Weldmar Hospicecare Trust
Caring for Dorset

Quality Account for 2015/2016

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 2015/2016

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1. Introduction

This is the sixth 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 2015/16, covers areas where we alone are responsible and it follows the statutory requirements of the regulatory authority. 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.*

2. Statement of accuracy and commitment to quality from CEO and Chair

Report from the CEO

I joined Weldmar Hospicecare Trust in January having worked in end of life care for 23 years. I passionately believe in ensuring people have the dignity, respect and care that they deserve at the end of their lives. I wish to ensure the services we offer are equitable, while managing a steadily growing demand not only in numbers but in the complexity of those who seek our support. Our approach to any financial 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 to 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 tailor a response. 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 Cicely 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 working in partnership with the NHS and other providers is key to ensuring patients and their families get the care they need regardless of their location in Dorset.

We have recently been inspected by the CQC and received an Outstanding Award which recognises the commitment and care that we give. However, we need to ensure we can reach as many people who need us as possible. We are therefore reviewing our strategy to ensure we can continue to give and grow our outstanding work.

"*People and families received outstanding care from exceptional staff and volunteers who developed positive, caring and compassionate relationships with them. The service promoted a culture that was caring and person centred. Staff worked together as a multidisciplinary team to provide seamless care for people".*
Care Quality Commission (CQC) June 2016 Inspection Report Joseph Weld Hospice."

Caroline Hamblett
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 highest 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 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 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 listen and explore more deeply exactly what has worked well, and what improvements we can make.

Stephen Baynard
Chairman of the Board of Trustees

3. Quality Improvement work in 2015/16

The quality, resilience and commitment of our staff at Weldmar Hospicecare Trust is perhaps best illustrated by our recent inspection report from CQC. In spite of challenges due to staff sickness, particularly in the community, which necessitated a rapid review of our methods of service delivery to ensure all community patients received good care, we received an overall outstanding grade. Staff across the Trust, namely doctors, nurses and education colleagues worked as a team to ensure comprehensive cover for our patients in the community. From a position of potential weakness the response of staff turned it into a positive experience enhancing team working across boundaries and reducing silo working.

Our challenges now are to embed, as fundamental, mentorship, support and clinical supervision for all nurses, particularly in the community, if we are to continue to develop robust and resilient clinical staff.

3.1 Wellbeing

Over the past year, as part of our current strategy we have been developing 'Wellbeing Services'. Under this umbrella sits our classic day respite service, where patients come for the day, give their carers a break and enjoy a good lunch, social contact and various diversions, games and creative work. We are now also developing services such as 'breathlessness and fatigue' clinics, holding educational sessions to encourage self care, complementary therapy on an appointment basis and considering a bathing service.

The more flexible service allows for patients to pick and choose what they would like, rather than feel they must spend the whole day with us. We hope to see patients earlier in their illness too, taking the pressure off our health care partners in the community. This is promoted through the Gold Standards Framework (GSF) meetings in GP surgeries, which are attended by our Weldmar Community Nurses. This service will become part of our general strategy review over the coming months.

Blandford Wellbeing Service opening 2016

Over the years we have had the support of 'F1s' (first year post graduate doctors) in rotation for a few months from Dorset County Hospital (DCH). This has been hugely beneficial to the doctors who come, learning about end of life care and communication skills, which will help them in whichever field of practice they finally choose. In addition we have benefitted from their enquiring minds, growing confidence and expertise. Unfortunately, this is being suspended for a while due to the impact of the new junior doctor contract, changes in rotas and other factors, but we hope the rotation will start again next year with F2 doctors (who are in their second year of postgraduate training).

3.2 Education

The Hospice Education Alliance (HEA @ Weldmar) is the provider of internal and external education based within Weldmar Hospicecare Trust. We also lead provision through being the hub for an alliance of End of Life Care Educators across Wessex. In 2015 we delivered End of Life Care education and training to 591 people in the Health Education England working across Wessex foot print.

All 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 our external and internal calendar for 2015:

- We delivered end of life care education and training to 485 people across the region, as the HEA @ Weldmar.
- The HEA @ Weldmar facilitated the GP refresher day, run for the Deanery at Dorset County Hospital: tackling Advance Care Planning (ACP) and difficult conversations, as well as an update on current pharmacological interventions in End of Life Care.
- As the Gold Standards Framework (GSF) Regional Centre we are supporting 12 care homes in phase 11 (2015) and a further 7 in phase 12 (2016) through the programme.
- We have a two phase pilot in progress for the GSF Domiciliary Care Agency programme.
- A series of three train the trainer programmes ran in 2015 to embed the Advance Care Planning work that was undertaken with third sector colleagues; this included our local Partnership for Older People Programme (POPPS) group, Age UK, British Heart Foundation. It gave opportunity to learn how to train and teach their colleagues to start/ have conversations around ACP.
- Within the Trust, in 2015 we had over 95% completion of Training Tracker units (e-based learning) by Weldmar Hospicecare Trust staff at level 1. This was supported with attendance at 92% for additional face to face statutory and mandatory training as indicated by job role and function.
- Our band 4 practitioners have started a Foundation Degree at Weymouth College and complete the Continuous Professional Development (CPD) award section of this in the summer of 2016
- We ran a second programme of our in-house leadership programme for band 6 staff. This had positive evaluation and is being revised for a further programme later in 2016/17
- Support has been given from the HEA @ Weldmar team to the Weldmar central clinical team to cover long term sickness. This has led to greater integration and a day a month allocated to teaching/ clinical input by the HEA @ Weldmar team
- The HEA @ Weldmar team continue to support clinically through active work with many groups including the medicines management group, clinical leadership group, clinical supervisor roles and running the monthly journal club.
- The HEA @ Weldmar meet with the HR team bi-monthly with consideration of workforce planning, performance partnership and Annual Performance Review (APR) processes, and preparatory training for line managers

