

Agenda Item:

7

Dorset Health Scrutiny Committee

Dorset County Council



Date of Meeting	17 November 2014
Officer	Director for Adult and Community Services
Subject of Report	Weldmar Hospicecare Trust Quality Account for 2013/2014
Executive Summary	<p>This report presents the fourth 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 the services and other stakeholders to see how the Trust works to improve the service.</p> <p>Patients of the Trust receive support from many different sources during their journey and the quality of the service they experience may be determined by the interaction of different providers as much as by any one provider alone. This report, on activity in 2013/14, covers areas where Weldmar Hospicecare alone is responsible and it follows the statutory requirements of the regulatory authority, even though these are poorly matched to hospice operations. The Trust hopes it will be of interest to the community, service users and commissioners.</p> <p>The Chief Executive of the Weldmar Hospicecare Trust will present the key messages from the Quality Account to Dorset Health Scrutiny Committee and will be happy to respond to questions on the content therein.</p>
Impact Assessment: <i>Please refer to the</i>	<p>Equalities Impact Assessment:</p> <p>Not applicable.</p>

<u>protocol</u> for writing reports.	Use of Evidence: Report provided by Weldmar Hospicecare Trust.
	Budget: None for Dorset County Council.
	Risk Assessment: Having considered the risks associated with this decision using the County Council's approved risk management methodology, the level of risk has been identified as: Current Risk: HIGH/MEDIUM/LOW (Delete as appropriate) Residual Risk HIGH/MEDIUM/LOW (Delete as appropriate)
	Other Implications: None.
Recommendation	That the Dorset Health Scrutiny Committee consider and comment on the report.
Reason for Recommendation	The work of the Committee contributes to the County Council's aims to protect and enrich the health and wellbeing of Dorset's most vulnerable adults and children.
Appendices	1 Weldmar Hospicecare Trust: Quality Account for 2013/2014
Background Papers	Report to Dorset Health Scrutiny Committee, 19 November 2013: http://www1.dorsetforyou.com/COUNCIL/commis2013.nsf/14ABE42CA4E6CC2880257C210033B4A0/\$file/Item%20%20-%20Weldmar%20Quality%20Account.pdf
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Weldmar Hospicecare Trust
Caring for Dorset

Quality Account for 2013/2014

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 illness

Quality Account for 2013/2014

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1. Introduction
2. Statement of accuracy and commitment to quality from CEO and Chair
3. Quality Improvement in 2012/13
4. 2013/14 Priorities for Improvement
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7. Statutory Statement of Assurance from the Board
8. Statement from Dorset Clinical Commissioning Group - pending
9. Statement from Dorset County Council - pending

Appendices: Minimum Data Set Statistics
Audit Register
NHS Contract Quality Monitoring Requirements

Joseph Weld Hospice marked its 20th Anniversary in January 2014 with a visit from the Right Reverend Bishop of Salisbury seen with the Director of Nursing and Patient Services.



Introduction

This is the fourth 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 they experience may be determined by the interaction of different providers as much as by any one provider alone. This report, on activity in 2013/14, 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.*



During the year our patient and family areas at Joseph Weld Hospice were refurbished thanks to a grant from the Department of Health

Comment on Facebook

'It wasn't just the clinical team I was impressed with it was everyone from before you walked through the door (counsellors, nurses, volunteers who provided services at home like massage and reiki) through the time we were in the hospice (receptionists, cleaners, chaplains, physio, kitchen staff as well as the clinical team) to now (social workers, family support, chaplains and all those who organise the remembrance occasions from the light up a life, sunflowers and so many more). You provided a fantastic service for my partner, me and my children from the moment we were told the cancer was terminal onwards'.

Report of the CEO

What don't we do well?

How we make opportunities to ask ourselves this question, how honest we are approaching it, how we respond and how we learn from the answers are at the core of ensuring that our services are excellent. That was the message of Professor Alastair Scotland OBE who gave Weldmar senior clinicians a seminar on how we might frame our continuing response to the challenges of the Francis report on Mid Staffs Hospital. Professor Scotland is one of the UK's most eminent advisers on patient safety and quality governance and gave extensive evidence to the Shipman and Francis enquiries as well as many others. We were most honoured that he agreed to help us in this way.

His message indicated the very real challenge at the heart of ensuring high quality care and that is that it is about culture rather than process. The most important responsibilities lie with the individual, and their determination to maintain their own high standards – but also contribute constructively and inclusively to addressing problems with others' performance. The organisation also has a key role, providing the opportunities to ask the question "What don't we do well" in a way which gets an honest answer and avoids the comforts of groupthink, and to ensure robust and informed challenge of the answers given. If we or those who use our services rely only on the regulators, or the standards imposed by our commissioners, then we will be working to the minimum tolerable, by no means a definition of quality to which we ascribe.

It is relatively easy for health organisations to respond to the unending quest for higher standards by invoking more robust processes and enforcing them with increasing rigour. However for all patients, but especially for those at the end of life, we need staff to be thoughtful, compassionate, flexible and responsive and they will not be if they are only judged by their adherence to externally imposed "standards". Similarly as an organisation dealing with an unremitting increase in the demands upon us, we need our staff to be flexible, able to work in new ways and with different partners. Without this willingness to take up the new, confident that if errors are made (as they may well be in new working environments) the organisation will deal with them constructively and kindly, Weldmar will never be able to expand and reach out to those who do not currently benefit from our services.

Getting all these forces into balance is the considerable challenge we, and all other healthcare providers, face and we present this Quality Account to show how well we feel we are doing at the moment, certain that the demands of the future will be different.

Alison Ryan Chief Executive

Comment on Reflections Form

'Many people have the wrong impression when the word hospice is mentioned as they tend to think it is for 'end of life care.' Whilst this may be true in some cases it is also to give respite and care. The care I have received here has been absolutely amazing. From the cleaners to the doctors everybody has been kindness and helpfulness far beyond anything I could have hoped for. The Joseph Weld Hospice is a place of tranquillity and care. The people of Dorset are so lucky to have this facility.'

Report from the Chair 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 a Forum of Advisors. These are individuals with specific expertise in various areas who offer their help, sitting on Board sub-committees and participating in inspections of our services which include confidential interviews with staff, patients and families and physical inspection of aspects of each facility. These inspections were developed during the year to include visits to patients we serve in their own homes. 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 as last year for the latest, unannounced, inspections the Trust was found to be completely compliant for each standard inspected, with some very positive comments made as well.

During the year Weldmar Hospicecare Trust changed an important part of its constitution extending the ability to be a member of the Trust to anyone in our community who wants to pay the small membership fee. While this recent change is not yet fully developed, we hope that in due course our new constituency of members will be able to tell us directly at public and Annual General meetings how they feel we are doing and what we need to do more of. We feel that this direct voice, speaking directly from the community we serve to the Board, will be the best guarantee we can have that we are getting it right with regard to Quality.

