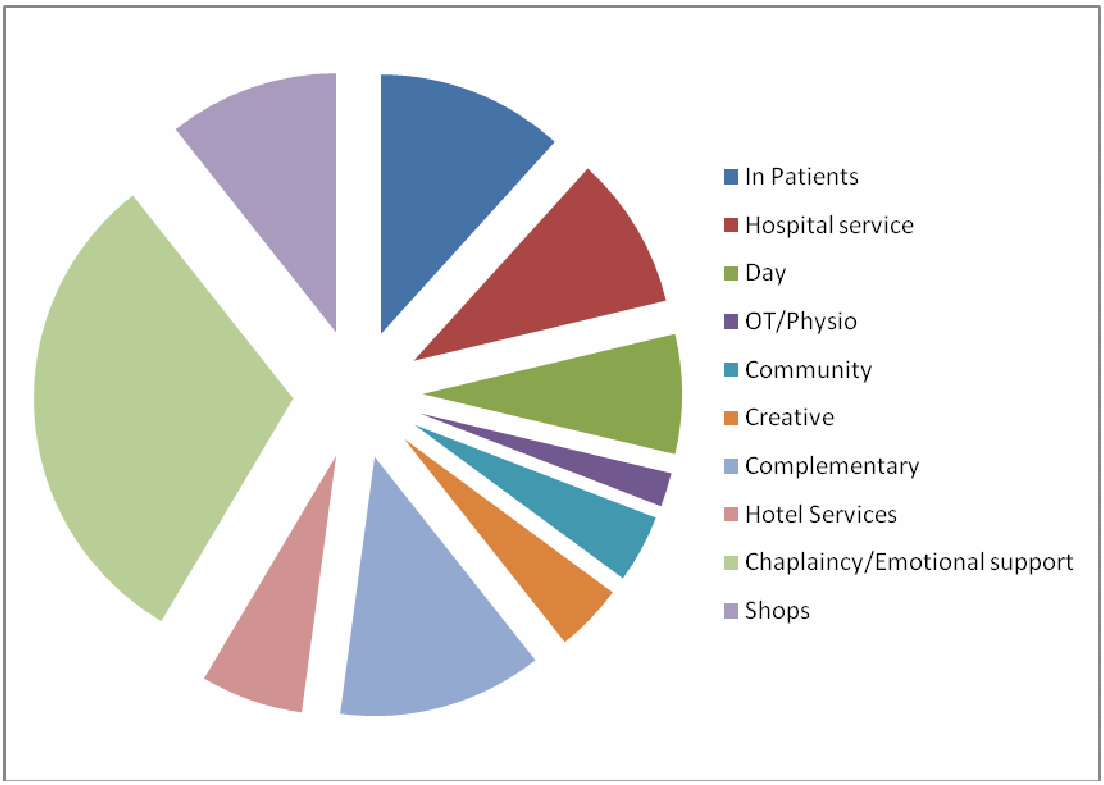
Audit	Change in Practice as result
Infection Control Audits: 1. Commodes 2. Maintenance 3. Mattresses 4. Auroscopes 5. Sharps audit 6. Help the Hospices cleaning audit	 New easier to clean commode brought and trialled – higher standard of cleaning thereafter Air filters changed more regularly Bedpan washer cleaned more regularly Some found to be substandard and discarded. New cleaning methodology Disposable ear pieces introduced Larger box for glass bottles, placed on wall away from public areas Cleaning on ward good, but improving. Cleaning rota developed
Controlled drugs and medication audits	Single checking introduced. Effective multidisciplinary teaching methods contributed to reducing errors Some changes to documentation. Increased teaching with junior doctors.
South West Hospices Benchmarking on medication errors, falls and pressure sores	We were below average on falls and pressure sores, slightly higher with medication errors. Action – as above. Also reviewed the categorization to ensure we are measuring like with like
Preferred place of death	This is part of a larger project and is not yet complete. After each death we look to see if the patient died where they had last stated they wanted to be.

