Agenda Item:

9

Dorset Health Scrutiny Committee

Dorset County Council

Date of Meeting	16 November 2015
Officer	Director for Adult and Community Services
Subject of Report	**Weldmar Hospicecare Trust Quality Account 2014/15**
Executive Summary	This is the fifth 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 2014/15, 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.
Impact Assessment: *Please refer to the protocol for writing reports.*	Equalities Impact Assessment: Not applicable.
	Use of Evidence: Report provided by Weldmar Hospicecare Trust.
	Budget: Not applicable.

	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: Not applicable.
Recommendation	That the Committee consider and comment on the Quality Report.
Reason for Recommendation	The work of the Health Scrutiny Committee contributes to the County Council's aim to protect and improve the health, wellbeing and safeguarding of all Dorset's citizens.
Appendices	1 Quality Account 2014/15, Weldmar Hospicecare Trust
Background Papers	None.
Report Originator and Contact	Name: Ann Harris, Health Partnerships Officer Tel: 01305 224388 Email: a.p.harris@dorsetcc.gov.uk

Weldmar Hospicecare Trust
Caring for Dorset

Quality Account for 2014/2015

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 2014/2015

Contents

Introduction
This is the fifth Quality Account of Weldmar Hospicecare Trust and is produced as a statutory requirement because Weldmar receives money from the NHS[1], 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 2014/15, 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

[1] *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, investments and reserves. We do not have different standards for patients, depending on the source of funds for the service.*

Visits from Owls at the new Wellbeing Centre

> I would just like to say how thankful I am to have such an amazing Trust as Weldmar in the local area. The help and support from the beginning to the end of my wife's illness was second to none. The aftercare for myself with the wonderful counselling supplied which took me from a very dark place back to understanding my bereavement and how to handle my loss and associated feelings.

Report from the CEO

In Dorset our challenge is to improve the quality of the services we offer, and those provided by our partners in care, while managing a steadily growing demand not only in numbers but in the complexity of those who seek our support. Statutory funding of our service has been flat lined for a number of years reducing our ability to expand to meet the demand. Our approach to these challenges has been, like our care, holistic. It includes our direct services to patients and families, our education services to raise standards internally and externally, our partnerships to improve care co-ordination, our documentation and measurement of the impact of our work.

We also need not to lose sight of the fact that people who have a diagnosis of non-malignant disease, those who are on the margins of society for any reason and those who have a fearful approach to end of life services, tend not access our services so readily as others. We have significantly changed our organisation to try and improve our accessibility for all these people by creating geographically based teams who can identify needs in their locality and create a response which matches. This has required considerable upheaval for staff whose commitment to improving service quality is to be greatly applauded.

This report focuses in particular on our direct care of patients and it is very pleasing to note that we are in the vanguard of those adopting the new national Outcome Assessment and

Complexity Collaborative (OACC) system for measuring the impact of care services. This toolkit, developed by Kings College London and the Cecily Saunders Institute, provides palliative care providers, for the first time, with a validated and robust method for assessing holistically patient wellbeing – and thus our efficacy. We will be reporting results from this in the next few years.

We are conscious however that we are only part of the care which surrounds our patients and the concerns we have expressed in the past about the robustness and responsiveness of home nursing services, especially in the more rural parts of Dorset, remain unabated. We struggle as an organisation working alone to resolve these issues. We hope that there will be some drive from our statutory partners to make progress in 2015/16.

Alison Ryan
Chief Executive

Report from 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 rigorous independent internal audit staff. Their processes 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 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.

In the end however the only quality measure we should rely on is the reported experience of patients and their families, and the degree to which we meet the needs of our community. Our constitution, which allows anyone interested to be a member and requires us to account to our community at two public meetings a year, gives an opportunity for their voice to be heard. We also have a well-developed public and patient involvement strategy which gives numerous opportunities for individuals to have their say and for us to explore more deeply exactly what has worked well, and what has worked less well, for them. The voice of the patient is increasingly heard at Board meetings and provides the focus for our deliberations – which is how it should be

Stephen Baynard
Chairman of the Board of Trustees

Quality Improvement work in 2014/15

General

Integrated Care

As reported last year our services are now based on a geographical division in South, Central and North areas of Dorset. This has facilitated a more integrated approach to care, both internally by creating community teams who work flexibly to ensure the right person, right place, right time for all the services we deliver and externally by improving our partnership working. An example of this is our district nurse rotation system in north Dorset,. A district nurse works with our community team over 6 months to enhance their skills in palliative care and returns to their place of work with more advanced knowledge and skills to use in their day to day work. This is proving a great success and we were accepted for a poster presentation by the Integration in Care Conference in London on 6 July 2015.

Certificate from Weldmar awarded on completion of District Nurse Rotation

However, providing care in the community generally through Community Healthcare Care Funding (CHC) is becoming increasingly difficult. Even if the funding is available there is often difficulty finding the staff to deliver the care. As mentioned in our last Quality Account we would dearly like to provide, with our partners, Marie Curie Cancer Care, the acute services and the CHC, a viable Hospice at Home service. To this end we will be running a small three month pilot this year to trial a 24 hour helpline, from the hospice and rapid response for those in the community, initially in Dorchester and Weymouth.

Working with Macmillan, we have made a successful bid for the post of Clinical Psychologist for the Trust and she will be starting in September this year. Her role will be threefold.

- To support patients and their families at Level 4, (NICE psychological standards for Cancer and Supportive Care 2004).
- To support clinical and non clinical staff in their care and reflective practice.
- To undertake a scoping exercise to explore the interface between mainstream psychological therapy services and specialist psychological provision within the acute hospital sector across Dorset.

Changing patient complexity

In the In-Patient Unit (IPU) we continue to see an increasing number of patients with complex symptoms. As expected, the number of patients with dementia is also increasing. Although we have worked hard on the 'dementia' agenda from an educational point of view, challenges remain in caring for these patients in a unit that is not entirely suitable for them. As services shrink in the community this adds to the complexity and is not an easy challenge. We will be looking to work as much as possible with our mental health colleagues in the community to support patients at home wherever possible, in familiar surroundings where patients with dementia are more comfortable. However, as with the national picture and Dorset's particular demographics, we too are now noticing there are fewer nurses applying for posts in the IPU and the community.

Education

The Hospice Education Alliance (HEA@ Weldmar) is the provider of internal and external education based within Weldmar Hospicecare Trust. In 2014 we delivered end of life care education and training to over 620 people - over 90% from external organisations. Our programmes have a robust evaluation process and are monitored through a quarterly trust wide education programme group, departmental team meetings and reporting to the Board through the education committee. The following are selected highlights from the year 14/15

For Weldmar Hospicecare Trust staff:

- Reviewed and delivered the Trust Induction, Mandatory and Statutory Training via 13 Training Tracker (on-line) modules and associated face to face teaching.

- Supported the development of the knowledge and skills assessments for the new District Nurse rotational post (band 5) in the North area which has continued to a second placement in 2015.

- Sourced a Foundation Degree programme for the new band 4 Advanced Practitioner posts

- Delivered a ten week classroom and work based learning programme for our band 6 clinical staff.

- Started to discuss the place of apprenticeships within the workforce at the Trust: initial conversation with The College(Bournemouth and Poole) regarding our first apprentice within hotel services

For external staff:

- Qualifications and Credit Framework (QCF) qualifications: City and Guilds accreditation. The HEA @ Weldmar has led nine hospices in working with The College (Bournemouth and Poole) to deliver End of Life Care (EoLC) Awards across the South

and South West. These programmes are being filled by staff from care homes, nursing homes as well as domiciliary care agencies.