Dr Geoffrey Guy MB BS
Chairman of the Board of Trustees

Comment on Reflections Form

'I would like to say how thankful I am to have such an amazing trust as Weldmar in the local area. The help and support from beginning to end of my wife's illness was second to none. Then the after care for myself with the wonderful counselling supplied, took me from a very dark place back to understanding my bereavement and how to handle my loss and associated feelings. I have nothing but great admiration and respect for L who counselled me and brought me back from the edge.'

Quality improvement work in 2013/14



General

Partnerships:

The quality of care experienced by our patients depends not just on our input but on that of the GPs and others in primary care, and the acute sector, and in the way we handle their journey between us. It is very good to report that our improved relations with Dorset County Hospital developed during the year resulting in the joint appointment of a consultant in Specialist Palliative Medicine who works between the two organisations. She is helping to bring DCH's declared aim of improving their End of Life care into focus. We are also working with DCH on ways of ensuring patients at home can get the rapid, flexible and responsive support they need if they are to have their symptoms managed properly and not be inappropriately admitted either to the hospital or the hospice.

The challenge is to provide a proper 24 hour nursing service for severely ill patients – a hospice at home in fact. Weldmar Hospicecare Trust dearly wants this to be available but currently commissioning of such services is split between Marie Curie Cancer Care (MCCC), Dorset Healthcare University Foundation Trust and a number of domiciliary care agencies funded through the Continuing Healthcare mechanism. We, together with MCCC, have struggled to find a way through this to create a viable home nursing service which can fill this one large remaining gap in services to people in Dorset. We hope daily that commissioners' intentions will become clearer.

Reconfiguration:

As we have reported for the last three years, Weldmar Hospicecare Trust has been reconfiguring its service to provide a more integrated approach to patient care, based on a geographical division into South, Central and North areas. There are significant geographical and demographic differences in these areas which mean different solutions to the care challenge are required. It has been very pleasing to note that in the South we now

offer a much richer service to home based patients than merely the specialist nursing and day hospice provision. We are able to send a team of people with different skills to a patient at home to meet many of their needs when and where they have them. In the Central area we are greatly developing the range of services including day hospice for patients in Bridport and the West and we are enhancing our joint work with nursing homes. In the North we are developing very strong links with the community hospitals and District Nurses, taking their staff on rotation training posts and working alongside them with our joint patients.

Education:

Hospice Education Alliance @ Weldmar is our Education service and during the year this service taught 355 delegates from other Dorset services, ranging from doctors and ambulance staff to care assistants and social workers on subjects ranging from End of Life Care, to MND, to psychological distress and “training the trainer”. These courses were funded by individuals and their employing organisation or NHS Dorset. One area where Weldmar Hospicecare Trust has special expertise is on the care of people with dementia at the End of Life and these courses have proved particularly popular.

Weldmar Hospicecare Trust has greatly invested in its ability to provide such input to other agencies and the outcome from this effort is that our partners have enhanced skills for working with our patients so they need only call on us when very specialist input is required. As a result patients are far more likely to be looked after in their own or nursing homes rather than being transferred to DCH or Joseph Weld Hospice.

Our own staff have benefitted also from a far more rigorous approach to their own Clinical professional development and this will continue in future years.

Line management:

For a clinical service the core of excellence will be found in the relationship between the manager or team leader and the staff providing care. It is in this relationship that quality management and assurance happens, skills are developed, patient issues dealt with and development needs addressed. To do this job properly clinical staff need to understand that investing time in the process (which means leaving patients' bedsides) is just as important as constant presence in the nursing environment. We have put more emphasis on this this year through a development programme for all staff and their managers, and included this time in our rostering so nobody should regularly find it necessary to forgo their 1:1s because of urgent care needs on the ward.

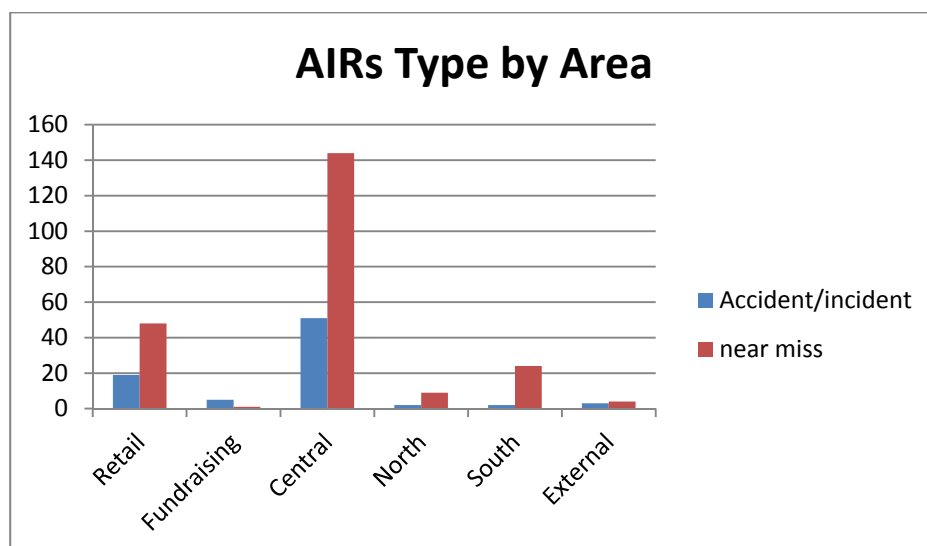
Adverse Incident Reporting (AIRs)

Staff and volunteers are encouraged to complete AIRS if they feel there is a concern regarding health & safety or a threat to quality, as well as when there is an actual incident. This allows Weldmar Hospicecare to be proactive in reducing risk. Workshops took place in the clinical areas in order to ascertain why there had been a decrease in AIRs reporting and issues raised by staff, which included access and comments responding to the AIRs by managers are being addressed.

Training regarding the completion of AIRs is included the induction for staff and patient care volunteers. In addition staff complete an online training tracker module regarding AIRs which is then available for reference. Existing volunteers are being invited in for training which includes AIRs.