Audits for 2013/14

Project Title	Project Type	Summary	Area	Start Date	End Date
SouthWest Nurses Management - including Pressure Sores, Falls and Drug Errors	Quarterly audit	Benchmarking project with SW on falls, pressure sores and medication errors	ALL	Quarterly	
Accountable Officer	Annual audit	HtH, CQC	ALL	Feb14	Apr14
Controlled Drugs Audit	Annual audit	HtH, CQC	CENTRAL	Apr14	May14
Falls audit	Monitoring	CQC, PCT,	CENTRAL	Monthly	Monthly
Inf prev - hand hygiene Central (1st priority)	Monitoring	HtH, CQC	CENTRAL	Mar13	Jun13
				Jun12	Sep12
				Sep13	Dec12
				Dec13	Mar13
Inf prev - hand hygiene South (2nd priority)	Monitoring	HtH, CQC	SOUTH	Apr13	Jun13
				Jul13	Sep13
				Oct13	Dec13
				Jan13	Mar13
Inf prev - hand hygiene North (3rd priority)	Monitoring	HtH, CQC	NORTH	Dec13	Feb14
				Feb14	May14
				May14	Aug14
				Aug14	Oct13
Commode Cleaning Infection Prevention group	Audit	Commodes Indentified via environmental audit	CENTRAL		
Decontamination audit			CENTRAL	Mar13	Apr13
	Audit	Audit of decontamination against policy, req for equipment register and CQC		Sep13	Oct13
Completeness of infection prevention information on transfer	Audit	To ensure all information is shared between organisations when patients are transferred	NORTH		Jun13

Patient and Carer Survey
The Trust participated in the 2013 national Hospice Patient Survey and although submissions have been made results and benchmarking has not been completed.

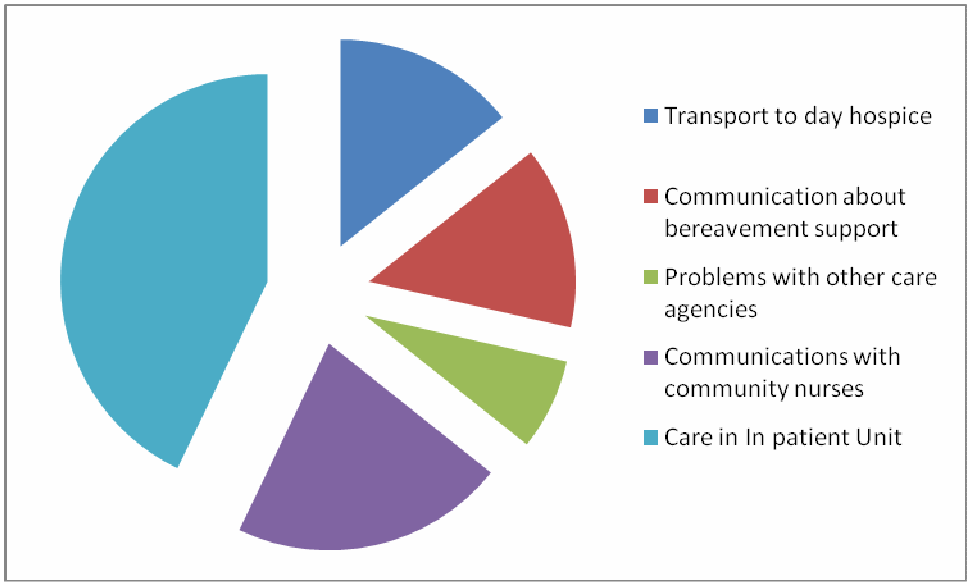
This formal survey is not however the only way in which the Trust gains feedback from patients and carers. We have a "Reflections" system which allows comments to be made without the formality of the complaints system, This year 73 reflections were received the highest ever. The areas covered were:



By far the majority of comments were very positive but there were comments and suggestions which made us consider changes to our services which included putting handrails in parts of our garden, looking at how we communicate to families of patients so they felt more in control, changing the format of our "Time to Remember" events, going paddling and ensuring toilet roll holders were checked for working and being full!