- A clear taxonomy of learning and development for all staff, clinical and non-clinical at Weldmar Hospicecare Trust, has been agreed at The Trust Board. This will be progressed in 2016
- Funding secured as the Hospice Education Alliance enabled us to support and lead collaborative work with other hospices in the Wessex footprint. These sites are delivering to a further 106 people. We are bringing forward into 2016 a further 209 places from our original bid to develop and run the Qualifications and Credit Framework (QCF) programmes.
- We go into 2016 having secured funding to support a new programme “Ambitions into Actions – shaping the future of End of Life care through education and training”. This programme is aimed at qualified practitioners from all disciplines and is scheduled across the whole of Dorset and Hampshire.

GSF Edcation Session November 2015

3.3 Food Information Regulations

Since the implementation of changes to the Food Information Regulations (2014), largely in relation to the management of allergens the Trust put in place workshops and training sessions. We are able to offer a variety of choices with quality meals made to order for those with both small and large appetites.

3.4 Health and Safety in 15/16

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. In response to feedback from staff specific online AIRs training for managers is now available for managers, as well as the generic training. This online training can be used as a tool at any point should a member of staff/ manager require additional support in completing AIRs.

AIRs involving other organisations are reported through the Weldmar online reporting system. Direct liaison takes place with the other organisation as soon as is practicably possible, in order that Weldmar Hospicecare can work in partnership with others to reduce risk. Other monitoring bodies CQC, Dorset Clinical Commissioning Group (DCCG) are involved as appropriate.

Health and Safety Priorities for 15/16

Lone working arrangements

Lone workers have access to a Skyguard device if they are going into a lone worker situation. These simple to use devices are effective in alerting for immediate assistance and are centrally managed so any signal for assistance is picked up by a 24 hour Response Centre. This new system of lone working replaces the sign in/out and buddy system for regular lone workers.

Conflict management

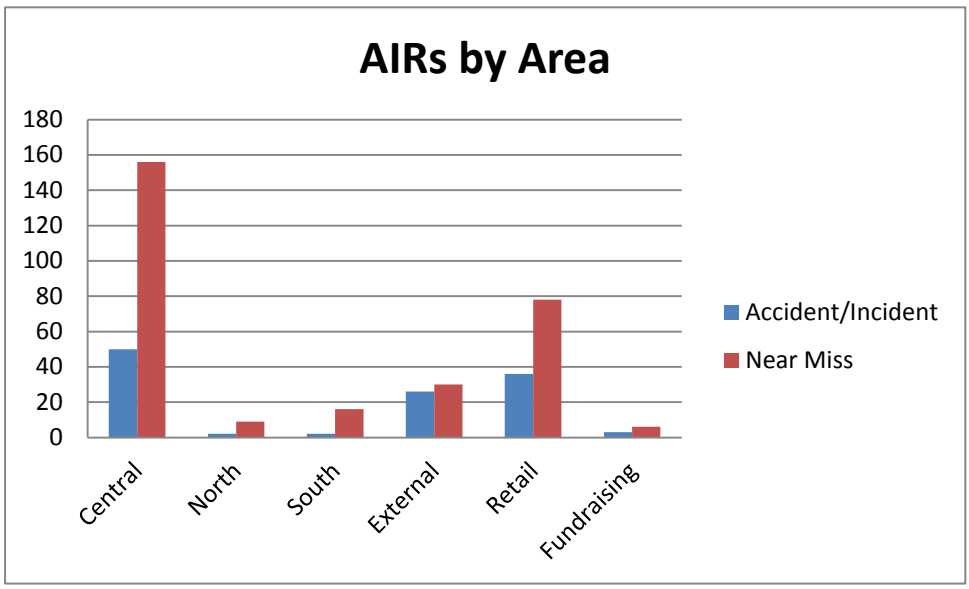
In response to the increasing number of incidents, particularly in the retail sector, online training has been devised which gives practical advice for both prevention and for managing a difficult situation. There are specific modules for different work areas.

Training for volunteers: Moving and Handling, Risk Reporting and Complaints

Patient care volunteers have received specific training regarding moving and handling which includes the moving of a person in an emergency situation, risk reporting, and outlines their role within the complaints management process. As a result of this training AIRs forms for volunteers have the addition of contact numbers - which include an out of office emergency phone number - in order that volunteers can escalate any concerns or changes regarding patients promptly.