1. Incident Type by Area

	Retail	Fundraising	Central	North	South	External
Accident/incident	19	5	51	2	2	3
Near miss	48	1	144	9	24	4



2. Severity of Injury by Area

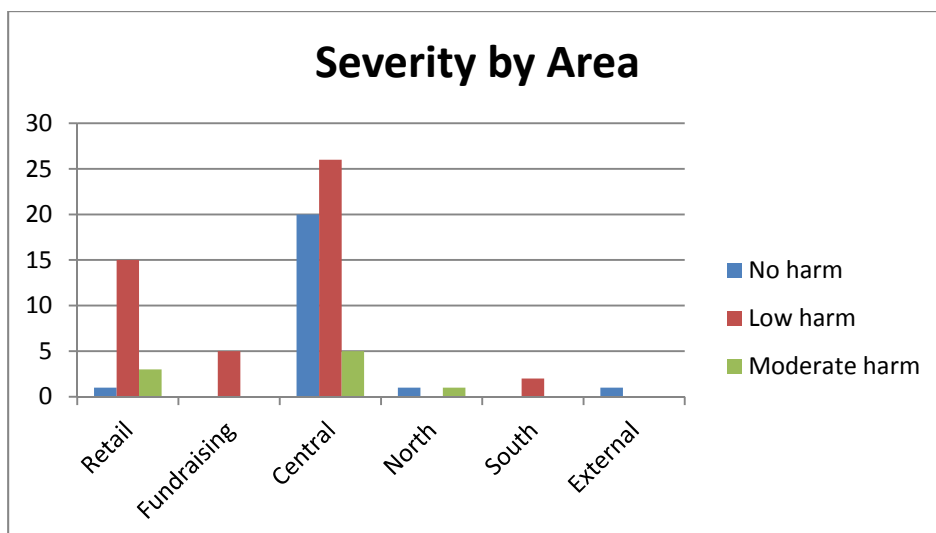
	Retail	Fundraising	Central	North	South	External
No harm	1	0	20	1	0	1
Low harm	15	5	26	0	2	0
Moderate harm	3	0	5	1	0	0
Severe harm	0	0	0	0	0	2

No harm – where no harm came to the person e.g. ‘no apparent harm’, ‘no complaints or pain or visible bruising’

Low harm - Where the incident resulted in harm that required first aid, minor treatment, extra observation or medication e.g. ‘small cut on finger’ graze on hand’

Moderate Harm – Where the harm was likely to require outpatient treatment, admission to hospital or surgery e.g. sustained fracture to wrist, one inch laceration over eye – taken to A&E for suturing.

Severe Harm – where permanent harm, such as brain damage or disability, was likely to result e.g. fracture neck of femur



Definition of the degree of harm as used by National Reporting and Learning System (NRLS)

Details of incidents categorised as Severe or Moderate Harm

Ref	Area	Detail	Degree of harm
1712	Retail	Volunteer experiencing pain in wrist at end of duty, needs X-ray	Moderate Harm
1718	North	Concerns regarding 111 service - concern sent to DCCG	Moderate Harm
1726	Retail	Staff struck on head with heavy object whilst sorting goods	Moderate Harm
1729	Central	Member of staff bitten during incident with patient	Moderate Harm
1731	Central	staff altered users chair without informing the user - resulted in injury requiring visit to GP and medication	Moderate Harm
1760	Central	Contractor cut thumb - taken to A&E (returned to work)	Moderate Harm
1786	Retail	Staff trip resulting in torn ligament	Moderate Harm
1853	Central	Fall	Moderate Harm
2007	Central	Fall	Moderate Harm
1723	External	Fractured Neck of Femur delay in gaining ambulance for pt at home	Severe Harm
1772	External	Concerns regarding delay in assessment and referrals for pt. with suspected Spinal Cord Compression at DCH	Severe Harm

Conclusions

We were pleased to note that the number of AIRS arising in clinical area rose during the year from 90 to 239, reversing the trend downwards witnessed the previous year and reverting to the levels of the past. This indicates that the barriers in the way of good reporting have been identified and largely removed. However, as will be seen below this remains a constant challenge.

The rise was principally in the number of near misses and concerns being noted – vital if the organisation is to learn before something bad happens. We continue to have “bad patches” in particular areas, notably medication errors and falls, which can be attributed to individuals – either inexperienced clinicians on training rotas, or particularly independently minded patients. We are aware that these human factors are unavoidable and so are constantly looking at ways of mitigating their impact such as enhanced supervision for new doctors prescribing medication and very careful assessment and warning monitors for the frail but independent patients.

Quality Account 13/14 Priorities

Volunteer contact/support if wanted.

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 they are 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 patient and 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 to clinical staff if they perceive concerns.

Desired Outcome : maintained contact with patients and families. Reassurance and faster response to change.

What happened:

Patients and carers are now offered volunteer support at the first assessment if required for specific tasks. However, we wanted to be able to offer a companion service too for those patients and carers who are perhaps more vulnerable or alone. Discussions with Dorothy House Hospice who have operated this scheme highlighted all sorts of issues we had to consider before we could launch into the programme. We now have written role descriptions to which we are carefully recruiting. There will be a pilot in summer 2014 when 6 volunteers (2 in each area) will undergo some training and then will be allocated to patients who would like this care. The volunteers will follow the patient wherever they may be – home, hospital or hospice or when being discharged to a nursing home for instance. As the integrated teams are blossoming some outreach work taking place eg a nurse from the In Patient Unit going home with an anxious patient to settle them in, much appreciated by the patient. Further progress will be reported next year.

MDT Working

Multidisciplinary Team (MDT) meeting development

Because: MDTs are resource intensive but vital meetings which determine the care plan for individuals. These plans need to 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 services based in the North, 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.

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

What Happened:

MDT meetings are now held in the North for the Northern patients, South for the Southern patients and the Central meeting covers the IPU and community patients in the central team, whether attending day care or care at home. Links by videoconferencing has meant better use of resources and has cut travelling time significantly, allowing more time for direct patient care. All members of the team hear about the patients they may have contact with in the future and there is much less repetition. Of course, as with any new system, it has created other challenges so work continues to be refined, especially to ensure that there is a comprehensive review of the patients in the IPU.

Clinical Leadership Group

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.

What Happened:

The group has been established with representation from north, central and south with the aim of setting clinical standards for the Trust and linking with national bodies to keep up to date. For example the group has reviewed the Dorset wide policy on resuscitation and updated ours. We started with sessions on 'changing hearts and minds' to ensure that the standards would be taken back to and be embedded in practice across the Trust. New, safer syringe drivers, introduced nationally, and now locally have meant we have undertaken a huge training programme for our staff and also delivered the programme Dorset wide for nursing homes etc. Audit activity includes setting the standard for the treatment of nerve pain which is to be followed by an audit shortly. At present we are concentrating on Outcome measures, notoriously difficult to pin point in palliative care, alongside our colleagues in the south west and nationally with the aim of being able to ensure our care is patient centred and addressing what is important to them and their carers.

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, ensuring that change is rapidly picked up on and the process is safe.

Desired Output: Being more open to referrals of patients earlier in their journey.

What Happened:

We have analysed referrals since starting the new triage system to see if we seeing patients earlier in their journey. However this does not seem to be the case yet. The referral criteria have been made clearer and constant attendance at the GSFs should improve this. The triage system has meant that the patient's issues do have a multidisciplinary airing initially to ensure the right person goes to see the patient from the start. The system will continue to be rolled out with better education of referrers, especially those in primary care.

Improvement of facilities at Joseph Weld

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.

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

What Happened:

Thanks to a Department of Health grant the refurbishment of the ward pantry and especially the sitting and dining areas has greatly improved the experience of coming to the hospice for patients and carers. The sitting area is modern, relaxing and more private. Anyone can help themselves to coffee and cake in the dining area and patients can now sit with their visitors to be served at lunch. Carers too can come and eat in the cheerful and bright Orangery. The guest room and en suite for relatives who want to stay overnight is now welcoming, comfortable and an oasis for those facing a difficult time.