- Dorset Compassionate Community: This network offers an opportunity to talk and consider the place of death and dying in society and links to the national Dying Matters Coalition. It is an eclectic group and we have led the steering group drawn from health and social care. Since September 2014 this group has continued to be both self-sufficient and self-sustaining.

- Advance Care Planning with the charitable sector: Two open learning events were run with pre and post conference questionnaires completed by attendees. All attendees were also invited to undertake a 'train the trainer' opportunity; giving skills to deliver the information to other third sector colleagues. This training has now received further funding and will run in 2015.

- Hospital and Community Champions Training: This project has been a resounding success. Each community hospital and each ward at Dorset County Hospital has had a registered and non-registered staff member trained in EoLC principles.

- Gold standards Framework (GSF): The negotiations to relocate the GSF regional centre from the Clinical Commissioning Group (CCG) to the HEA @ Weldmar started in the autumn of 2014. This was completed in spring 2015 and our first programme for Care Homes starts July 2015.

HEA @ Weldmar becomes GSF Regional Centre

Celebrating International Nurses' Day

An event was held at Joseph Weld Hospice on Tuesday 12 May 2015 to celebrate International Nurses Day. Professor Elizabeth Rosser, Deputy Dean, Education and Professional Practice in the Faculty of Health and Social Sciences and Professor of Nursing at Bournemouth University, gave an inspirational keynote speech on leadership to Weldmar team members from all disciplines as well as external visiting colleagues.

This was followed by presentations from colleagues from the multi-professional clinical and educational teams on a wide range of topics. Attendees also had the opportunity to meet and speak to patients attending day care as well as participate in some complementary therapy taster sessions. Poster presentations about initiatives that are currently being taken forward by WHT clinical and education team members were also available to view throughout the day. We hope to advertise this event more widely next year.

Weldmar Community Nurse in Trimar, Weymouth

Food Information Regulations

The Government's Food Information Regulations (2014), made changes to the management of allergens. In December 2014 workshops were held which were attended by all areas across Weldmar Hospicecare. The workshops looked of the impact of these changes. As a result processes have been put in place to ensure all patients, staff and members of the public are given correct information pertaining to the allergens within the food produced / served by Weldmar Hospicecare Hotel Services team. The management of allergens when foods have been donated has been a difficult area to tackle in order to balance the legislative requirements and meet the needs of the patients.

In the last couple of years we have worked hard to improve our delivery of quality meals for patients and relatives. A new chef turned our catering provision around from institutional

fare to one of the best restaurants in Dorset. Meals are now made to order, beautifully presented and tempting for those with a small appetite (and large). Unfortunately the chef has moved on, but left a legacy and change in culture that lives on.

> "The hospice is a wonderful place, the doctors, nursing, but what I want to comment on is the food. This has made so much difference to my husband's stay - both the wonderful quality of the food and being asked what he wants by such sympathetic people."

Catering Team at Joseph Weld

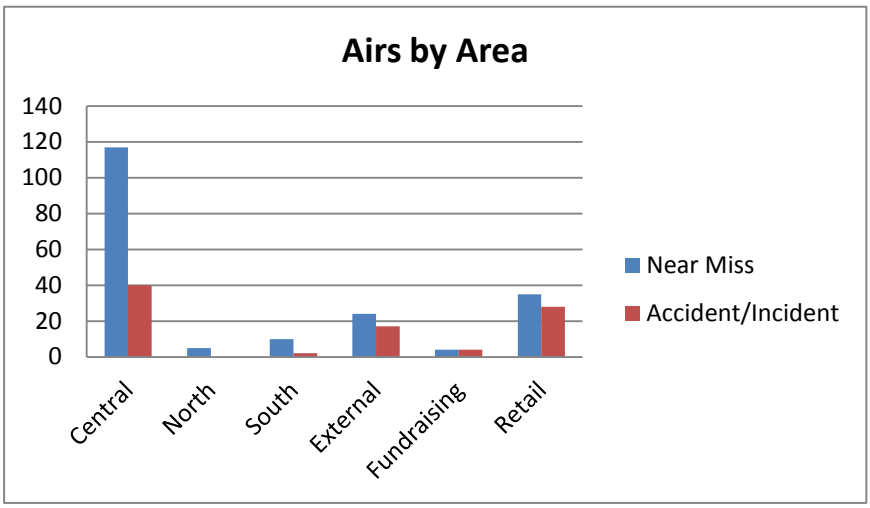
Health and Safety in 14/15

Adverse Incident Reporting (AIRs)
Staff and volunteers are encouraged to complete AIRS if they feel there is a concern regarding health and 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.

The AIRs process looks at what went wrong in the individual incident or near miss and what can be put in place to prevent the same thing happening again. In some cases the changes need to be implemented as part of other projects. In other cases changes are made and there is a requirement to follow up after a specific amount of time in order to assess the changes have been successful. Weldmar Hospicecare is keen to ensure all outstanding issues are followed up. As a result an electronic AIRs has been developed and regular reports are generated in order that the Risk Panel are aware of any outstanding risks, can review actions and take appropriate action to ensure they are addressed.

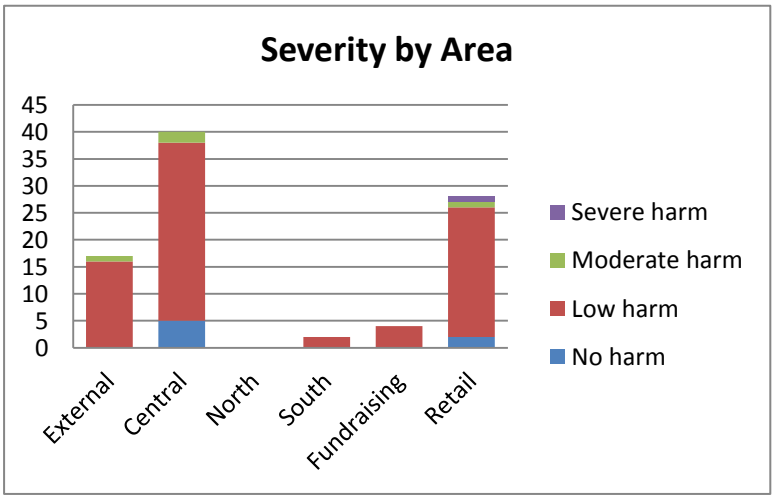
Incident Type by Area 14/15 (12 months)

	Central	North	South	External	Fundraising	Retail
Near Miss	117	5	10	24	4	35
Accident/Incident	40	0	2	17	4	28



Severity of Injury by Area

	External	Central	North	South	Fundraising	Retail
No harm	0	5	0	0	0	2
Low harm	16	33	0	2	4	24
Moderate harm	1	2	0	0	0	1
Severe harm	0	0	0	0	0	1



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 facture 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

Severity	**Details of incident**
Moderate Harm	Member of public fell outside Trust property requiring transfer to A&E
	2 x Injury to staff (RIDDOR)* (off sick for more than 10 days after injury)
	Patient fall at home requiring transfer to A&E
Severe Harm	1 x Injury to volunteer, fell and broke leg while loading van (RIDDOR)*

***Reporting Injuries, Disease and Dangerous Occurrences Regulator (RIDDOR)**

Conclusions
The Central Area includes the In Patient Unit so a greater than average number of AIRs would be expected from that area. There remains a challenge for community based staff to identify near misses and incidents and report them as readily. External AIRs are those we raise with external agencies about near misses or incidents. As reported earlier many of these this year have been about failures of domiciliary care for patients where nursing has not been available or arrangements for providing it have not been robust. Many of these cases are covered by CHC arrangements. On the whole the response to these has been disappointing.