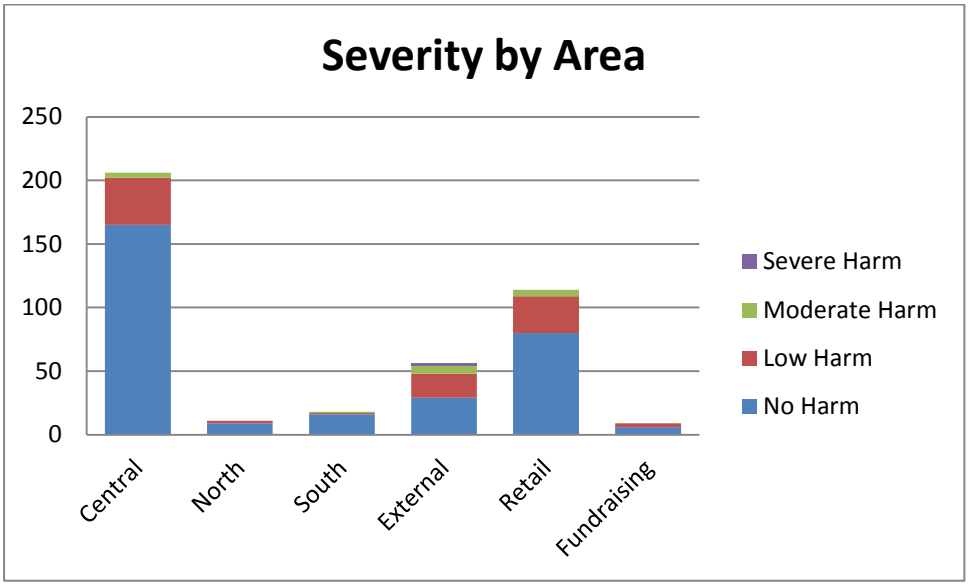
Incident Type by Area 15/16 (12 months)

	Central	North	South	External	Retail	Fundraising
Accident/Incident	50	2	2	26	36	3
Near Miss	156	9	16	30	78	6



Severity of Injury by Area

	Central	North	South	External	Retail	Fundraising
No Harm	165	9	16	29	80	6
Low Harm	37	2	1	19	29	3
Moderate Harm	4	0	1	6	5	0
Severe Harm	0	0	0	2	0	0



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	**Severe Harm**
2	Pressure sore on admission (grade 4)
	Moderate harm
1	Injury sustained during fit
4	Staff injuries whilst undertaking tasks (taken to hospital) *1
2	Staff injuries whilst undertaking tasks (resulting in a period of absence from work) *1
1	Pressure sore developed during stay at Weldmar (grade 3)
6	Pressure sore on admission (grade 3)
1	Member of the public unwell taken to hospital
1	Volunteer unwell taken to hospital

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

In order to comply with the duty of candour all reportable patient safety incidents were reported to CQC during 2015 and analysed by the Clinical Governance Committee to develop action plans as appropriate.

Health and Safety Priorities for 16/17

- Review of New Online Conflict Training
- Continuing to encourage people to use AIRs
- Review of Risk assessment process in the retail sector

3.5 Patient and Carer Feedback

Complaints: There were 6 complaints over the year (the same as last year). None of the complainants felt it necessary to take the complaint to the Chairman or the Health Ombudsman.

Area of Practice Complaints 2015-16

Quality Requirement	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Number of complaints received	1	1	1	0	1	0	0	1	0	0	1	0
Percentage of complaints acknowledged within 3 operational days	100 %	100 %	100 %	n/a	100 %	n/a	n/a	100 %	n/a	n/a	100%	n/a
Percentage of complaints responded to within agreed timescales (20 working days)	100 %	100 %	100 %	n/a	100 %	n/a	n/a	100 %	n/a	n/a	100%	n/a
Number of complaints referred to the Ombudsman	0	0	0	n/a	0	0	0	0	0	0	0	0
Date when last complaints summary published on website	Feb-15	Feb-15	Feb-15	Feb-15	Feb-15	Feb-15	Feb-15	Feb-15	Feb-15	Feb-15	Feb-15	Feb-15