The new facilities opened at the end of March and preliminary feedback has been 100% positive.



A drumming workshop with carers

Priorities for 14/15

Review of Assurance mechanisms for patient safety

Because: Learning from the Francis report prompts this review to ensure that all are sighted on the actual standards of care given in any part of the organisation.

Covering:

- Review our AIRs reporting system to ensure robust data collection and learning takes place.
- Review Trustee and Board performance to ensure solid governance at all levels.
- Focus on known areas of risk particularly :
 - pressure areas,
 - the assessment from admission to discharge or death, care,
 - improved documentation tool (on Crosscare electronic patient record) and use thereof for ease and efficiency of reporting

Desired Output: Complete transparency of service quality

Transfers of care especially from the acute sector

Because: this is traditionally an area where standards are at risk and we now have opportunities with joint medical staffing to improve some of our links.

Covering:

- Replacement of the Liverpool care Pathway in the acute sector
- Gaining Weldmar access to the Somerset Cancer Register (at DCH) improving transfer of care records.
- Joint work on rapid community response

Desired Output: reduction in complaints or negative reports about transfers of care.

Day Service Review

Because: patients referred relatively early need a wide choice of support mechanisms to enhance their well-being and independence for longer. A “day centre” nursing home model does not fit the bill for many. Patients supported effectively through day hospices are less likely to need admission to either the acute sector or the hospice.^{1 2}

Covering:

- More choice for patients to pick and choose which service they would like e.g. complementary therapy, fatigue clinic, art therapy, lunch only or a bath.
- Respite care to continue at least one day a week.
- Work with the Living Tree in Bridport. Open day care services in Bridport (Hospital)

Desired Output: Better uptake of day hospice places and enhanced delivery of the preferred place of care when this is at home.

¹ *Help the Hospices commission into the future of hospice care: Current and future needs for hospice care: an evidence-based report*
Natalia Calanzani, Irene J Higginson, Barbara Gomes 2013

² *Brumley R, Enguidanos S, Jamison P, et al. Increased satisfaction with care and lower costs: results of a randomized trial of in-home palliative care. J Am Geriatr Soc. 2007; 55: 993-1000*

Patient and Carer Feedback

Complaints: There were three complaints raising six issues. None were passed to the Health Ombudsman. One complainant found the whole situation hard to understand, The rest were happy with their experience of the system.

		Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Total year to end Mar-14	
Complaints Monitoring Report: Number of complaints by category and outcome		2						0	1	0	0	0	0	3
Number & % complaints acknowledged within 3 operational days	Number	0	0	0	0	1	1	0	1	0	0	0	3	
	%	n/a	n/a	n/a	n/a	100	100	n/a	100	n/a	n/a	n/a	100	
Number & % of complaints responded to within agreed timescales	Number	0	0	0	0	1	1	0	1	0	0	0	3	
	%	n/a	n/a	n/a	n/a	100	100	n/a	100	n/a	n/a	n/a	100	

Details of lessons learnt and actions taken

Issue 1

Poor communication following discharge from service and subsequently trying to access care.

Actions: Keep in touch with patient post discharge.

Changing phone answer service for patients so always answered by person and not voice mail

Follow up on phone conversations.

Issue 2

Complainant struggling to understand what was happening in general.

Actions: Constant reassurance and explanations and bereavement support offered on an ongoing basis.

Issue 3

Family anxiety about deterioration of respite patient when discharged.

Actions: Be very clear to relations on discharge as to why condition has changed.

Issue 4

Part of a wider NHS investigation – bulk of complaint relates to NHS care. Weldmar only involved for short period.

Re Weldmar: there was a misunderstanding over 'just in case' drug.

There were communication issues relating to the patient moving between towns.

Actions: Reassurance given to family as much as possible and bereavement services offered.

Issue 5

Relating to communication and explanation to carers about coordinated care

Actions: Staff to spend more time discussing and explaining

Issue 6

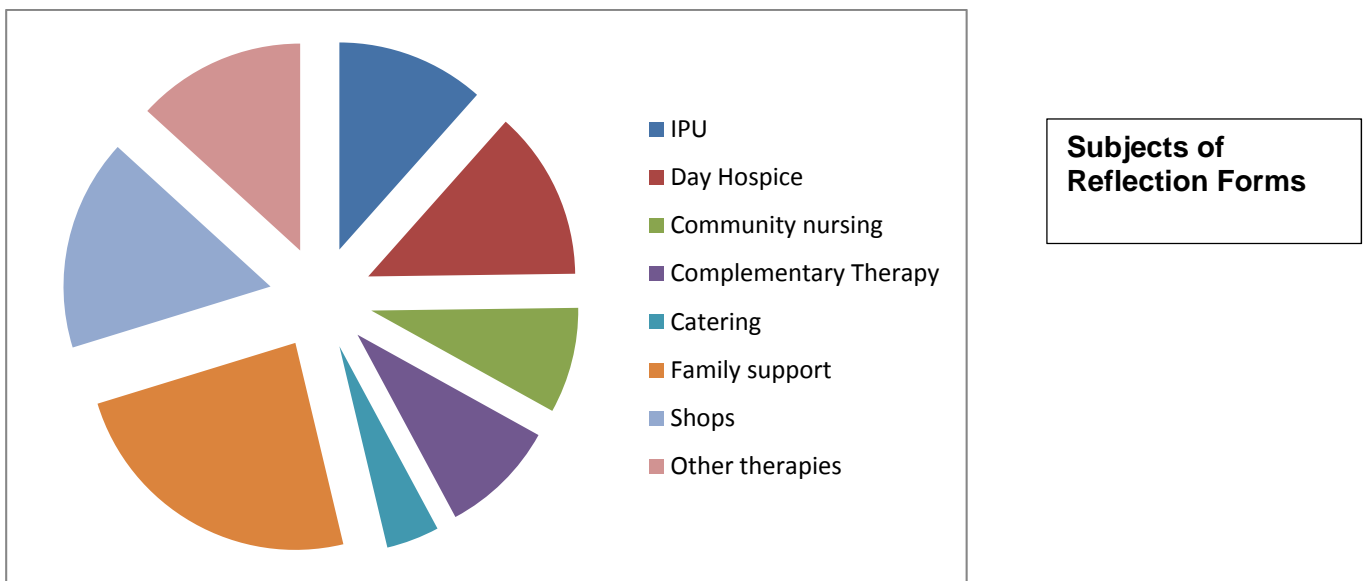
Following a complex discharge from hospice, when patient insisted on going home communication with other agencies was poor.

Action points: DNs and GPs to be fully apprised of issues around discharge and future plans.