Each of our three operational areas holds "Have Your Say" Events which include focus groups and questionnaires covering the day and in-patient services. These cover the same ground as the national survey but are conducted 6 monthly to give us early warning of changes and problems which are arising. Again the responses were overwhelmingly positive. We believe that most people wishing to be negative now feel able to use the **Complaints system.**

During the year there were 14 clinical complaints, 10 in writing and the others verbally; by far the greatest number we have ever received. They were on the following subjects.



Aspects of communications predominated. In some cases our actions, both in care and follow up for bereavement were good practice - but they were not what the individual expected and we had not adequately explained beforehand what to expect. For instance we do not follow up for bereavement support for 6 weeks; this is believed to be best practice but when a family member is expecting us to follow up immediately after the death they feel deserted when we do not do so. We have since amended our literature so bereaved relatives understand that we will leave a gap between the death and our follow up.

We also fed back to nurses both in the community and in the in-patient unit the elements of complaints which indicated that the way we dealt with some issues such as PEG feeds and mouth care did not always correspond with what the patients saw as good care – and they have since amended their practice.

We reflected on why we had this increase in complaints and felt there were no general trends that indicated care standards were slipping. The heaviest quarter was Jan – March 2013 – since then there have been no clinical complaints,. This was the period when there was the most publicity around the Francis Report and we wondered if this had influenced the readiness of patients and families to use complaints as a way of giving critical feedback. It was also a period when, for some weeks, over 60% of our community team were non-operational because of sickness, imposing heavy stresses throughout the clinical organisation. This may have impacted.

NHS Quality monitoring These are areas which are monitored as part of our NHS contract. Reports have to be provided, in the majority of cases, monthly.

13/14 contract ref	WHT no.	Description	Weldmar definitions		Reporting period						
			Type	Sub-type	As and when	Weekly	Monthly	Quarterly	Six monthly	Annual	Other timescale
1.1	108	Summary Monthly contract report: - Summary level report showing the contract plan and actual for the reporting period with associated variances and marginal rates for all PbR and Non-PbR services. - Report to show plan and/or budget and variance against plan and/or budget - Format of report and data items to be defined for each Provider by Information/ Service Design	Statistics				✓				
1.3	109	Non-PbR Report (activity via SUS): Full Patient Level Dataset by Point of Delivery (POD), including activity, cost and associated fields. Service and data items per prior year reports	Statistics				✓				
1.4	110	Data outside SUS/National Reporting Systems: Summary report supported by patient/GP practice level costed datasets for all contracted items that are not reported via SUS incuding (but not limited to) individually priced drugs and devices), diagnostics, maternity	Statistics				✓				
1.15	68	Delayed Transfer of Care: Summary data for delayed transfer of care using CCG template.	Clinical	Discharge		✓	-				

2.1	106	Service Quality Performance: Report detailing performance against:- - Operational Standards - National Quality Requirements - Local Quality Requirements - Never Events - Quality Incentive Schemes - Details of any thresholds that have been breached and any Never Events that have occurred - Details of all requirements satisfied - Details of, and reasons for, any failure to meet requirements - Details of progress towards satisfying any Quality Incentive Scheme Indicators, including details of all Quality Scheme Indicators satisfied or not satisfied The outcome of all root cause analyses and audits performed pursuant to Service Condition 22 (Venous Thromboembolism)	QA				✓				
2.2	107	Service Quality Scorecard: Data as per scorecard - template as contained in Schedule 5 Part A	QA				✓				
2.3	79	*Details of all Never Events including nil returns and prevented Never Events (as per NPSA definition)Wrongly prepared high-risk injectable medication; Maladministration of potassium-containing solutions; Wrong route administration of chemotherapy; Wrong route administration of oral/enteral treatment; Intravenous administration of epidural medication; Maladministration of insulin; Overdose of midazolam during conscious sedation; Opioid overdose of an opioid-naïve Patient; Inappropriate administration of daily oral methotrexate;Falls from unrestricted windows; Entrapment in bedrails; Transfusion of ABO-incompatible blood components; Misplaced naso- or oro-gastric tubes; Wrong gas administered; Failure to monitor and respond to oxygen saturation; Air embolism; Misidentification of Patients; Severe Scalding of Patients;*	Safety	Never Events			✓		-		
2.4	99	Never Event RCAs: Copy of Providers RCA Report	Safety	Never Events	✓						
2.8 & Schedule 4 - C: Local Quality Reqs Domain 5 (pg 46)	2	Percentage of falls assessments completed within 48 hrs of admission.	Clinical	Falls			✓	-			
2.8	3	Number of patients falling more than once.	Clinical	Falls			✓	-			