Niggle Amnesty

During the year staff were invited to report on 'niggles' that have bothered them for some time and not been sorted. These came from all departments. The clinical ones were as follows:

No. of niggles	Niggle detail	Action taken
3	Night staff repeating assessments when the patient is often asleep and there has been no change in condition	This is being looked at through the practice improvement system on the unit
2	Getting regular, timely breaks and having the time back	Review of rostering and time management undertaken'.
1	A sister should be on a late and an early shift	
3	Not everyone uses the electronic diary, therefore difficult to track down if concern about lone working	New electronic system being rolled out in 2015
2	People not using the lone worker system that exists, means extra work for those having to track at the end of the day	

3	Drs all taking their break together	This, on reflection was considered a useful time for the Drs in the IPU to get together and communication between them has improved. They are always contactable when required.

Health and Safety Priorities for 15/16

- New lone working system being introduced
- Training for volunteers on sharing information with staff and vice versa when patient's condition changes
- Continuing to encourage people to use AIRs

> "My 10 year old grandson said when we arrived at JWH the other day; I wouldn't mind dying here it is really nice. These words sum up the love and caring my husband, me and my family have received from all the staff."

Review 14/15

Review of Assurance Mechanisms for Patient Safety

Because:
Learning from the Francis Inquiry report (2013) ensures that as an organisation we are continually reviewing and improving our services to ensure that everyone is focussed 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.

Focus on known areas of risk particularly :

- pressure areas, mouth care, manual handling: the continual assessment from admission to discharge or death
- improved documentation tool (on Crosscare electronic patient record) and use thereof for ease and efficiency of reporting

Desired Output:
Complete transparency of service quality

What Happened:

Adverse Incident Reporting (AIRs)

The AIRs system is used as a learning tool, not for blaming people. This encourages people to report incidents and for the organisation to be open in its governance. AIRs are reviewed as they happen and on a quarterly basis for trends through the clinical governance system. Falls, pressure area care and medication errors are also benchmarked nationally.

This year we have:

- Included training on the completion of AIRs in 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.
- By autumn 2015 all existing patient care volunteers have received AIRs training either during the induction day or by attending workshops.

Focus on Known Areas of Risk

In order to review areas of risk and constantly improve practice on the In-Patient Unit (IPU), including assessment from admission to discharge, a new Practice Improvement Initiative has been introduced over the past eight months.

Every three months, members of the IPU Nursing team identify an area of practice that they wish to review on the unit:

- Current practice is audited to identify areas for improvement eg pressure area care, mouth care.
- Literature/ articles pertaining to the topic area are displayed on a notice board in the IPU Nurses' Station
- The evidence relating to the area of practice is reviewed to ensure that the team are working to the latest best practice principles
- Educational sessions with a group and / or one to one basis take place.

A further audit of practice is subsequently undertaken two to three months later to review, assess and embed practice.

As an outcome of implementation of the Practice Improvement Initiative, several areas of practice on the IPU have been improved including:

- Pressure Area Care: Care on the whole was good. However, the auditing and documentation of the care did not reflect the standard of care given. The statistics were therefore inaccurate. The assessment, management and documentation of pressure areas has since been revised to reflect best practice. This has led to increased recognition of the need to review pressure areas as soon as possible (and to document the plan of care within 6 hours) on admission and throughout the patient's stay, as well as more vigorous and regular formal assessment.
- Mouthcare: Practice was amended on the unit to reflect latest evidence and as an outcome of the initial audit findings.
- Manual Handling: The use of appropriate equipment has improved as a result of the focus on this area of practice.

As the Practice Improvement Initiative has proved successful in engaging IPU nursing team members and improving practice the topics for review next year have already been identified by the team and include psychological care and nutrition.

"My husband was only with you for a few days before he passed away. It was the first time in years that he was at peace. Thank you for not making me feel like a nuisance. You made us both feel at ease and at home. It gave me some comfort that I was able to stay with him. I was by his side when he passed away. So thank you from the bottom of my heart, please never stop what you are doing."

Nursing Staff at Joseph Weld thanking our volunteers

Improved Documentation

Much has been achieved in this area this year, in streamlining documentation, making our electronic tools fit for purpose and more accurate for reporting purposes and ensuring the cycle is complete.

- Clinical Records Monitoring Group (CRMG) meet bi- monthly to audit randomly selected set of records against the Clinical Recording Standards. The group have been looking at the consistency and quality of data sourced from our electronic patient record system (Crosscare). This has identified a wide range of data entry inconsistencies and data quality issues which mean that our reports are at times unreliable or inaccurate.. This work is steered by the Clinical Documentation Group (CDG), as part of the clinical governance structure. Improvement and development work is delivered via two main sub-groups – the Clinical Records Monitoring Group (CRMG) and the Clinical Data Quality Group (CDQG).
- A third group of Crosscare Mentors has been established to support training and communication needs of Crosscare users across the Trust. The approach is one of motivating and empowering users to achieve clear standards. These standards have been set against a backdrop of national guidelines linked to the requirements of the main professional bodies (the General Medical Council, Nursing and Midwifery Council and Health Professionals Council).

A major review of the Admission Assessment window for the IPU on Crosscare has been undertaken. As an outcome:

- documentation of the assessment of patients' needs is comprehensive and streamlined
- increased user satisfaction with the revised system
- increased efficiency of time taken for documenting the assessment has been reduced from forty five to twenty minutes.
- A new management plan window enables any member of the clinical team to rapidly review the overall plan for the patients. This is particularly useful for on call team members who may not know the patient well but may be requested to undertake urgent review.

Transfers of care especially from the acute sector

What happened:

The Liverpool Care Pathway has now been replaced with an End of Life Care Plan which is in place in the hospitals and the hospice. Weldmar has gained access to the Somerset Cancer Register in use at Dorset County Hospital (DCH). We also have useful access to the DCH electronic service giving up-to-date results of tests etc. (Integrated Clinical Environment)

A further useful development this year to support improved transfer of care is the more detailed 'transfer of care' window on Crosscare. As long as the palliative care nurses see/know the patient in the hospital before transfer and fill in this window on Crosscare, we have a much better picture of the situation.

Having a new jointly appointed consultant in Specialist Palliative Medicine working across the acute trust and hospice is also helpful.

Although we have had no complaints or negative comments about transfer of care and the transfer documentation has improved where the palliative care nurses are involved, we have had several poor clinical information transfers. One patient was transferred without drugs, one had a pressure sore although we had been told their skin was intact. Sometimes agency nurses in the acute sector cannot find the information when we phone. For example a wife of a patient reported her husband had not had his bowels opened for 7 days while in hospital, yet there seemed to be no record of this on the ward. This is an ongoing area for improvement.

This is traditionally an area where standards are at risk but we now have opportunities with joint medical staffing to improve our links and reduce clinical risk.

We are also taking part in a task and finish group, looking at rapid discharge from hospital in the last few months and this year we will be piloting a rapid response service with our partners.

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. [2] [3]

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 throughout North, South and Central areas.
- Work with the 'Living Tree Support Group' 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.

What happened:
The Trust undertook an internal and external consultation exercise and major review of day service provision in 2014 to inform future development of the service. As an outcome it was clear that there was a need for a more flexible, locally based service that empowered and supported patients with a life threatening illness, to self-manage their condition, symptoms and wellbeing as well as provide support to their carers earlier in the pathway.