As reported last year there were 14 clinical complaints in 2012/13 – by a long way the greatest number ever received. This year’s 3 is in line with previous years. We do not feel that the 2012/13 experience reflected a real problem in our services (except in one area where we had had a temporary staffing problem) but was more to do with the general public concerns being generated by the Mid Staff publicity and that around the review of the Liverpool Care Pathway. Other hospices experienced similar blips. Nevertheless it is very reassuring that our numbers have fallen back to where they have been in the past.

Surveys and Reflections

The national hospice survey of patients was not run in the last year. Weldmar receives direct feedback however through its Reflections leaflets which are available everywhere and may be returned signed or not. In the last year we received 93 forms – this highest yet. Only 3 of the reflection on clinical issues were negative. Comments from Reflections forms have been quoted throughout this report.



Have Your Say ‘South Day Care, Trimar’

Between August 2013 & June 2014 the South Area Team sent (or gave out by hand) **51** ‘Have Your Say’ Questionnaires to any patient that was having their attendance reviewed at 3 months, or who were being discharged from the Day Service. **20** completed questionnaires were returned.

Feedback covering all areas of our day service was overwhelmingly positive with the following comments being made:-

- “excellent, marvellous, outstanding, good quality and choice of food, environment always spotless, very nice and treated with every respect, what wonderful staff you employ, I feel that the volunteers deserve a gold star for their patience, humour and kindness, all very nice, love going to Trimar, drivers are exceptionally helpful”

The things patients indicated they valued the most from their attendance at day services included:-

- “A chance to get out , a break for carers/relatives, caring environment, complementary therapies, activities and stimulation”

Some things that patients told us they would like us to improve at Trimar included:-

- “Having a buddy for the day would have helped me navigate and select an activity and may have made me less anxious on my first day”, “Introduce new clients to other patients as not always done”, “start earlier, 9.30/10.00”, “fresh air, occasional time limited ‘meditation sessions’ and ‘gentle music and movement exercise”



Weldmar volunteers joined the National Hospice Care Week theme “Count me In” Campaign pledging to spread news of the benefits of good End of Life Care.

Where we can implement changes based on these comments (such as the buddy for a day), we have.

Staff

The Key performance indicators for our staff are:

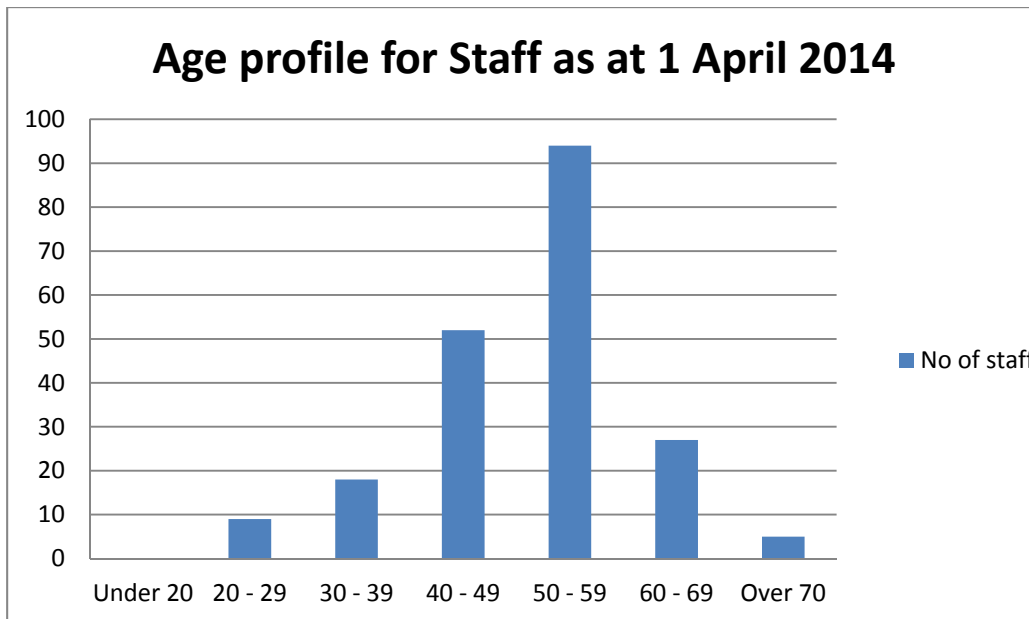
- Turnover
- Sickness Absence
- Staff Satisfaction Survey
-



Part of the Joseph Weld Hospice team – nurses, doctor, creative therapist, counsellor, administrative support and fundraising!

This report covers the twelve months ending 31st March 2014 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 2014 was 201; there were 26 joiners and 21 leavers over the twelve months, giving an annual staff turnover rate of 16.1%. For comparative purposes, the staff turnover rate for 2011/12 was 10.45%. The higher rate includes more retirees (not surprising given the age profile), TUPE transfers, a death in service but also redundancies and dismissals.

Of the 21 leavers, there were 6 age retirements. The remaining 15 leavers moved on for a variety of reasons. If involuntary departures and retirements were removed from the figures, the staff turnover rate for the twelve months would be 8.29% (7.46% last year). The age profile for staff at 1 April 2014 is:



SICKNESS ABSENCE

The sickness/absence rate for 2012/13 was 4.93% (last year 4.84%). If long term sickness/absence is excluded, the rate falls to 3.01%. We are actively working with line managers to ensure sickness is being properly managed because unforeseen absence can put unnecessary strains on teams especially those providing care.



Celebrating nurses day in May 2014

STAFF SATISFACTION SURVEY

111 (56%) members of staff filled in the 2014 survey a great improvement on last year (73) . Of the 33 areas explored, 29 showed improved scores, in 17 of these the improvement was greater than 4%. The greatest improvements were in the areas around line management where considerable investment has been made in a continuing programme to improve standards and the amount of 1:1 support staff get. We still need to do work on this however to maintain the improvement. Stress and work/ life balance remain areas of difficulty.

Volunteers

As can be seen below, volunteers not only perform myriad tasks which create real quality for our patients but they also do so out of their good will and humanity, making patients feel even more valued.

The governance around the quality of volunteer input has been greatly strengthened during the year through the creation of job role guidelines, clear responsibilities for performance management and a committee structure which keeps the Board sighted and aware of issues about volunteers and also issues being raised by volunteers.