Details of lesson learnt and actions taken

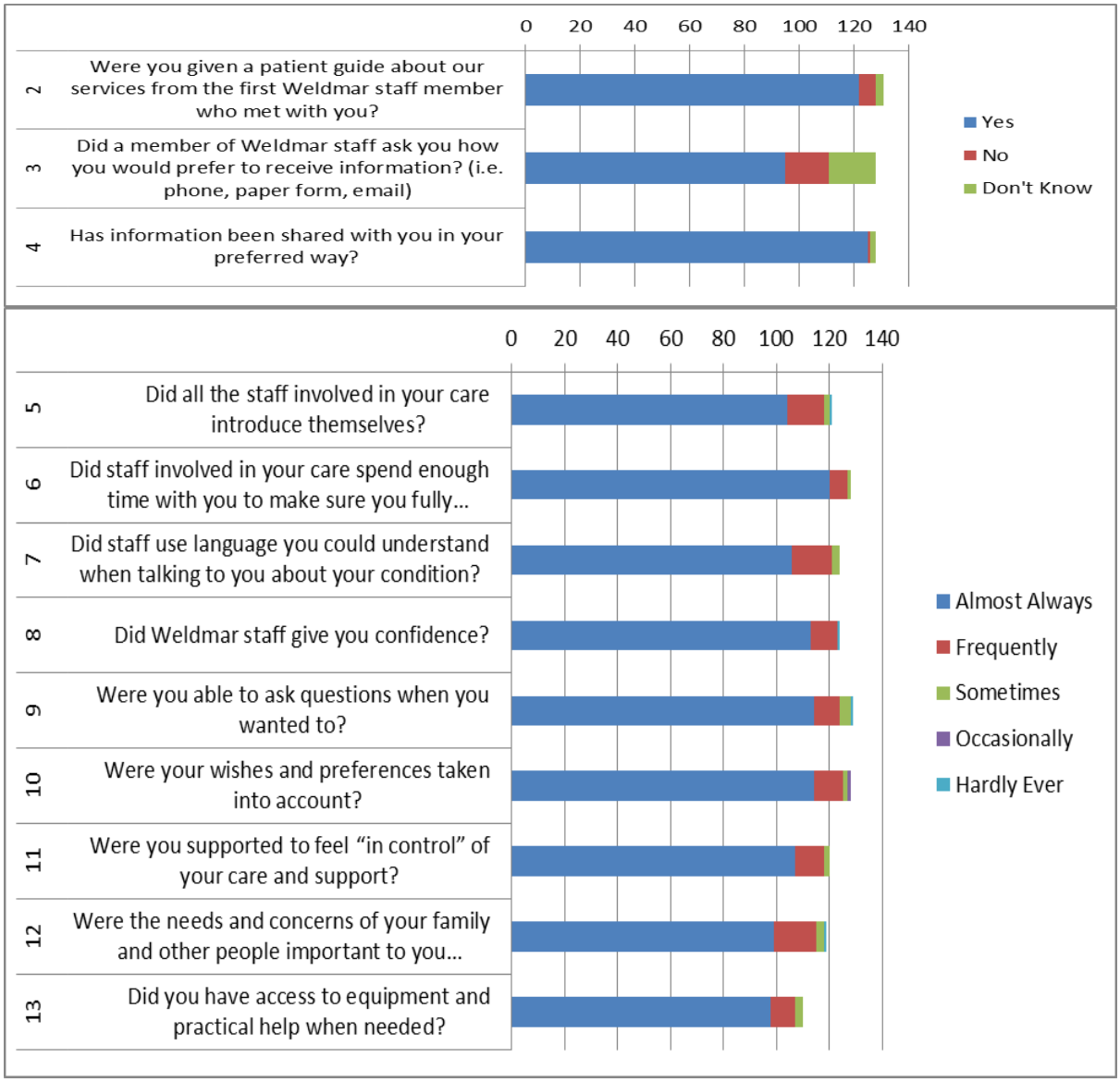
	Issue	Action
1	Wife thought she had been coerced into having her husband discharged home. (Her husband wanted to go home to die.) Did not want to make the necessary changes to her house to allow for a hospital bed	Be clearer with families why we need to have discharge discussions with families in order to cater for patients' wishes.
2	We had sent a letter to a house with the keycode on the envelope	Reviewed admin. systems to ensure this does not happen again
3	Delay in completing a form for care at home. Staff member needed evidence and this took time	Keep the person informed when there are delays
4	Communication issues. Promising contact, but not making it and relying on someone else to instead. Contact also when at home, lacking	Ensure we always contact when we say we will. Clarify the best way of communicating with someone with the individual. Discuss with the hospital team for seam free care.
5	Relative felt she had to be a nurse, not a daughter in the last weeks of her mother's life. No care available and little respite. Too little too late. Complex situation with many agencies involved.	On going issue getting care in the community. Funding available, but no care. Pilot a 24/7 advice line (done) and rapid response. Better respite care required and consideration of respite for patients with dementia.
6	Complex case where relative felt the morphine being prescribed was causing the symptoms. Relationship with one of our Drs	Unfortunately, this was a misunderstanding of the medical condition, cause and effect. Explained to the complainant.

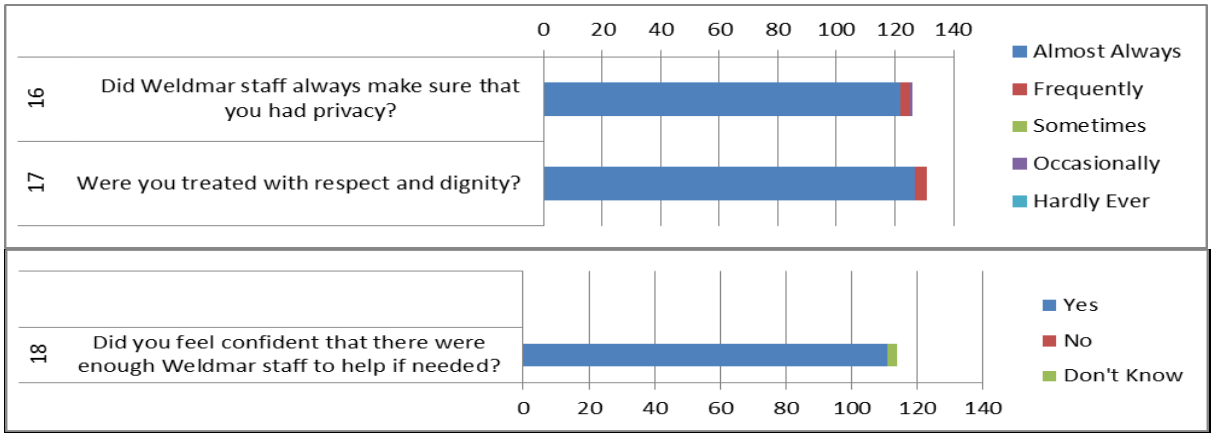
Summary

Two complaints came from the IPU, three from the community and one about mail received from us. Poor or inadequate communication is often at the root of the problem. Sometimes patients and relatives find it difficult to accept what is being said to them and this can lead to misunderstanding. We continually strive to improve communication skills throughout the Trust. The lack of clinical nursing leadership (unable to appoint) in our central area has contributed to a high level of sickness in one area of the community. This will be addressed by reviewing the idea of developing a training centre for the Trust, where clinical staff of all levels can be taught and mentored before working alone in the community. We must be able to 'grow our own' staff, as we look to the future of increasing workloads and a decreasing number of people in the care profession.

Surveys and Reflections

Below is the table showing responses to the Patient Experience Questionnaire for 2015-16





Lambs visit patients at Weldmar

Reflections

These forms are available throughout the Trust for anyone to reflect positively or negatively on any element of the service. During 2015/16 WHT received a total of **94** Reflection Forms commenting on various areas of the Trust's services.