We have therefore revised and expanded the day service provision to include:

- Change of name from Daycare to Wellbeing Centres, which are being established across the Trust in Bridport, Blandford and Sherborne which are in addition to existing services based in Dorchester, Shaftesbury and Weymouth.
- Services are available to patients to access at an earlier stage in their journey. A range of programmes have been developed including:
- Improved support service for Carers
- Access to practical information, advice and support services including a drop in service for patients, relatives, visitors and the general public.
- Improved access to new locally based services

[2] Help the Hospices commission into the future of hospice care: Current and future needs for hospice care: an evidence-based report. Natalie Calanzani, Irene J Higginson, Barbara Gomes 2013

[3] Brumley R, Enguidanos S, Jamieson 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

A typical 'menu' of Wellbeing Services on offer includes:

- '*Understand and Manage'* Programmes: Exploring a range of symptoms such as Breathlessness, Fatigue, Anxiety, Stress, Loss of Appetite/Nutrition, spirituality and how to improve daily living with those experiences.
- '*Planning for the future'* workshops: including Will Writing, Advanced Care Planning, Funeral Planning
- *Complementary Therapy Treatments:* including Massage, Aromatherapy, Reiki
- *Keeping Fit and Gentle Exercise:* including Chair Exercise, Yoga, Pilates
- *Pamper Sessions:* including Beauty treatments and Relaxation
- *Advice and Information:* People can 'drop in' and speak to a trained volunteer who will support them to access a range of services or signpost them to appropriate service or agency.
- *Creative Expression* workshops: including art and craft activities, drama and music therapy, storytelling
- *Talking Therapies:* providing emotional support to patients and relatives/carers.

These elements of the service are being phased in over a period of nine months across the north, central and south areas from April 2015.

It is intended that these sessions will be delivered in addition to the existing social day respite service; as patients attending day respite reported they derived considerable benefit from the social interaction and health professional review / advice available. The respite element it provided to carers was also highly valued.

Comfort in Day Respite Centre

Chrysalis Program

This is a new program, open to patients at an earlier stage in their disease. The program utilises a holistic approach to care that accesses participants' unconscious and conscious processes. This approach will be using both verbal and non-verbal activities and reflection.

By the end of the program it is hoped that participants will have developed a deeper understanding of their own and others' emotional, cognitive, spiritual, social and behavioural responses to a diagnosis of advanced life limiting illness. It is hoped that this understanding will lead to improvement in participants' wellbeing and coping strategies and support them in preparing for the future.

The Arts at Weldmar

We commenced delivery of the new Wellbeing service programme in Bridport for all patients diagnosed with a life threatening illness on the 10 June 2015. This is in addition to the social group that we currently deliver on a weekly basis at the hospital.

Living Tree Support Group and Enhanced Bridport Service

We have worked in partnership with members of the Living Tree Support Group, Bridport and West Dorset Sports Trust and Dorset CGG over the past year. Living Tree Support Group members and health care professionals based in the Bridport area had raised concern about the lack of access to cancer support services within the local community. As an outcome of this partnership working, the 'Stepping Out Cancer Rehabilitation Programme' has been developed and implemented.

Funding for the project has been obtained via funding partners including Macmillan Cancer Support, Dorset CCG, West Dorset District Councils Leisure Development Fund and Inspired by 2012 Health and Wellbeing Legacy Fund.

The programme is being managed as a project over a two year period and is the subject of a robust evaluation process which is being conducted by Bournemouth University.

Patient and Carer Feedback

Complaints: There were 6 complaints over the year. With one complaint we were a little late in giving a full feedback after the investigation. None of the complainants felt it necessary to take the complaint to the Chairman or the Health Ombudsman.

CCG requirement		Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Complaints Monitoring Report: Number of complaints by category and outcome		1	1	0	1	0	0	1	0	0	0	0	2
Number & % complaints acknowledged within 3 operational days	Number	1	1	0	1	0	0	1	0	0	0	0	2
	%	100%	100%	n/a	100%	n/a	n/a	100%	n/a	n/a	n/a	n/a	100%

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

Details of lesson learnt and actions taken

Issue 1
Poor communication to the GP and district nurse of a vulnerable patient discharged at the weekend. Patient wanted to go home, issues of safeguarding but didn't want a package of care.
Action: Ensuring a family meeting before discharge, as is normal practice. Ensure thorough

communication with community staff before discharge, especially where the patient is vulnerable

Issue 2
Feeling of a rapport not being built up with patient, nurses prioritisation of care in IPU questioned, table being left out of reach and call bell not working, difficulty with handling syringe driver.
Action: Visited relative at home to listen and apologise. New syringe drivers – education was in progress, reflection by the team on the aspects of care highlighted, checking bells remain attached to the wall more frequently. Review of nursing management of priorities within day to day care. Ongoing education around communication.

Issue 3
Carer complained of what she saw as 'blunt' communication by a community nurse.
Action: visited couple at home to apologise and seek to understand better . Discussed with nurse who had not intended to be blunt and was sorry that it came across as such.

Issue 4
Relative felt she did not receive enough support and involvement in care decisions on the In Patient Unit. Some confusion over the end of life care plan and the Liverpool Care Pathway.
Action: Visited complainant at home to discuss and apologise. Reviewed with staff on ward and clinical records. Although documented how much support was given to the relatives, this was not their impression. Check at time of supporting carers that they feel supported. Access for staff to education for staff on pre-bereavement

Issue 5
Weldmar did not live up to the expectations of care for a patient with cancer and dementia and family in the community. Issues with communication, including no response to a phone call at the weekend. Care too little, too late.
Action: visited family at home apologised for shortcomings and misunderstandings. Ensure nurses explain what the service does, what it doesn't provide and signpost to other more appropriate services if necessary. A daily review of caseload by the area team, so does not rely on one member of staff and potential issues picked up quickly. Further work on communication and care of patients with dementia and their carers.

Issue 6
Staff member accompanied patient to visit relative at some distance, but hadn't realised how far they had to go. Mobile phone ringing constantly and staff member discussing private life with patient.
Actions: Discussion with staff involved. Plan journeys better, keep mobile on silent when necessary. Remember boundaries around private life.

It was disappointing to see a rise in complaints from last year, from three to six. All complaints, except for one, came from our Central area, three from the In Patient Unit and three from the community. There was always a component of poor, or breakdown of communication in each complaint and an element of case management. Education and training in communication skills is ongoing. Where an individual needs encouragement in this area it is noted in their annual appraisal, to ensure monitoring and support throughout the year. This year, in the Central area, the community team was almost completely renewed and, although the doctors have been supporting the training of the new staff, we had no success in appointing the nursing clinical lead. This year we will be reviewing the clinical leadership structure within the central team.

Surveys and Reflections

Up until this year we have used the Hospice UK survey, which is analysed centrally and benchmarked with other hospices. However, because of falling returns, we often do not reach the required minimum to enable benchmarking and therefore did not find the system very useful. This year, we have decided to introduce some new ways of collecting patient and carer feedback, alongside the Reflection' forms and complaints. These include a new survey, sent out 2 months after the patient first has contact with our service, and for next year (15/16) as one of our priorities focus groups and 'Discovery' interviews.