2.8	4	Audit of 10 or 20% of total (whichever is greater) sets of notes of patients who fell in hospice	Clinical	Falls			✓	-			
2.13	100	Independent Investigations commissioned by provider: - Email outlining reason for investigation and timescale for completion.	QA		✓						
2.15	18	Number of Medication Errors, by speciality, by severity of harm.	Clinical	Medication				✓	-		
2.15	19	Number of Medication Errors relating to controlled drugs, by speciality, by severity of harm.	Clinical	Medication				✓	-		
2.15	20	Medication Errors - Outcomes of lessons learnt from Root Cause Analyses	Clinical	Medication				✓	-		
2.16	15	Medication Controlled Drug Incidents: Advise of significant incidents concerning controlled drugs which may affect another organisation	Clinical	Medication	✓	-					
2.17	17	CQC Self Assessment on Controlled Drugs - Copy to be submitted to CCG Medicines Manager and CD Accountable Officer in the Local Area Team (LAT)	Clinical	Medication						✓	
2.18	101	Medication - Audit Plan: Medicines Audit Plan detailing all audits to be undertaken that demonstrates compliance with national guidance	Clinical	Medication						✓	
2.19	102	Medication - Audits: Provision of Commissioner approved audits: - To demonstrate that services are delivered in accordance with national guidelines and recommendations on medicines management - To demonstrate services are delivered in accordance with the regulations for and natonal recommendations on good practice for the safe management of controlled drugs -To demonstrate compliance with community-wide formulary and Non-formulary prescribing - To demonstrate level of compliance with local prescribing and medicines management policies	Clinical	Medication					✓		
2.22	103	Medication - Non Formulary: Audit of Policy that covers prescribing of non-fomulary drugs, consent of patients and dissemination of formulary updates	Clinical	Medication						✓	

		and shared care agreements									
2.23	16	Medication- Occurrence Reports: Word with supporting data in excel. To LAT Accountable Officer for Controlled Drugs and copied to CCG medicines manager	Clinical	Medication				✓			
2.33	111	Audit Reports: Progress report on Annual Audit Plan -progress report on each Audit -Details of non-compliance with Audit Plan -Actions to address non-compliance -Proposed actions to address any identified areas for concern resulting from an audit	QA	Medication					✓		
2.35	21	Exception report on compliance with NICE Technology Appraisals and Clinical Guidance	Safety	Alerts				✓			
2.36	55	Surveys - as detailed in Schedule 6 Part G: - Details of the results of all surveys including identification of any actions reasonably required to be taken as a result of the Survey. - Details of actions to improve performance against categories falling into the lowest 20% or have not improved since last survey. - Progress against remedial action plans. To include: Staff survey - annual to be agreed with commissioner Service User survey - to be agreed with commissioner Staff survey (Diversity Awareness) January 2014	QA-Patient	Patient/ Carers feedback							✓
2.37	94	Safeguarding Compliance: Exception report detailing any areas of non compliance with policies contained in Schedule 2 Part L.	QA	Safeguarding				✓			
2.38	80	Safeguarding Training: Report on the number and % of staff trained to - Children Level 1 - Children Level 2 - Children Level 3 - Adults - MCA/DOLS	Workforce	Education			✓	-			