Volunteers come in all shapes and sizes

Patient Care Volunteer Activity	Tasks Undertaken	Hours Worked	(average)
Community:			
Transport (own car)	189	378	2 hrs
Collecting prescriptions	5	5	1 hr
Sitting	23	1,104	2 hrs for 24 wks
Befriending	17	1,224	3 hrs for 24 weeks
Shopping	5	120	1 hr for 24 wks
Dog Walking	0	0	1 hr for 24 wks
Gardening	2	6	3 hrs
HH Reception	233	466	2 hrs
Admin duties	359	886	2-3 hrs
Social Group	360	1,440	4 hrs
Jam Che (Gentle Touch) (incl HH)	9	27	1 hr for 3 wks
Family Support (emotional support)	101	202	2 hrs variable wks
Chaplaincy	10	10	1 hr
Complementary Therapy (qualified practitioners)	95	380	1 hr for 6 wks
Refreshments	9	18	2 hrs
Day Hospice:			
Daycare Help	249	747	3 hrs
Transport (own car)	193	386	2 hrs
Minibus	111	222	2 hrs
Hair Dressing	21	42	2 hrs
Creative Therapy	64	128	2 hrs
Jam Che (Gentle Touch)	185	370	2 hrs
Arts Therapy	5	10	2 hrs
Chaplaincy	172	440	2-3 hrs
Reception (John Greener)	82	246	3 hrs
Handyman & Gardening	12	24	2 hrs
In-Patient Unit:			
Ward	795	1,590	2 hrs
Meal Assistant (feeding)	29	29	1 hr
Ward Clerk	1	3	3 hrs
Sitting	37	74	2 hrs
Carers' Support Group	26	52	2 hrs
Chaplaincy	200	600	3 hrs
Hand & Nail Care	26	52	2 hrs
Reception	1,011	3,033	3 hrs
Flower Arranging	209	418	2 hrs
Family Support (qualified counsellors & coffee mornings / events)	145	290	2 hrs
Pets As Therapy	52	52	1 hr
Jam Che (Gentle Touch)	24	48	2 hrs
Handyman & Gardening	9	18	2 hrs
Totals	5,075	15,140	

Information Governance Toolkit

The Trust undertook a self assessment using the NHS Information Governance toolkit Version 11 with the following results. There is an Action Plan to bring those areas where the score is 2 up to standard 3, normally a matter of Audit.

11-114	Responsibility for Information Governance has been assigned to an appropriate member, or members, of staff	3
11-115	There is an information governance policy that addresses the overall requirements of information governance	3
11-116	All contracts (staff, contractor and third party) contain clauses that clearly identify information governance responsibilities	3
11-117	All staff members are provided with appropriate training on information governance requirements	3
Confidentiality and Data Protection Assurance		
11-202	Personal information is only used in ways that do not directly contribute to the delivery of care services where there is a lawful basis to do so and objections to the disclosure of confidential personal information are appropriately respected	3
11-209	All person identifiable data processed outside of the UK complies with the Data Protection Act 1998 and Department of Health guidelines	na
11-213	There is a publicly available and easy to understand information leaflet that informs patients/service users how their information is used, who may have access to that information, and their own rights to see and obtain copies of their records	2/3
11-214	There is a confidentiality code of conduct that provides staff with clear guidance on the disclosure of personal information	3
11-215	All new processes, services and systems are developed and implemented to comply with information security, information quality and confidentiality and data protection requirements	3
11-216	There are appropriate confidentiality audit procedures to monitor access to confidential personal information	2/3
Information Security Assurance		
11-304	Monitoring and enforcement processes are in place to ensure NHS national application Smartcard users comply with the terms and conditions of use	na
11-316	There is an information asset register that includes all key information, software, hardware and services	3
11-317	Unauthorised access to the premises, equipment, records and other assets is prevented	3
11-318	The use of mobile computing systems is controlled, monitored and audited to ensure their correct operation and to prevent unauthorised access	3
11-319	There are documented plans and procedures to support business continuity in the event of power failures, system failures, natural disasters and other disruptions	3
11-320	There are documented incident management and reporting procedures	3
11-321	There are appropriate procedures in place to manage access to computer-based information systems	3
11-325	Policy and procedures are in place to ensure that Information Communication Technology (ICT) networks operate securely	3
11-412	Clinical Information Assurance	
	Procedures are in place to ensure the accuracy of service user information on all systems and /or records that support the provision of care, support and advisory services	3

STATUTORY STATEMENT OF ASSURANCE FROM THE BOARD

The following are statements that all providers must include in their Quality Account. Many of these statements are not directly applicable to specialist palliative care providers, and therefore explanations of what these statements mean are also given.

Review of Services

During 2013/14 Weldmar Hospicecare Trust provided the following 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 bereavement support

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 2013 -2014, and also fundraising and trading activity. The grant allocated by NHS Dorset represents approximately 25% of the Trust's total income (30% of clinical costs). The remaining income is generated through fundraising, shops and lottery activity and investments.

Participation in National Clinical Audit

- During 2013/14 no national clinical audits or confidential enquiries covered NHS services provided by Weldmar Hospicecare Trust
- During the period Weldmar Hospicecare Trust participated in no (0%) national clinical audits and no (0%) confidential enquiries of the national clinical audits and national confidential enquiries it was eligible to participate in.
- The national clinical audits and national confidential enquiries that Weldmar Hospicecare Trust was eligible to participate in during 2013/14 are as follows: NONE
- The national clinical audits and national confidential enquiries that Weldmar Hospicecare Trust participated in during 2013/14 are as follows: NONE
- The national clinical audits and national confidential enquiries that Weldmar Hospicecare Trust participated in and for which data collection was completed during 2013/14 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.
- Weldmar Hospicecare Trust was not eligible in 2013/14 to participate in any national clinical audits or national confidential enquiries 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 2013/14 audits or enquiries related to specialist palliative care.