Pilot of new survey: To date we have sent out 229 postal surveys, and received 46 back, 23 of which were entered electronically by the patient, and 23 received by post. This is a 16% response rate which is disappointing and well below the generally cited 50% expected for postal surveys or 30% for on line surveys. We think this may be because we are sending them too soon after referral and people therefore may not be motivated to respond because they do not have enough experience of our services on which to comment. There are also times when nurses identify reasons not to send a survey, for example sensory or cognitive impairment, or because of the patient's clinical status.
Our positive 'reflection forms' far outweigh any negative comments. Some are quoted throughout this report.

Results

Although there was a low response rate on the whole they were positive. However, there were two areas of care which need addressing *in all areas* of the Trust:

1. Have you had the opportunity to discuss your wishes for future care up until the end of your life? (Known as advance care planning)
Of the 12 who answered 'no', 8 would have liked the opportunity
2. Did Weldmar staff talk to you about your religious or spiritual needs, values or beliefs?
Of the 16 who answered 'no', 4 would have liked to have been asked

Both these areas require sensitive communication, time, knowledge and skill to address, and can be seen as difficult and therefore avoided or postponed. It is an area we need to address within Weldmar but also in the wider health care system.

In relation to bereaved people, it has been agreed that we will hold a series of focus groups to elicit information about the experiences of bereaved people supported by Weldmar. These will be facilitated by staff from the bereavement team supported by area teams, and will take place once a year in each area, but with people being able to select any of the sessions regardless of where they live.

Reflections

These forms are available throughout the Trust for anyone to reflect positively or negatively on any element of the service.

During 2014/2015 WHT received a total of **161** Reflection Forms commenting on various areas of the trust's services.

- **64.7%** related to patient care services.
- **35.3%** provided commentary on our retail service (Charity shops/outlets)

Overwhelmingly, the majority of feedback relating to patient care services that were received during this period, **99.9%** has been positive and full of praise.

The remaining **0.1%** of commentary was treated as, and responded to, as a complaint or service improvement suggestion.

Quality Account 2015/16 Priorities for improvement

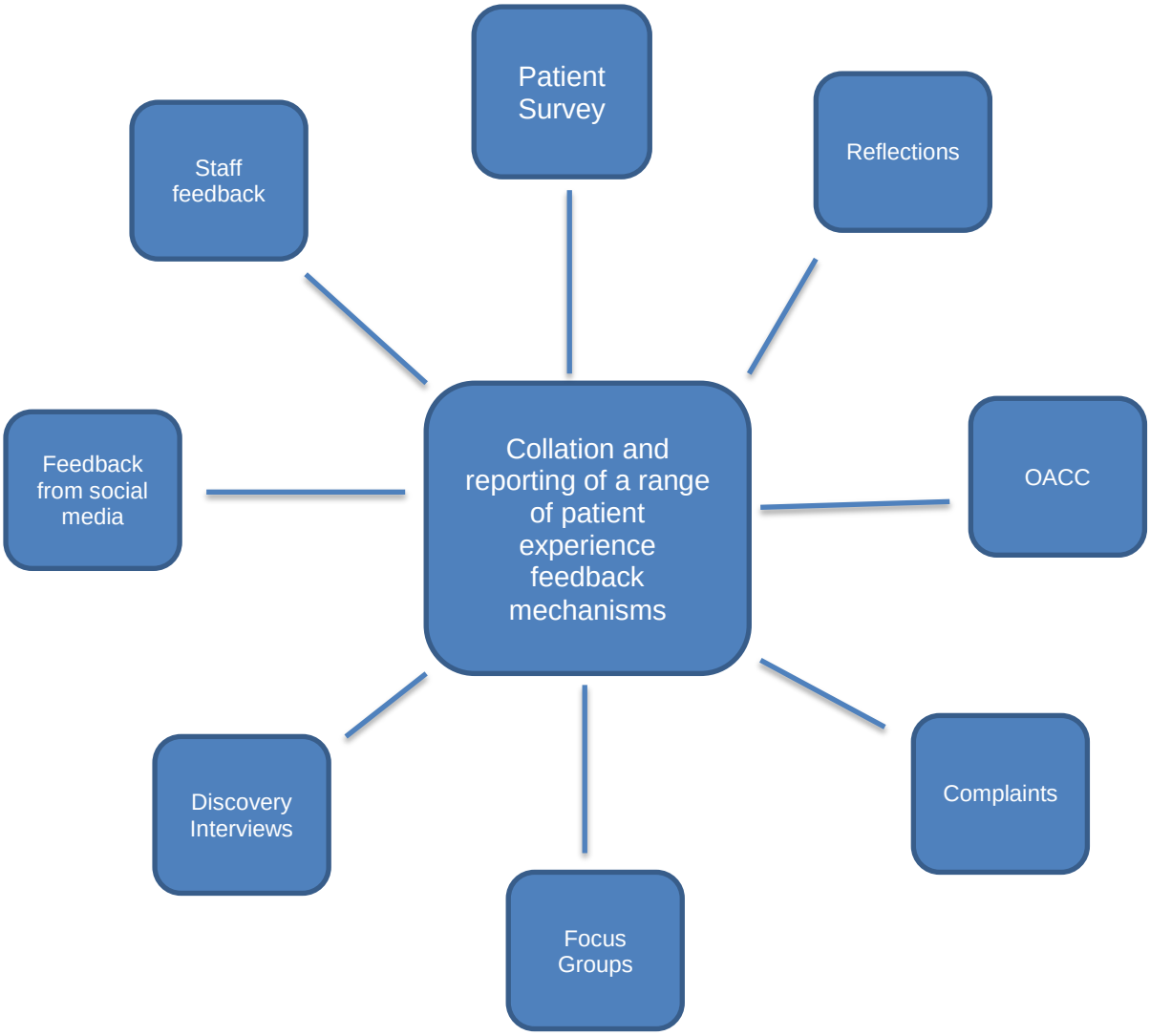
1. Improved Quality of Feedback from Patients and Carers

Because: Hospice services have struggled over the years to get feedback from patients and carers about the care they want and the efficacy of the care they actually receive. This has been difficult because most tools have concentrated on only one part of patient care eg symptom relief and therefore are not holistic. We constantly receive many very positive comments, which, although gratifying, do not help us improve care and services in a patient driven way.

Covering: Direct feedback from patients and carers through a new validated system from King's College, Outcome Assessment and Complexity Collaborative (OACC)[4] health services and health care professionals are required to demonstrate that they meet the needs of individual patients and their families, and that they do this in an effective and efficient way from the patient and carer's point of view. This suite of measures can be used to improve team working, drive quality improvement, deliver evidence on the impact of services, inform commissioning and, most importantly, achieve better results for patients and families. We also intend to introduce other ways of measuring satisfaction such as Discovery Interviews, quality based interviews with families of deceased patients.

[4] OACC Outcome Assessment and Complexity Collaborative, launched in 2013 Dr Fliss Murtagh and team Kings College, London, Cicely Saunders Institute and Partners.

Desired Outcomes: Being able to deliver more patient centred and led, responsive care and services to patients and their families.



This is the model we will be using in 2015/16.

2. Reporting and action on Equality and Diversity

Because: we are not good enough at gathering and recording equality and diversity information and therefore planning for the areas we are not reaching such as: prisons, ethnic minorities, homeless etc

Desired Outcomes: Better recording, more awareness and analysis of areas we are not reaching and a plan for reaching them.

3. Pilot a Rapid Response/24 hour service

Because: Things can go wrong at home, usually out of hours, services are not fast to respond and may respond inappropriately by admitting someone to hospital, who dies shortly afterwards. People want to stay at home as long as possible, sometimes some reassurance on the phone is all they need, or someone to sit with the patient while a carer gets some much needed rest. The pilot will cover Dorchester and Weymouth in the first instance. We will work with partners to support the community services, without taking over. We would like the commissioners to support an integrated 24 hour service in the long run.