Comments on different parts of the service:

- 24 x Carer Support, Chaplaincy, Bereavement Support
- 14 x Complementary Therapies
- 15 x InPatient Unit
- 13 x Day Hospice/Social Group
- 6 x Remembrance Services
- 8 x Children's event/support
- 6 x Other (including maintenance & education)
- 4 x Community Nurse
- 1 x Volunteer Services
- 3 x Catering/Hotel Services

The forms were completed by the following:

- 30 x Bereaved Relative
- 21 x Carer
- 13 x Patients
- 12 x Anonymous
- 10 x Staff
- 6 x Healthcare Professionals
- 2 x Volunteer

All of the comments received were shared with individual members of staff (where named) and /or departments immediately upon receipt. Overwhelmingly the majority of feedback received has been positive, praiseworthy and complementary indicating a very high level of satisfaction with a wide range of services provided across the Trust.

A small number of comments made prompted us to reflect upon and give consideration to how we deliver our services.

Children's Bereavement Event Easter 2016

3.6 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) to see how they correspond with agreed national 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).This group has found it a very useful exercise. Whilst identifying some inconsistencies and putting in place a training process for improvement they have been heartened by the clear improvement in quality. This work is under the umbrella of the Clinical Documentation Group (CDG), as part of the clinical governance structure. The membership is a peer group only which seems to work very well and feeds into the Mentoring group, see below. 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.

A continuous review of windows on Crosscare has been undertaken to reduce duplication and simplify the process as well as enhancing reporting processes. 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.

Joseph Weld Hospice

4. Priorities for improvement 2016/17

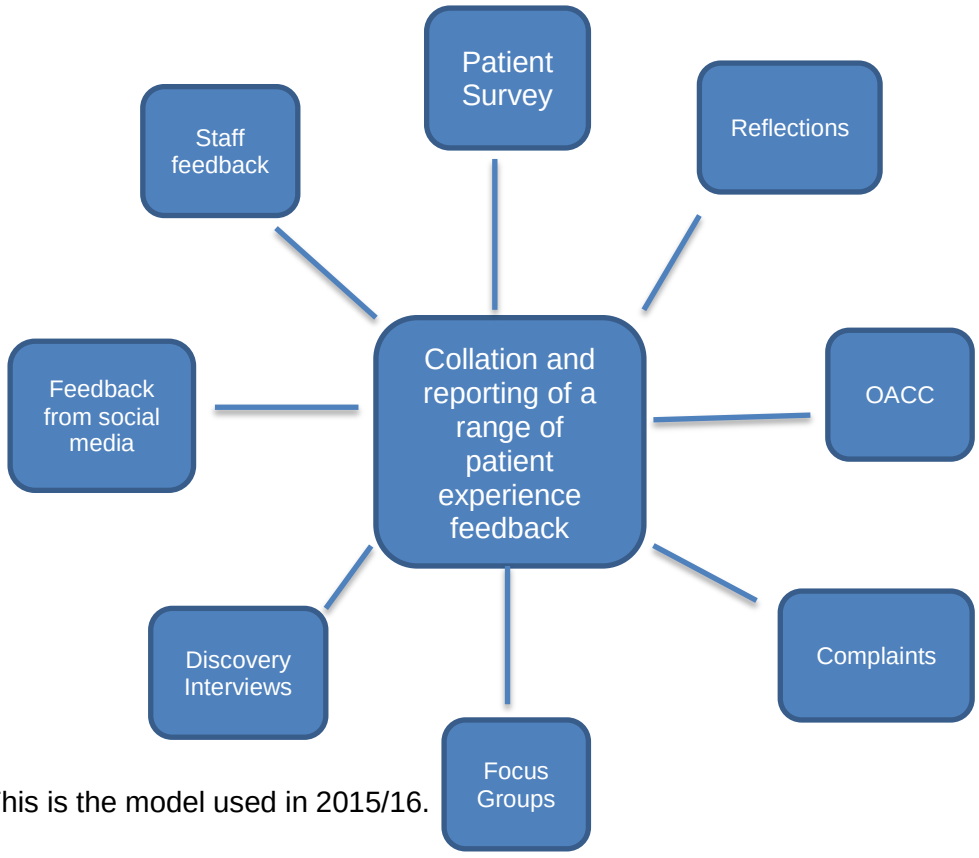
4.1 Improved Quality of Feedback from Patients and Carers

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, e.g. 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)[2] 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, which are quality based interviews with families of deceased patients.

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

Ongoing Actions 2016/17: Develop 'you said we did' reporting to feedback on comments and complaints.



This is the model used in 2015/16.

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

4.2. Reporting and action on Equality and Diversity

Being aware that we are not good enough at recording and gathering equality and diversity information and not reaching areas such as: prisons, ethnic minorities, homeless etc

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

What we did:

- We have continued to encourage recording of all protected characteristics on our patient recording system. During the year there has been some improvement in the completeness of this data in relation to the protected characteristics of sexual orientation, religion or belief and race.
- We have requested an amendment to the patient recording system by the developers to enable the protected characteristic of disability to be specifically recorded – this has been promised but release date for the software update is not yet confirmed.
- Protected characteristics data collected from staff, patients and volunteers is compared with the same data for the local population to ensure our service provision and delivery is meeting the needs of our local population.
- A Web links document has been added to the Education and Development (E & D) Intranet page providing information for staff detailing local support services related to some of the priority groups identified – such as ethnic minorities, travellers, LGBT, homeless, people with disabilities.
- Introduced Hospice UK Action Plan – working towards equality and diversity.