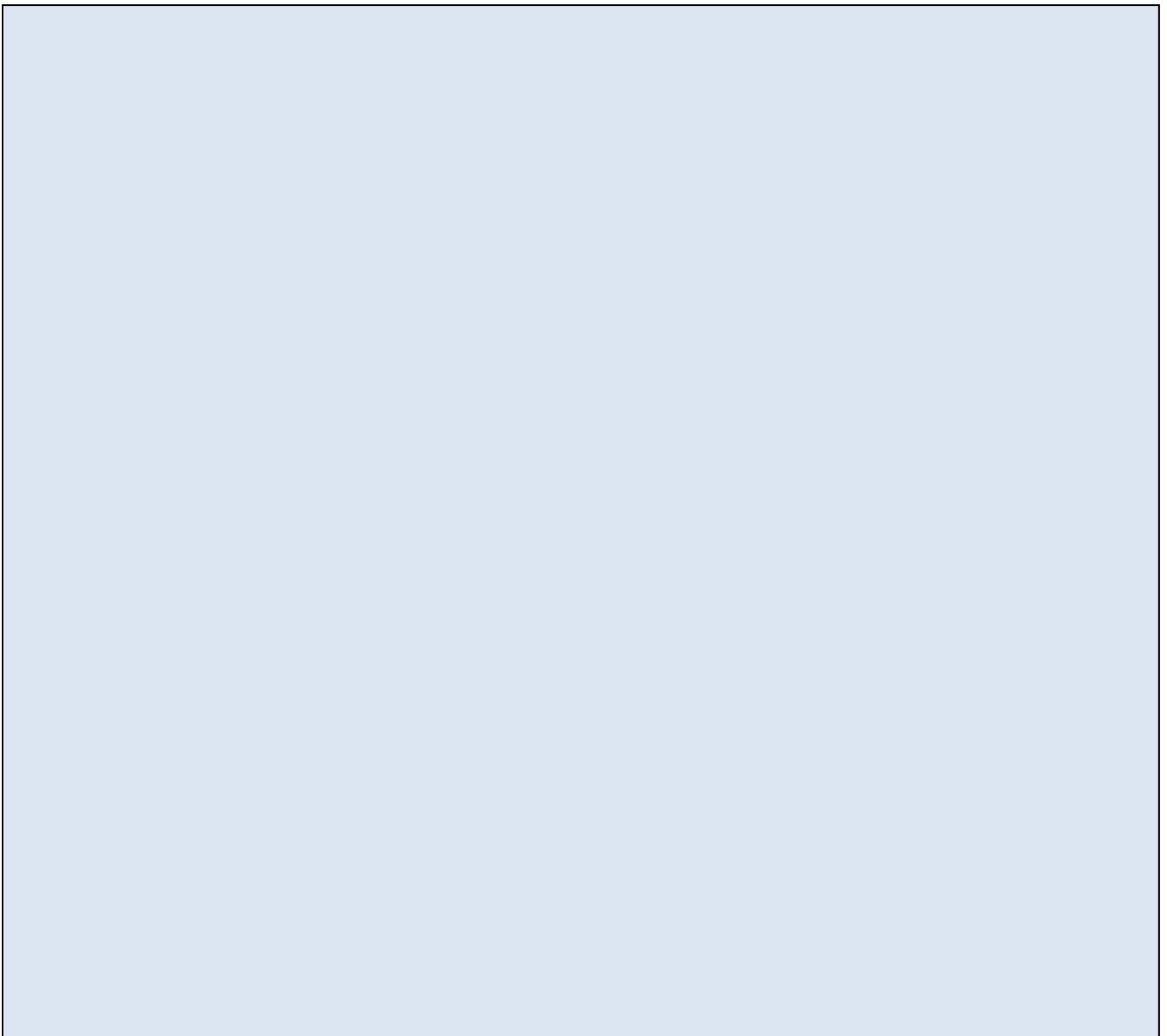
The Hospice will also not be eligible to take part in any national audit or confidential enquiry in 2013/14 for the same reason.

Statement from the Care Quality Commission

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

- The service may only be provided for persons aged 18 years or over
- A maximum of 18 patients may only be accommodated overnight
- Notification in writing must be provided to the Care Quality Commission 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 by the Care Quality Commission (CQC) As last year the report indicate that Weldmar Hospicecare Trust was entirely compliant on the standards inspected.



'My husband was initially reluctant to attend Trimar Day Hospice but, come Thursdays my son could hardly keep up with his dad when accompanying him to the building in Greenhill, such was his eagerness to get there and see everyone. ' (Letter)



Patients attending Shaftesbury Day hospice decided they wanted to spend their hospice day out at the Gillingham and Shaftesbury Show – so they did!

Use of the CQUIN payment framework

Weldmar Hospicecare Trust income in 2013/14 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework.

Research

The number of patients receiving NHS services provided by Weldmar Hospicecare Trust in 2013/14 that were 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 during 2013/14 to the Secondary Users service for inclusion in the Hospital 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 Payment by results clinical coding audit during 2013/14 by the Audit Commission.

Results of 13/14 Audits

<p>Infection Control Audits:</p> <ol style="list-style-type: none"> 1. Use of verbal handover window (installed on electronic patient care system, after it was highlighted that this information was poorly recorded 2. Handwashing audit- one person (out of 5) did not wash hands after care, one (out of 5) was wearing jewellery and one (out of 5) had longer nails than is allowed. With regular on line training there are no longer practical demonstrations. 3. Catheter audit : Reasons all correct for inserting catheters. Catheter associated infections are low Aseptic techniques observed 4. Decontamination of equipment: 33/37 items were clean (no dust, debris body fluids) 4 items were found to have dust or debris on. 5. Sharps bins: not in holders in the patient bays 	<ol style="list-style-type: none"> 1. Documentation of handover from other agencies to the hospice on infection control has improved dramatically, demonstrating infection control issues were managed on handover 2. All staff were reminded of good practice. This is an on-going audit, carried out at regular intervals 3. Maintain good practice 4. Mini education session to a group of people, message in monthly update. Re audited 3 months later all clean 5. Holders placed in all patient bays to increase safety
<p>Controlled drugs and medication audits</p>	<p>DCH Pharmacy created current signatories list including Drs and pharmacists for easy access. Education on how to make a correction properly in the controlled drug register.</p> <p>Junior Drs prescribing, using best practice – to be monitored by mentor/Medical Team. Nurses to alert Drs to incorrect/poor prescriptions.</p>
<p>The use of a drug (Buscopan) in bowel obstruction- different ‘as needed’ doses being prescribed by different doctors. Many underdosing</p>	<p>Drs agreed on best practice from audit and review of literature in prescribing for this condition. To repeat audit later in 2014</p>
<p>Preferred place of death</p>	<p>Part of a south west audit – looking at 1 months statistics- 83% of Weldmar deaths were in their place of choice, just above average for the south west.</p>
<p>Venous thrombo- embolism (VTE) management</p>	<p>Improvement in assessment and documentation of appropriate treatment</p>
<p>Falls, Medication Errors and Pressure sores</p>	<p>The regional quarterly benchmarking has been adopted by Help the Hospices as a National Benchmarking tool</p>

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.

We met requirements in each of these areas during the year

(ii) Active discharge planning with safe and appropriate discharge facilitated	Norovirus - Number of bed days lost
Delayed Transfer of Care: Summary data for delayed transfer of care using CCG template.	Outbreak Management: - Number of identified infected patients (inc C-Diff and Norovirus) isolated within 2 hours - % infected patients isolated within 2 hours
95% of falls assessments completed within 24 hrs of admission.	Number of Medication Errors, by speciality, by severity of harm.
Number of patients falling more than once.	Number of Medication Errors relating to controlled drugs, by speciality, by severity of harm.
Audit of 10 or 20% of total (whichever is greater) sets of notes of patients who fell in hospice	Medication Errors - Outcomes of lessons learnt from Root Cause Analyses
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)	Medication Controlled Drug Incidents: Advise of significant incidents concerning controlled drugs which may affect another organisation
Infection Report: - Number of patients with MRSA Bacteraemia - Number of patients with MSSA - Number of patients with E-Coli bloodstream infections	CQC Self Assessment on Controlled Drugs - Copy to be submitted to CCG Medicines Manager and CD Accountable Officer in the Local Area Team (LAT)
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	Medication - Audit Plan: Medicines Audit Plan detailing all audits to be undertaken that demonstrates compliance with national guidance
MRSA Root Cause Analysis Reports	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 national 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
Clostridium Difficile - Death Certificates: Number of deaths where C-Diff is identified under Section 1 (a) Cause of Death on the death certificate	Medication - Non Formulary: Audit of Policy that covers prescribing of non-formulary drugs, consent of patients and dissemination of formulary updates and shared care agreements
Clostridium Difficile - Cluster: C-Diff outbreak Root Cause Analysis Reports. "outbreak" is defined as 2 or more cases in same area within 28 days.	Occurrence Reports to the PCT Accountable Officer for Controlled Drugs
Norovirus Outbreak: Number of wards and/or beds closed due to Norovirus (empty and full beds)	VTE Episode Prophylaxis Reports
Norovirus - Number of cases of Norovirus	
Norovirus - Number of bays and ward closures	