Desired Outcomes: Learn from a rapid response/24 hour helpline pilot about the difficulties, the resources required for a wider 24 hour service

> "Community nurses very supportive telephoning regularly and visiting if needed within half an hour. Can't ask for better."

Staff

Recruitment and sickness absence 14/15

Recruitment

This report covers the twelve months ending 31st March 2015
The total number of full and part time permanent staff employed at 31st March 2015 was 211.
There were 31 joiners and 26 leavers, giving an annualised staff turnover rate of 12.32%.
For comparative purposes, the staff turnover rate for 2013/14 was 16.1%.
Of the 26 leavers, there were 10 age retirements 2 redundancies, 2 dismissals and 1 death in service. If the 15 involuntary leavers were removed from the figures, the annualised staff turnover rate for the twelve months would be 5.21%.

Sickness Absence

The sickness/absence rate for the twelve months ending 31st March 2015 was 5.07% (% hours lost against contracted hours). If long term sickness/absence is excluded, the rate falls to 2.80%. We currently have 6 members of staff away on long term sick.

For comparative purposes, the sickness/absence rate for 2013/14 was 4.93%, falling to 3.01% if long term sickness/absence is excluded.

2014 Employee Satisfaction Survey Results

Summary

This year's results continue the pleasing improvement noted last year with again a higher response rate 55% (54%) and improvements in 17 measures over last year.

Only 5 questions show a year on year deterioration greater than 3%. These are related to workforce levels and morale although these scores are over 50% positive . We will be working in these areas this year.

Staff Awards

For the first time in the history of Weldmar we held a sponsored Staff Awards ceremony, where the staff nominated their colleagues or teams for an award within 6 categories. Although some were dubious about the idea initially, a great time was had by all at the sponsored event, held in the Pavilion in Weymouth.

Staff Awards at the Pavillion in Weymouth

Volunteer Activity

As can be seen by the volunteer activity we appreciate the huge input we have from volunteers especially active in areas of complementary therapy and family support, which are, incidently, the areas where we receive the most frequent complimentary reflection forms.

We have volunteer input to our governance system too, which means their voice is heard up to the Board.

We plan to work more and more with volunteers to support the care we give at home. As ever we celebrated volunteers week this year.

Patient Care Volunteer Activity	**Tasks Undertaken**	**Hours Worked**	(average)
Community:			
Transport (own car)	111	222	2 hrs
Social Group Transport (own car)	234	468	2 hrs
Collecting prescriptions	6	6	1 hr
Sitting	13	624	2 hrs for 24 wks
Befriending	16	1,152	3 hrs for 24 weeks
Shopping	3	72	1 hr for 24 wks
Dog Walking	0	0	1 hr for 24 wks
Gardening	1	3	3 hrs
HH Reception	222	444	2 hrs
Admin duties (incl Finance, governance groups, office support)	362	1,086	2-3 hrs
Social Group	461	1,844	4 hrs
Jam Che (Gentle Touch) including Hammick House	9	27	1 hr for 3 wks
Jam Che (Gentle Touch) Bereavement Coffee Morning	2	4	2 hrs
Family Support (emotional support)	33	65	2 hrs variable wks
Chaplaincy (incl events / services)	27	57	1-3 hrs
Complementary Therapy (qualified practitioners)	258	1,032	1 hr for 6 wks (typically 4 wks)
Carers' Support Group	10	20	2 hrs
Refreshments	4	8	2 hrs
Wellbeing Centres:			
Daycare Help	220	660	3 hrs
Transport (own car)	117	234	2 hrs
Minibus	67	134	2 hrs
Hair Dressing	79	158	2 hrs
Hand & Nail Care	84	168	2 hrs
Creative Therapy	105	210	2 hrs
Jam Che (Gentle Touch)	183	366	2 hrs
Arts Therapy	42	42	1 hr
Chaplaincy	65	151	2-3 hrs
Reception (John Greener)	40	120	3 hrs
Handyman & Gardening	3	6	2 hrs
Hotel Services	30	120	4 hrs
In-Patient Unit:			
Ward	635	1,270	2 hrs
Meal Assistant (feeding)	5	5	1 hr
Ward Clerk	1	3	3 hrs
Sitting	7	14	2 hrs
Chaplaincy	58	174	3 hrs
Hand & Nail Care	12	24	2 hrs
Reception	867	2,601	3 hrs

Flower Arranging	241	482	2 hrs
Family Support (qualified counsellors & coffee mornings / events)	112	223	2 hrs variable wks
Pets As Therapy	42	42	1 hr
Jam Che (Gentle Touch)	64	128	2 hrs
Handyman & Gardening	24	48	2 hrs
Hotel Services	120	240	2 hrs
Totals	**4,995**	**14,757**	

Thank you to our volunteers

Information Governance

Req No	Description	Status	Attainment Level		Action
Information Governance Management					
12-101	There is an adequate Information Governance Management Framework to support the current and evolving Information Governance agenda	Reviewed And Updated	Level 3	Assign Owners	Edit
12-105	There are approved and comprehensive Information Governance Policies with associated strategies and/or improvement plans	Reviewed And Updated	Level 3	Assign Owners	Edit
12-110	Formal contractual arrangements that include compliance with information governance requirements, are in place with all contractors and support organisations	Reviewed And Updated	Level 3	Assign Owners	Edit
12-111	Employment contracts which include compliance with information governance standards are in place for all individuals carrying out work on behalf of the organisation	Reviewed And Updated	Level 3	Assign Owners	Edit
12-112	Information Governance awareness and mandatory training procedures are in place and all staff are appropriately trained	Reviewed And Updated	Level 3	Assign Owners	Edit
Confidentiality and Data Protection Assurance					
12-200	The Information Governance agenda is supported by adequate confidentiality and data protection skills, knowledge and experience which meet the organisation's assessed needs	Reviewed And Updated	Level 3	Assign Owners	Edit
12-201	Staff are provided with clear guidance on keeping personal information secure, on respecting the confidentiality of service users, and on the duty to share information for care purposes	Reviewed And Updated	Level 3	Assign Owners	Edit
12-202	Personal information is shared for care but 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	Reviewed And Updated	Level 3	Assign Owners	Edit
12-203	Individuals are informed about the proposed uses of their personal information	Reviewed And Updated	Level 3	Assign Owners	Edit
12-205	There are appropriate procedures for recognising and responding to individuals' requests for access to their personal data	Reviewed And Updated	Level 3	Assign Owners	Edit
12-206	There are appropriate confidentiality audit procedures to monitor access to confidential personal information	Reviewed And Updated	Level 3	Assign Owners	Edit
12-209	All person identifiable data processed outside of the UK complies with the Data Protection Act 1998 and Department of Health guidelines	Answered	Not Relevant	Assign Owners	Edit