Ongoing actions 2016/17:

- Continued commitment to improvement of patient recording of protected characteristics.
- Development of links with local groups working with people most likely to be underrepresented in our service provision, including travellers, people living with dementia or people with learning disabilities.
- Implementing actions identified in the Hospice UK Action Plan.
- Consideration of the requirements of the Accessible Information Standard.

4.3 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 covered Dorchester and Weymouth in the first instance.

Desired Outcomes: Learn whether a 24/7 service is needed.

What happened:
The pilot ran from 5 October to 14 December 2015. During this time 177 calls were received (patients 40, Carers 100 and other health care professionals 37). Interestingly most calls were in the morning, and few at night.

Day of week

Monday	31
Tuesday	15
Wednesday	22
Thursday	17
Friday	28
Saturday	35
Sunday	57

Call handler

IPU Nurse	136
Weldmar Community Nurse	91
Weldmar Doctor	1

Primary reason for call

Symptom & Medication advice	86
Issues with care or carers	24
Issues with pt transport	2
Bmt advice & support	9
Request for WCN visit	15
General follow up	44

Primary Outcome

Call to 111	25
Call to 999	3
Contact with DN	27
Contact with GP	9
Call to patient transport services	4
Return call to carer/pt	27
Liaise with WHT doctor	11
Other WHT prof	11
WCN	65

Carer felt 24/7 call had indeed been helpful/reassuring in placing patient in a safe environment, preventing emergency admission to hospital setting which patient did not want. She knew GP who had called to house and felt this helped. She felt call was personal and reassured by alleviating 'her worst nightmare'

Questions to staff and some feedback:

What do you consider the main benefits of this service for patients and carers?

- Reassurance at the end of a phone, comforting to know there is always someone there to help. May prevent symptoms escalating, or issues escalating to an emergency.

- help and advice, security for patient and carers
- point of access for information for patients and carers, this service is beneficial as they may feel isolated, frightened or worried in certain situations
- Patients and carers are able to speak to a person quickly and not get an automated service are referred on to make another telephone call. Their issue will be resolved or they will be assisted and reassured in a timely manner
- Having a voice to talk to.
- It provides a personal service of reassurance
- Callers I have spoken with have commented they have been comforted by (a) being able to speak to someone (b) speaking to someone immediately, even if I haven't been able to give advice other than signposting.

Ongoing Actions 2016/17
This was a successful pilot, able to reach many people and prevent inappropriate admissions to hospital. The service was run mostly by the IPU and community nurses. This had an impact on the nurses' time during their shifts on the IPU and the resources of a permanent service needs to be carefully considered.
Next steps are to investigate and, if financially viable, develop and deliver a 24/7 helpline service.

4.4 Refurbishment of Hospice

During 2016/17 it is planned to refurbish areas of the hospice to enhance the environment for patients and their families, including dementia patients.

4.5 Increasing numbers in the MND Clinic

The hospice has successfully run an MND clinic, in partnership with the NHS hospital in Poole, at Joseph Weld Hospice for many years. It is however becoming a victim of its own success and during 2016/17 plans will be developed to extend this service if financially viable.

5. Staff

Recruitment and Sickness Absence 15/16

Recruitment
This report covers the twelve months ending 31st March 2016 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 2016 was 227 .There were 42 joiners and 29 leavers during the twelve months, giving an annualised staff turnover rate of 12.78%. For comparative purposes, the staff turnover rate for 2014/15 was 12.32%.
A breakdown of the above data is shown below.

Staff Group	Staff Numbers	Joiners	Leavers	Staff Turnover
Clinical Staff	90	9	8	8.89%
Retail Staff	68	20	13	19.12%
Hotel Services	16	3	3	18.75%
Admin/Mgt.	53	10	5	9.43%
Total Trust	**227**	**42**	**29**	**12.78%**

Sickness Absence
The sickness/absence rate for the twelve months ending 31st March 2016 was 4.37% (% hours lost against contracted hours). If long term sickness/absence is excluded, the rate falls to 2.78%. We currently have 8 members of staff away long term sick.

For comparative purposes, the sickness/absence rate for 2014/15 was 5.07%, falling to 2.80% if long term sickness/absence is excluded.

Disciplinary and Dismissal Procedures
During the twelve months under review, the following action was taken under the Disciplinary and Dismissal Procedures:

1 Written warning.
1 Final written warning.
2 Dismissals.
2 Redundancy dismissals.

There was no evidence of discriminatory practice identified in the operation of the Disciplinary or Dismissal Procedures.

Grievance Procedure
During the twelve months under review, the Grievance Procedure was invoked on 3 occasions. There was no evidence of discriminatory practice.

Whistleblowing Policy
No member of staff invoked the Whistleblowing Policy during the period under review.

2015 Employee Satisfaction Survey Results

Summary
This year's results are again pleasing and help to consolidate the significant improvements which were achieved in response to many of last year's questions. This year 115 questionnaires were completed - a response rate of 54.25%. Last year's response rate was 54.15%, (almost identical with the previous year). 70 questionnaires were completed on line (40 last year) and 45 completed in hard copy. Highlights from this year's results are as follows. All percentage figures shown indicate strongly agree/agree.