2.39	36	Safeguarding - Compliance Report / Audit: Progress Report on compliance with the Children Act incorporating the results of locally agreed audits. Reports to include: - Reference to lead responsibilities of the Provider - Arrangements for Safeguarding Processes including (but not limited to) MARAC, MAPPA, DV, PREVENT, MCA, DOLS and MHA	QA	Safeguarding				✓	-		
2.40	104	Learning Disability Self-Assessment: Report on actions taken to address identified areas for improvement	QA					✓			
2.44	23	Number of acquired pressure sores by grade reported separately	Clinical	Pressure sores			✓	-			
2.44	24	Number admitted with pressure sore(s)	Clinical	Pressure sores			✓	-			
2.44 & Schedule 4 C: Local Quality Reqs Domain 5 (pg 46)	25	Percentage of patients admitted that have been risk assessed for developing a pressure sore within 24 hrs of admission	Clinical	Pressure sores			✓	-			
2.45	112	Pressure Ulcers - Stage 3 & 4: Declared on STEIS as an IRRP	Clinical	Pressure sores	✓						
2.46	113	Acquired Pressure Ulcers - RCA Reports: Copy of full RCA report for all Stage 3 & 4 Acquired Pressure Ulcers	Clinical	Pressure sores	✓						
2.48	105	Copy of Reports from or in response to Regulatory or Supervisory Bodies (as per General Conditions 15.3)	QA		✓						
3.1	6	Performance against HCAI Reduction Plan: Performance against each milestone including: - Details of and reasons for any failure (copy of RCA) Proposed action to address any reason for failure -Number of beds closed due to HCAI (including empty/full beds)	Clinical	Infection			✓				

3.6	8	Infection Report: - Number of patients with MRSA Bacteraemia - Number of patients with MSSA - Number of patients with E-Coli bloodstream infections	Clinical	Infection			✓		-		
3.7	95	MRSA Bacteraemia Notifications: Proforma A to be submitted within 48hrs Proforma B to be submitted within 5 operational days Proforma C to be submitted within 45 days Proforma D to be submitted within 4 months	Clinical	Infection	✓						
3.8	13	MRSA Root Cause Analysis Reports (within 45 operational days of occurrence)	Clinical	Infection	✓	-					
3.9	9	Clostridium Difficile - Death Certificates: Number of deaths where C-Diff is identified under Section 1 (a) Cause of Death on the death certificate	Clinical	Infection	✓	-	-	-	-	-	
3.10	14	Clostridium Difficile - Cluster: C-Diff outbreak Root Cause Analysis Reports. "outbreak" is defined as 2 or more cases in same area within 28 days.	Clinical	Infection	✓						
3.11	114	Norovirus Outbreak: Number of wards and/or beds closed due to Norovirus (empty and full beds) (Daily email to infection control team)	Clinical	Infection	✓						
3.12	10	Norovirus - Number of cases of Norovirus	Clinical	Infection			✓		-		
3.12	11	Norovirus - Number of bays and ward closures	Clinical	Infection			✓		-		
3.12	12	Norovirus - Number of bed days lost	Clinical	Infection			✓		-		
3.13	96	Outbreak Management: - Number of identified infected patients (inc C-Diff and Norovirus) isolated within 2 hours - % infected patients isolated within 2 hours	Clinical	Infection			✓				
4.1	30	Equality Monitoring Reports - Performance against Equality Requirements	QA	Equality				✓			
4.2	31	DDA/MCA: Action Plans to evidence compliance with Disability Discrimination Act and Mental Capacity Act	QA	DDA/MCA						✓	

4.3	86	Percentage of staff to have basic Learning Disability awareness as part of induction	Workforce	Education						✓	
4.4	82	MCA/DOL - Number of Staff trained as a percentage of overall applicable staff	Workforce	Education				✓			
5.1	54	Complaints Monitoring Report: - Number of complaints by category and outcome - Number & % complaints acknowledged within 3 operational days - Number & % of complaints responded to within agreed timescales - details of lessons learnt and actions taken - Total number of complaints referred on to the Ombudsman - review of complainant satisfaction with complaints process	QA-Patient	Complaints			✓				
5.2	88	Complaint Communication -sample of letters and responses including all those relating to quality of care issues	QA-Patient	Complaints			✓				
7.1	89	VTE Episode Prophylaxis Reports: Monthly audit Report describing compliance with NICE guidelines in relation to the prescription and administration of VTE prophylaxis if clinically indicated following VTE risk assessment	Clinical				✓				
11.1	77	Summary Report: - Monthly number of IRRP declared including nil returns - % compliance with STEIS data entry requirements	Safety	IRRP			✓				
11.2	75	RCA Investigations: Summary of RCA (Root Cause Analysis) investigations and associated action plans submitted within 72 hrs of completion	Safety	RCA	✓		-				
11.3	26	Incident Reporting: Report all incidents and breaches of confidentiality / information security to the CCG within 72hrs of occurrence.	QA	Data	✓		-				
11.4	90	SIRI Report: Number of SIRI declared by month - proposed action to improve - total number of safety incidents - number of incidents by level of harm - number of incidents by division / directorate / department / speciality	Safety	SIRI			✓				