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.	Service Quality Performance: Report detailing performance against:- - Operational Standards - National Quality Requirements - Local Quality Requirements - Never Events - Quality Incentive Schemes
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.	- 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)
Nutritional Screening: 95% of all admissions screened within 24 hours of admission to hospital. Trajectory to be agreed by the end of Q1 and Consequence of Breach will only apply if trajectory is missed.	
Number of acquired pressure sores by grade reported separately	Service Quality Scorecard: Data as per scorecard - template as contained in Schedule 5 Part A
Number admitted with pressure sore(s)	Independent Investigations commissioned by provider: - Email outlining reason for investigation and timescale for completion.
95% of patients admitted that have been risk assessed for developing a pressure sore within 6 hrs of admission	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
Pressure Ulcers - Stage 3 & 4: Declared on STEIS as an IRRP	Learning Disability Self-Assessment: Report on actions taken to address identified areas for improvement
Acquired Pressure Ulcers - RCA Reports: Copy of full RCA report for all Stage 3 & 4 Acquired Pressure Ulcers	Copy of Reports from or in response to Regulatory or Supervisory Bodies (as per General Conditions 15.3)
8.2 Sleeping Accommodation Breach: Threshold > 0	Provider Performance Reports presented to their Board
"Saving Carbon, Improving Health" Summary of Providers progress on climate change adaptation, mitigation and sustainable development including performance against carbon reduction management plans.	NHS Constitution Compliance - Self Assessment: Provider self assessment against the Rights and Pledges contained within the NHS Constitution.
Sustainable Development Strategy: Board approved sustainable development strategy	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 or green against ELCQuA measures
Carbon Management and Climate Change Adaptation Action Plan Performance against plan.	Safeguarding Compliance: Exception report detailing any areas of non compliance with policies contained in Schedule 2 Part L.
Initial assessment and annual re-assessment: Progress Report	
Incidents and breaches of confidentiality / information security.	
DDA/MCA: Action Plans to evidence compliance with Disability Discrimination Act and Mental Capacity Act	
Equality Monitoring Reports - Performance against Equality Requirements	

<p>Safeguarding Reports - Report on progress of compliance with policies in Section C Part 7.2</p> <p>Safeguarding - Compliance Report / Audit: Progress Report on compliance with the Children Act incorporating the results of locally agreed audits.</p> <p>Reports to include:</p> <ul style="list-style-type: none"> - Reference to lead responsibilities of the Provider - Arrangements for Safeguarding Processes including (but not limited to) MARAC, MAPPA, DV, PREVENT, MCA, DOLS and MHA 	<p>Supporting specialists and generalists to meet the end of life care needs of patients with a diagnosis other than cancer</p> <p>(i) individual patient case support to primary care teams</p>
<p>Complaints Monitoring Report:</p> <ul style="list-style-type: none"> - 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 complainant satisfaction with complaints process 	<p>(ii) support provided to non cancer networks</p>
<p>Complaint Communication</p> <ul style="list-style-type: none"> -sample of letters and responses including all those relating to quality of care issues 	<p>(iii) specialist sessions provided for non cancer diagnosis</p>
<p>Surveys - as detailed in Schedule 6 Part G:</p> <ul style="list-style-type: none"> - 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. 	<p>Adverse Events</p> <p>Number of Adverse Events for all categories identified using the Global Trigger Tool</p>
<p>(iv) Patient feedback indicates positive experiences; and where necessary changes are implemented if feedback indicates concerns</p>	<p>Patient Safety Incident Report AIRS Summary Report:</p> <ul style="list-style-type: none"> - 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.
<p>(i) Carer reflections and feedback indicate positive experiences</p>	<p>Exception report on compliance with NICE Technology Appraisals and Clinical Guidance</p>
<p>(ii) Carers views used to inform service development</p>	<p>Central Alert System (CAS):</p> <p>Report detailing compliance with NPSA Alerts and MHRA, CMO, CEO and CNO Briefings</p>
<p>(iv) Hospice respite provision available to meet carers needs</p>	<p>Duty of Candour:</p> <p>Each failure to notify the Relevant Person of a suspected or actual Reportable Patient Safety Incident (as per Guidance)</p> <p>(Consequence of breach - recovery of the cost of the episode of care or £10,000 if the cost of care is unknown)</p>
<p>(i) patients on an end of life pathway who have an appropriate personalised care plan (100%)</p>	<p>Monthly number of IRRP declared including nil returns (SUI - tbc by PCT)</p> <p>- % compliance with STEIS data entry requirements</p>
<p>(i) Number and % of patients who have an Advance Care Plan in place when they are referred to the Service</p>	<p>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;</p>
<p>(ii) Number and % of patients who have an Advance Care Plan undertaken whilst with the Service</p>	
<p>(i) attendance at GSF meetings (100%)</p>	
	<p>Never Event RCAs:</p> <p>Copy of Providers RCA Report</p>

NRLS Incident Reports Summary & analysis of NRLS reporting	(ii) Face to face assessment in the community or in hospital is available for at least 8 hours a day, Monday to Friday
Summary of RCA (Root Cause Analysis) investigations and associated action plans submitted within 3 working days of completion	(iii) Urgent face to face assessment is available at the weekend for at least eight hours a day
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	(iv) Inpatient admission, available 7 days a week, from at least 8am - 8pm, 24 hours a day
Final SIRI (Serious Incidents requiring investigation) investigation reports and action plans	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.
Details of patient numbers accessing inpatient services - 4 beds (1,460 bed nights p.a.)	Safeguarding Training: Report on the number and % of staff trained to - Children Level 1 - Children Level 2 - Children Level 3 - Adults - MCA/DOLS
Details of specialist community nurse activity (4 FTE nurses)	Percentage of staff to have basic Learning Disability awareness as part of induction
Details of patient numbers accessing day care services (2,000 day care sessions p.a.)	MCA/DOL - Number of Staff trained as a percentage of overall applicable staff
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	All appropriate internal staff have undertaken holistic needs assessment training
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	Senior SPC nursing staff have the skills and competencies to support physical assessment and prescribing for patients (increasing number of nurse prescribers)
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 including (but not limited to) individually priced drugs and devices), diagnostics, maternity	Education is provided in a variety of settings to non specialist staff at all levels (as per service specification - Para 2.2)
(i) % of patients who are cared for in their identified preferred place of care 95% of Service Users where the package of care is available to support this.	Workforce Indicators: As per embedded scorecard
Numbers and brief details of referrals to inpatient services unfulfilled	
(i) Telephone advice is available 24 hours a day, 365 days a year	