There were some questions where one or another department had a markedly lower score from the Trust average and these were marked with *. The issues are being taken up by the CEO with the relevant Director(s):
Questions 1-5: I understand the Hospice Strategy **(96%);** My department works towards clear goals **(91%);** I am kept informed of changes **(83%);** I am involved in decisions affecting my work **(80%);** There is good teamwork in my department **(83%)**
Questions 8-12: I have confidence in the effectiveness of my line manager **(88%);** I am given regular feedback by my line manager **(92%);** I am treated fairly by my line manager **(92%);** I have regular 1:1 meetings with my line manager **(93%);** My performance has been appraised accurately **(95%);**
Questions 13&14: I am encouraged to develop my skills **(89%);** I have significantly enhanced my skills over the last year **(79%).**
Questions 15&16: I am given the opportunity to express my views **(87%);** I am encouraged to contribute ideas within my dept. **(88%).**
Question 17: I am rewarded fairly with pay and conditions for the work I do **(76%).**

Questions 20&21: My line manager shows a sincere interest in my career and provides me with the support I need **(89%);** I am adequately supported in coping with the stresses of the job **(84%).**
Question 22: Organisation systems and procedures are clearly defined **(84%).**
Question 26: I feel respected and appreciated at Weldmar **(81%).**
Question 27: I feel able to give honest feedback to management **(75%).**
Question 28: Overall I am satisfied with my job **(92%).**
Question 29: I am satisfied with my work/life balance **(80%)**
Question 30: I do what I am best at every day **(89%).**

Responses which expressed concern were:

Question 6: Communication throughout Weldmar is regular and effective **(61%).**
Question 18: Staff are considered to be the Trust's most important asset. **(61%).**
Question 19: Staffing levels are adequate for the workload **(53%)*.**
Question 23: I believe management will take action as a result of this survey **(64%).**
Questions 24&25: Morale in my department is satisfactory **(65%).** Morale throughout the organisation is satisfactory **(53%).**
Question 7: The responses to this question were corrupted in transferring across to SQL.

Action taken in response to last year's questionnaire survey was as follows:

- Move the online questionnaire from the website to the intranet for ease of completion.
- Set an earlier deadline to encourage the completion of questionnaires.
- Introduce the Performance Partnership Scheme, in particular regular 1:1 meetings with line managers, in order to listen to staff, involve staff in decision making, and improve the performance management of the organisation as a whole.

6. Volunteer Activity

1 April 2015 to 31 March 2016

Patient Care Volunteer Activity

	Tasks Undertaken	Hours Worked	(average)
Community:			
Admin duties (incl Finance, governance groups, office support)	470	1,410	2-3 hrs
Befriending	5	360	3 hrs for 24 weeks
Carers' Support Group	19	38	2 hrs
Chaplaincy (incl events / services)	32	58	1-3 hrs
Collecting prescriptions	9	9	1 hr
Companion	3	216	3 hrs for 24 weeks
Complementary Therapy (qualified practitioners)	34	204	1 hr for 6 wks
Family Support (emotional support)	82	82	1 hr
Gardening	1	3	3 hrs
HH Reception	198	396	2 hrs
Jam Che Bereavement Coffee Morning	7	14	2 hrs
Jam Che (Gentle Touch) including Hammick House	5	15	1 hr for 3 wks

Refreshments	4	8	2 hrs
Sitting	9	432	2 hrs for 24 wks
Social Group	395	1,580	4 hrs
Social Group Transport (own car)	177	354	2 hrs
Transport (own car)	59	118	2 hrs
Wellbeing Centres:			
Arts Therapy	42	42	1 hr
Chaplaincy	27	54	2 hrs
Creative Therapy	98	196	2 hrs
Daycare Help	179	537	3 hrs
Hair Dressing	120	240	2 hrs
Hotel Services	20	80	4 hrs
Jam Che (Gentle Touch)	160	320	2 hrs
Meal Assistant (feeding)	11	11	1 hr
Minibus	86	172	2 hrs
Reception (John Greener)	52	104	2 hrs
Recreational	12	48	4 hrs
Transport (own car)	64	128	2 hrs
In-Patient Unit:			
Chaplaincy	52	156	3 hrs
Family Support (qualified counsellors & coffee mornings / events)	210	278	1-3 hrs
Flower Arranging	250	500	2 hrs
Handyman & Gardening	66	132	2 hrs
Hotel Services	106	218	2-4 hrs
Jam Che (Gentle Touch)	118	236	2 hrs
Meal Assistant (feeding)	6	6	1 hr
Pets As Therapy	76	76	1 hr
Reception	811	2,433	3 hrs
Sitting	6	12	2 hrs
Ward	623	1,246	2 hrs
Totals	**4,704**	**12,522**	

Thanking our volunteers during Volunteers' Week 2015

7. Information Governance

IG Toolkit Version 13 (2015-2016) Assessment

Req No	Description	Status	Attainment Level
Information Governance Management			
13-101	There is an adequate Information Governance Management Framework to support the current and evolving Information Governance agenda	Reviewed And Updated	Level 3
13-105	There are approved and comprehensive Information Governance Policies with associated strategies and/or improvement plans	Reviewed And Updated	Level 3
13-110	Formal contractual arrangements that include compliance with information governance requirements, are in place with all contractors and support organisations	Reviewed And Updated	Level 3
13-111	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
13-112	Information Governance awareness and mandatory training procedures are in place and all staff are appropriately trained	Reviewed And Updated	Level 3
Confidentiality and Data Protection Assurance			
13-200	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
13-201	The organisation ensures that arrangements are in place to support and promote information sharing for coordinated and integrated care, and staff are provided with clear guidance on sharing information for care in an effective, secure and safe manner	Reviewed And Updated	Level 3
13-202	Confidential personal information is only shared and used in a lawful manner and objections to the disclosure or use of this information are appropriately respected	Reviewed And Updated	Level 3
13-203	Patients, service users and the public understand how personal information is used and shared for both direct and non-direct care, and are fully informed of their rights in relation to such use	Reviewed And Updated	Level 3
13-205	There are appropriate procedures for recognising and responding to individuals' requests for access to their personal data	Reviewed And Updated	Level 2
13-206	Staff access to confidential personal information is monitored and audited. Where care records are held electronically, audit trail details about access to a record can be made available to the individual concerned on request	Reviewed And Updated	Level 3
13-209	All person identifiable data processed outside of the UK complies with the Data Protection Act 1998 and Department of Health guidelines	Answered	Not Relevant
13-210	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,	Reviewed And Updated	Level 3