11.5	78	SIRI Investigation Reports: Final SIRI (Serious Incidents requiring investigation) investigation reports and action plans. Reported within 45/60 operational days of completion. Word.	Safety	SIRI	✓						
11.6	91	Adverse Events: Number of Adverse Events for all categories identified using the Global Trigger Tool	Safety				✓				
11.7	76	Patient Safety Incident Report: - Number of incidents reported by level of harm, clinical area, theme, actions taken to mitigate risks and lessons learnt. - Number of incidents, themes, trends, and learning for incidents graded as severe/high/ moderate risk that do not meet SIRI criteria.	Safety	AIRS			✓		-		
11.8	74	Central Alert System (CAS): Report detailing compliance with NPSA Alerts and MHRA, CMO, CEO and CNO Briefings	Safety	Alerts				✓	-		
11.9	92	NRLS Incident Reports Summary & analysis of NRLS reporting	Safety	NRLS					✓		
14.1	93	"Saving Carbon, Improving Health" Summary of Providers progress on climate change adaptation, mitigation and sustainable development including performance against carbon reduction management plans.	QA	Carbon						✓	
14.2	34	Sustainable Development Strategy: Board approved sustainable development strategy	QA	Carbon						✓	-
14.3	32	Carbon Management and Climate Change Adaptation Action Plan: Performance against plan.	QA	Carbon						✓	
14.4	33	Carbon Management: Initial assessment and annual re-assessment: Progress Report	QA	Carbon						✓	
17.5	97	Provider Performance Reports presented to their Board	QA				✓				
17.6	87	Workforce Indicators: As per embedded scorecard	Workforce	HR Stats			✓	-			
17.7	98	Workforce Assurance Framework: - Demonstrate that the Provider is ensuring safe staffing levels and skill mix using recognised evidence based and workforce assurance tools. - Evidence that the Provider Board is reviewing these.	Workforce					✓			

17.8	37	NHS Constitution Compliance - Self Assessment: Provider self assessment against the Rights and Pledges contained within the NHS Constitution.	QA						✓		-
Out 1a & Schedule 4 - A: Local Quality Reqs Domain 4	63	*(i) % of patients who are cared for in their identified preferred place of care* *Threshold: 95% of Service Users where the package of care is available to support this.*	Statistics	PPC				✓	-		
Out 1b	64	*(ii) Active discharge planning with safe and appropriate discharge facilitated*	Clinical	Discharge					✓		
Out 1c	58	*(iii) Patients have their needs met in a timely and expert way through the provision of specialist OT, Physiotherapy (where necessary or referral to community services) and Psychological Therapy services (up to Level 3) where necessary.*	Not required						✓		
Out 2a	65	*(i) Control of patient symptoms*	Not required						✓		
Out 2b	56	*(iv) Patient feedback indicates positive experiences; and where necessary changes are implemented if feedback indicates concerns*	QA-Patient	Patient/ Carers feedback					✓		
Out 3a	43	*(i) Carer reflections and feedback indicate positive experiences*	QA-Patient	Patient/ Carers feedback					✓		
Out 3b	44	*(ii) Carers views used to inform service development*	QA-Patient	Patient/ Carers feedback					✓		
Out 3c	45	*(iv) Hospice respite provision available to meet carers needs*	Quality	Respite					✓		
Out 4a	59	*(i) Telephone advice is available 24 hours a day, 365 days a year*	Statistics	Service Provision					✓		
Out 4b	60	*(ii) Face to face assessment in the community or in hospital is available for at least 8 hours a day, Monday to Friday*	Statistics	Service Provision					✓		
Out 4c	61	*(iii) Urgent face to face assessment is available at the weekend for at least eight hours a day*	Statistics	Service Provision					✓		
Out 4d	62	*(iv) Inpatient admission, available 7 days a week, from at least 8am - 8pm, 24 hours a day*	Statistics	Service Provision					✓		
Out 5a	49	*Supporting specialists and generalists to meet the end of life care needs of patients with a diagnosis other than cancer* *(i) individual patient case support to primary care teams*	Quality	Non cancer					✓		