12-210	All new processes, services, information systems, and other relevant information assets are developed and implemented in a secure and structured manner, and comply with IG security accreditation, information quality and confidentiality and data protection requirements	Reviewed And Updated	Level 3	Assign Owners	Edit
Information Security Assurance					
12-300	The Information Governance agenda is supported by adequate information security skills, knowledge and experience which meet the organisation's assessed needs	Reviewed And Updated	Level 3	Assign Owners	Edit
12-301	A formal information security risk assessment and management programme for key Information Assets has been documented, implemented and reviewed	Reviewed And Updated	Level 3	Assign Owners	Edit
12-302	There are documented information security incident / event reporting and management procedures that are accessible to all staff	Reviewed And Updated	Level 3	Assign Owners	Edit
12-303	There are established business processes and procedures that satisfy the organisation's obligations as a Registration Authority	Reviewed And Updated	Not Relevant	Assign Owners	Edit
12-304	Monitoring and enforcement processes are in place to ensure NHS national application Smartcard users comply with the terms and conditions of use	Answered	Level 3	Assign Owners	Edit
12-305	Operating and application information systems (under the organisation's control) support appropriate access control functionality and documented and managed access rights are in place for all users of these systems	Reviewed And Updated	Level 3	Assign Owners	Edit
12-307	An effectively supported Senior Information Risk Owner takes ownership of the organisation's information risk policy and information risk management strategy	Reviewed And Updated	Level 3	Assign Owners	Edit
12-308	All transfers of hardcopy and digital person identifiable and sensitive information have been identified, mapped and risk assessed; technical and organisational measures adequately secure these transfers	Reviewed And Updated	Level 2	Assign Owners	Edit
12-309	Business continuity plans are up to date and tested for all critical information assets (data processing facilities, communications services and data) and service - specific measures are in place	Reviewed And Updated	Level 3	Assign Owners	Edit
12-313	Policy and procedures are in place to ensure that Information Communication Technology (ICT) networks operate securely	Reviewed And Updated	Level 3	Assign Owners	Edit
12-314	Policy and procedures ensure that mobile computing and teleworking are secure	Reviewed And Updated	Level 3	Assign Owners	Edit
12-323	All information assets that hold, or are, personal data are protected by appropriate organisational and technical measures	Reviewed And Updated	Level 3	Assign Owners	Edit
12-324	The confidentiality of service user information is protected through use of pseudonymisation and	Reviewed	Level 2	Assign Owners	Edit

	anonymisation techniques where appropriate				
Clinical Information Assurance					
12-400	The Information Governance agenda is supported by adequate information quality and records management skills, knowledge and experience	Reviewed And Updated	Level 3	Assign Owners	Edit
12-401	There is consistent and comprehensive use of the NHS Number in line with National Patient Safety Agency requirements	Reviewed And Updated	Level 3	Assign Owners	Edit
12-402	Procedures are in place to ensure the accuracy of service user information on all systems and /or records that support the provision of care	Reviewed And Updated	Level 3	Assign Owners	Edit

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 2014/15 Weldmar Hospicecare Trust provided the following services to the NHS:

- Inpatient Unit – 5 beds
- Day Hospice
- Community Specialist Palliative Care service
- 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 2014 -2015, 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 2014/15 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 2014/15 are as follows: NONE

• The national clinical audits and national confidential enquiries that Weldmar Hospicecare Trust participated in during 2014/15 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 2014/15 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 2014/15 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 2014/15 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 2015/16 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) No inspection of Weldmar Hospicecare Services was carried out in 2014/15

Appendix 1

The National Council for Palliative Care – Minimum Data Sets

	2014/15	2013/14	2012/13	2011/12	2010/11	2009/10
Inpatient Unit						
Total number of patients	244	218	241	236	199	216
New patients	176	191	211	208	178	191
% Occupancy	73.68%	72.8%	80.5%	71.6%	79.9%	75.3%
% returning home	40.1%	30.3%	35.7%	34.1%	31.4%	34.9%
Average LOS	14.8 days	15.9 days	14.2 days	12.9 days	16.2 days	13.2 days
Day Hospice						
Total number of patients	123	139	136	125	99	129
Sessions held	254	310	302	364	349	353
Attendances	1623	1961	2205	2011	1844	2028
Average length of care	181.6 days	243.5 days	225 days	239.6 days	189.5 days	209.2 days
Community Service						
Total number of patients	1008	988	976	970	970	902
Total contacts face to face	7972	8474	4850	5698	5904	4585
Total contacts telephone	12372	11150	10219	10242	10789	9982
Average length of care	109 days	99.7 days	95.2 days	90.4 days	101.5 days	96 days
Family support						
Total number of clients	189	193	181	298	382	986
Total contacts	1355	1204	1034	1804	1693	2398
Average length of care	248.2 days	215.8 days	159.7 days	133.2 days	127.2 days	121.8 days
Outpatients	72	151	149	144	145	114

To note: 10% increase in the total number of patients in the community over the last 5 years
As recognised by many hospices in the UK, the format of MDS figures is no longer fit for purpose. This, plus the need to record information in the right place at the right time in our developing electronic patient record system has led to inaccuracies and /or not comparing like with like.

For example above: Family support. Although we appear to have decreased the number of clients, this is inaccurate as the work of the bereavement volunteers is not included. Also pre-bereavement care is not counted at present. Referrals to the service are now being recorded through triage. As reported on Page 12, this is work in progress and we are establishing a new Clinical Services Balanced Scorecard which has sections on patient and family experience, activity, quality and clinical workforce development which will be used for reporting purposes.

Appendix 2

Results of 14/15 Audits

Falls, medication errors and pressure sores	Benchmarking nationally and with the south west. Our documentation and AIRs reporting of all these areas has improved after our Practice Improvement Project on the In Patient Unit. We benchmark well with other hospices, slightly higher with medication errors (mostly documentation errors)
Nerve pain audit- treatment of	• Result : Changed the documentation to facilitate data extraction for a future audit. • Using evidence based practice for treatment
Audit spirituality assessments and documentation pre and post a questionnaire to heighten awareness	• 86.1% completed the assessment pre questionnaire, 86.6% after • questions on the patient electronic care record are to be redesigned. • Spirituality training is going to become a mandatory part of induction of new staff.
Dorset Network audit on face to face contact with patients	• Similar standards across Dorset. • Documentation improved
Medication Safety Thermometer (national document)	• We give high risk drugs, but have had no need to give an antidote eg naloxone for morphine. • Improvement of our medicines reconciliation required
Multidisciplinary team meetings	• A deputy chair to be appointed • Need for quiet when plan formulated during meeting • Quarterly reporting for each area
Use of Buscopan in bowel obstruction	We are now using higher doses of Buscopan after comparing our practice with evidence based practice
Individualised End of Life Care Plan (IELCP)	Of the 147 deaths on the IPU, 118 were on a IELCP Of the remaining 29, 21 suddenly deteriorated, 7 had a sudden event, 1 missed

Infection Control Audits Actions 14/15

Bed and Mattresses Mattresses numbered 3 mattresses were condemned as zip area was seen to be leaking	• To be easily identified • Now replaced
Catheters Unknown reasons to why people have catheters inserted when admitted from community Insertion remains for rationalised reasons	New question added on crosscare window Continue to observe
Decontamination All areas clean at time of audit	One stethoscope was discarded, as not recognised to be trusts own
Sharps Temporary closure: not closed Needle safe in full use	Aiming to be added to new teaching sessions, this to be reiterated in training sessions No concerns with this
Commodes Commode underside not always cleaned effectively	New commodes bought (easy to clean) and new way of storing clean commodes (seat inverted) Ongoing audit
Hand hygiene 88% compliance No change since previous audit findings 1 member of staff long finger nails	Spoken to at time of audit