Out 5b	50	*(ii) support provided to non cancer networks*	Quality	Non cancer					✓		
Out 5c	51	*(iii) specialist sessions provided for non cancer diagnosis*	Quality	Non cancer					✓		
Out 6	46	*(i) attendance at GSF meetings (100%)*	Quality	GSF					✓		
Out 7a	83	*Education is provided in a variety of settings to non specialist staff at all levels (as per service specification - Para 2.2)*	Workforce	External Provision						✓	
Out 7b	84	*All appropriate internal staff have undertaken holistic needs assessment training*	Workforce	Education						✓	
Out 7c	85	*Senior SPC nursing staff have the skills and competencies to support physical assessment and prescribing for patients (increasing number of nurse prescribers)*	Workforce	Education						✓	
Out 8	40	*(i) patients on an end of life pathway who have an appropriate personalised care plan (100%)*	Quality	Care Planning					✓		
Out 9a	41	*(i) Number and % of patients who have an Advance Care Plan in place when they are referred to the Service*	Quality	Care Planning					✓		
Out 9b	42	*(ii) Number and % of patients who have an Advance Care Plan undertaken whilst with the Service*	Quality	Care Planning					✓		
Out 10a	69	Details of patient numbers accessing inpatient services - 4 beds (1,460 bed nights p.a.)	Statistics	Activity				✓			
Out 10b	70	Details of specialist community nurse activity (4 FTE nurses)	Statistics	Activity				✓			
Out 10c	71	Details of patient numbers accessing day care services (2,000 day care sessions p.a.)	Statistics	Activity				✓			
Out 11	57	*Numbers and brief details of referrals to inpatient services unfulfilled*	Statistics	Referrals					✓		
Schedule 4 - A: Operational Standards CB_B17	67	8.2 Sleeping Accommodation Breach: Threshold > 0	QA	Bed mngmt			✓			✓	
Schedule 4 - C: Local Quality Reqs (pg 45)	38	Working towards End of Life Care through the use of the End of Life Care Quality Assessment Tool (ELCQuA): 9 Quality Statements to be fully completed by 31 March 2014 showing amber of green against ELCQuA measures	QA	ELCQuA				✓		-	

Schedule 4 - B: National Quality Reqs (pg 44)	115	Duty of Candour: Each failure to notify the Relevant Person of a suspected or actual Reportable Patient Safety Incident (as per Guidance) (Consequence of breach - recovery of the cost of the episode of care or £10,000 if the cost of care is unknown)	Safety	Reporting			✓			-	
Schedule 4 - C: Local Quality Reqs Domain 2 (pg 45)	116	Improving care for people with Learning Disability: 95% of service users with a learning disability receive enhanced assessment of care needs upon emergency admission to hospital. Provider must have system in place to assess whether Service Users have Learning Disabilities and to what extent these may require adjustment to care.	Quality	Care Planning			✓			-	
Schedule 4 - C: Local Quality Reqs Domain 4 (pg 46)	117	Assessments and individual care plans for identified main Carers are started within 4 weeks of a service user assessment: 100% of identified main Carers to be offered an assessment. Of those accepting care plans are started within 4 weeks of Service User assessment.	Quality	Care Planning			✓			-	
Schedule 4 - C: Local Quality Reqs Domain 5 (pg 46)	118	Nutritional Screening: 95% of all admissions screened within 24 hours of asmission to hospital. Trajectory to be agreed by the end of Q1 and Consequence of Breach will only apply if trajectory is missed.					✓			-	