Appendix 3

NHS Contract Quality Monitoring Requirements

1.1 Clinical - Discharge (Length of Stay and Delayed Transfer Report
Total days stayed
Total number of patients
Average length of stay
Number of patients staying more than 30 days
Number of days for patients staying more than 30 days
Delayed Transfer report
Active Discharge planning with safe and appropriate discharge facilitated
1.2 Clinical - Falls
Percentage of falls assessments completed within 24 hrs of admission
Number of patients falling more than once
Audit of 10 or 20% of total (whichever is greater) sets of notes of patients who fell in hospice
1.3 Clinical - Infections
Number of beds closed due to HCAI (including empty/full beds)
Number of patients with MRSA (on admission)
Number of patients with MRSA (hospice acquired)
Number of patients with MSSA
Number of patients with E-Coli bloodstream infections
Number of cases of Norovirus
Norovirus - Number of bays and ward closures
Norovirus - Number of bed days lost
Outbreak Management: - No. & % of identified infected pts (inc C-Diff & Norovirus) isolated within 2 hrs
MRSA Bacteraemia Notifications:
MRSA Root Cause Analysis Reports.
Clostridium Difficile - Death Certificates: Number of deaths where C-Diff is identified under Section 1 (a) Cause of Death on the death certificate.
Clostridium Difficile - Cluster: C-Diff Root Cause Analysis Reports "outbreak" is defined as 2 or more cases in same area within 28 days.
Norovirus Outbreak: Number of wards and/or beds closed due to Norovirus (empty and full beds)
1.4 Clinical - Medication
Medication Controlled Drug Incidents: Advise of significant incidents concerning controlled drugs which may affect another organisation.
Occurrence Reports to the PCT Accountable Officer for Controlled Drugs
CQC Self-Assessment on controlled drugs - Copy to be submitted to CCG Medicines Manager and CD Accountable Officer in the Local Area Team (LAT)
Number of Medication Errors, by speciality, by severity of harm *(non controlled drugs)*
Number of Medication Errors relating to controlled drugs, by speciality, by severity of harm.
Medication Errors - Outcomes of lessons learnt from Root Cause Analyses
Medication - Audit Plan: Medicines Audit Plan detailing all audits to be undertaken that demonstrates compliance with national guidance.
Medication - Audits: Provision of Commissioner approved audits.
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
1.5 Clinical - Pressure Sores
Number of patients who acquired pressure sores, by grade.
Number admitted with pressure sore(s)
95% of patients admitted that have been risk assessed for developing a pressure sore within 6 hrs of admission
Pressure Ulcers - Stage 3 & 4: Declared on STEIS as an IRRP
Acquired Pressure Ulcers: Copy of full RCA Report for all Stage 3 & 4 Acquired Pressure Ulcers
1.6 Clinical - Other
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.
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.
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.
2. QUALITY ASSURANCE
8.2 Sleeping Accommodation Breach: Threshold > 0

"Saving Carbon, Improving Health" Summary of Providers progress on climate change adaptation, mitigation and sustainable development incl. performance against carbon reduction management plans.
Carbon Management and Climate Change Adaptation Action Plans Performance against plan.
Carbon Reduction Management: Initial assessment and annual re-assessments Progress Report
Sustainable Development Strategy: Board approved sustainable development strategy
Incidents and breaches of confidentiality / information security.
Action Plans to evidence compliance with Disability Discrimination Act and Mental Capacity Act
Equality Monitoring Reports - Performance against Equality Requirements
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)
Safeguarding Compliance: Exception report detailing any areas of non-compliance with policies contained in Schedule 2 Part L.
NHS Constitution Compliance - Self Assessment: Provider self-assessment against the Rights and Pledges contained within the NHS Constitution.
Working towards End of Life Care Quality Assessment Tool (ELCQUA): 9 quality statements to be fully completed by 31 March 2015 showing amber or green against ELCQUA measures.
Audit Reports: Progress on the Annual Audit Plan: Progress 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.
Copy of Reports from or in response to Regulatory or Supervisory Bodies
Learning Disability Self-Assessment: Report on actions taken to address identified areas for improvement.
Provider Performance Reports presented to their Board
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)
Service Quality Scorecard: Data as per scorecard - template as contained in Schedule 5 Part A
Independent Investigations commissioned by the Provider: Email outlining reason for investigation and timescale for completion.
3. QUALITY ASSURANCE (PATIENT)
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 complainant satisfaction with complaints process
Complaint Communication --sample of letters and responses including all those relating to quality of care issues
(i) Carer reflections and feedback indicate positive experiences
(ii) Carers views used to inform service development
Surveys - as detailed in Schedule 6 Part G:
(iv) Patient feedback indicates positive experiences; and where necessary changes are implemented if feedback indicates concerns
4. QUALITY
Patients on an end of life pathway who have an appropriate personalised care plan
Number and % of patients who have an advanced care plan undertaken whilst with the Service
Attendance at GSF meetings
Supporting specialists and generalists to meet the end of life care needs of patients with a diagnosis other than cancer: (i) Individual patient care support to primary care teams
(ii) support provided to non-cancer networks
(iii) specialist sessions provided for non-cancer diagnosis
Implementation of staff Friends and Family Test (FFT)
Early implementation of FFT in all outpatient and day case departments by 1 January 2015
FFT Increased response rates; inpatients
FFT decreasing negative responses
5. SAFETY
Central Alert System (CAS): Reporting compliance with NPSA Alerts and MHRA, CMO, CEO and CNO

Briefings
Summary of RCA (Root Cause Analysis) investigations and associated action plans submitted within 3 working days of completion
AIRS Summary Report: 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 graded as severe/high/moderate risk that do not meet SIRI criteria.
Monthly number of IRRP declared including nil returns : % compliance with STEIS data entry requirements
Final SIRI (Serious Incidents Requiring Investigation) investigation reports and action plans.
SIRI Report: Number of SIRI declared by month: Proposed action to improve; Total number of safety incidents; Number of incidents by level of harm by division / directorate / department / speciality
Exception report on compliance with NICE Technology Appraisals and Clinical Guidance
Never Events
Never Event RCAs: Copy of Providers RCA Report
Duty of Candour:
NRLS Incident Reports: Summary & analysis of NRLS reporting
Adverse Events: Number of Adverse Events for all categories identified using the Global Trigger Tool
6. ACTIVITY STATISTICS
Hospice respite provision available to meet carers needs
Details of patient numbers accessing inpatient services - 4 beds (1,482 bed nights p.a.)
Details of specialist community nurse activity (4 FTE nurses)
Details of patient numbers accessing day care services (2,036 day care sessions p.a.)
Numbers and brief details of referrals to inpatient services unfulfilled
Telephone advice is available 24 hours a day, 365 days a year
Face to face assessment in the community or in hospital is available for at least 8 hours a day, Mon to Fri
Urgent face to face assessment is available at the weekend for at least eight hours a day
Inpatient admission, available 7 days a week, from at least 8am - 8pm, 24 hours a day
% 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.*
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.
Non-PbR Report (activity via SUS): Full Patient Level Dataset by Point of Delivery (POD), including activity, cost and associated fields.
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
7. WORKFORCE
Safeguarding Training: Report on the number & % of staff trained to Children Level 1, 2, 3; Adults; MCA/DOLS
All appropriate internal staff have undertaken holistic needs assessment training
Senior SPC nursing staff have the skills and competencies to support physical assessment and prescribing for patients (increasing number of nurse prescribers)
Percentage of staff to have basic Learning Disability Awareness as part of induction
Education is provided in a variety of settings to non-specialist staff at all levels
Workforce Indicators: As per embedded scorecard
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.
Staffing Levels Publicly displayed
Staff turnover
Staff appraisal rate
Mandatory training rate
Sickness rate
Number of staff receiving Clinical supervision
Percentage of eligible staff receiving clinical supervision