	information quality and confidentiality and data protection requirements		
Information Security Assurance			
13-300	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
13-301	A formal information security risk assessment and management programme for key Information Assets has been documented, implemented and reviewed	Reviewed And Updated	Level 2
13-302	There are documented information security incident / event reporting and management procedures that are accessible to all staff	Reviewed And Updated	Level 3
13-303	There are established business processes and procedures that satisfy the organisation's obligations as a Registration Authority	Answered	Not Relevant
13-304	Monitoring and enforcement processes are in place to ensure NHS national application Smartcard users comply with the terms and conditions of use	Reviewed And Updated	Level 2
13-305	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
13-307	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
13-308	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
13-309	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
13-313	Policy and procedures are in place to ensure that Information Communication Technology (ICT) networks operate securely	Reviewed And Updated	Level 3
13-314	Policy and procedures ensure that mobile computing and teleworking are secure	Reviewed And Updated	Level 3
13-323	All information assets that hold, or are, personal data are protected by appropriate organisational and technical measures	Reviewed And Updated	Level 3
13-324	The confidentiality of service user information is protected through use of pseudonymisation and anonymisation techniques where appropriate	Reviewed And Updated	Level 3
Clinical Information Assurance			
13-400	The Information Governance agenda is supported by adequate information quality and records management skills, knowledge and experience	Reviewed And Updated	Level 3
13-401	There is consistent and comprehensive use of the NHS Number in line with National Patient Safety Agency requirements	Reviewed And Updated	Level 3

13-402	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 

8. Statutory 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 2015/16 Weldmar Hospicecare Trust provided the following services to the NHS:

- Inpatient Unit – 4 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 Quality Accounts.

What this means:

Weldmar Hospicecare Trust is partly funded through an NHS contract linked to activity through a Community Contract for 2015 -2016. The funding allocated by NHS Dorset CCG represents approximately 25% of the Trust's total income (30% of clinical costs). The remaining income is generated through fundraising, shops, lottery activity and investments.

Participation in National Clinical Audit

- During 2015/16 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 2015/16 are as follows: NONE
- The national clinical audits and national confidential enquiries that Weldmar Hospicecare Trust participated in during 2015/16 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 2015/16 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. NONE
- Weldmar Hospicecare Trust was not eligible in 2015/16 to participate in any national clinical audits or national confidential enquiries and therefore there is no information to submit.
- The number of patients receiving relevant health services provided or sub-contracted by Weldmar Hospicecare Trust in 2015/16 that were recruited during that period to participate in research approved by a research ethics committee: NONE
- A proportion of Weldmar Hospicecare Trust income in 2015/16 was conditional on achieving quality improvement and innovation goals agreed between Weldmar Hospicecare Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2015/16 and for the following 12 month period are available electronically via www.weld-hospice.org.uk

- Weldmar Hospicecare Trust has not participated in any special reviews or investigations by the CQC during the reporting period.
- Weldmar Hospicecare Trust did not submit records during 2015/16 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data as we are not eligible to submit to this system.
- Weldmar Hospicecare Trust Information Governance Assessment Report overall score for 2015/16 was as detailed in Section 7 above.
- Weldmar Hospicecare Trust was not subject to the Payment by Results clinical coding audit during 2015/16 by the Audit Commission.

What this means:
As a provider of specialist palliative care Weldmar Hospicecare Trust is not eligible to participate in any of the national clinical audits or national confidential enquiries. This is because none of the 2015/16 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 2016/17 for the same reason.

9. 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) A CQC inspection of Weldmar Hospicecare was carried out in March 2016 and a grading of 'Outstanding' was given.

10. CQC Ratings Grid

Ratings	
Overall rating for this service	Outstanding ☆
Is the service safe?	Good ●
Is the service effective?	Outstanding ☆
Is the service caring?	Outstanding ☆
Is the service responsive?	Outstanding ☆
Is the service well-led?	Good ●

11. Statement from NHS Dorset

“Over the past year Weldmar has striven to maintain its focus on improving the quality of care provided to individuals. The report outlines the range of quality improvement work and training that has been undertaken over the last year. This has been reflected in the CQC “outstanding” rating that was recently awarded to the Trust. The key priorities identified for 2015/16 have also shown improvement. In particular the development of the wellbeing strategy and services; designed to be more flexible to meet individual’s needs. There has also been extensive training provided by the Trust across Wessex and increased responsiveness to health and safety issues for staff and volunteers. Feedback from patients and carers continues to be a key priority for the Trust and this is reflected within the quality account.

The CCG has not been actively engaged in the development of the Quality Improvement Priorities that the organisation has set for 2016/17 but is in broad support of these priorities and looks forward to working with Weldmar during the year.”

Day Trip from Trimar on MV Freedom round Weymouth Bay

Appendix 1

The National Council for Palliative Care – Minimum Data Sets

	2015/16	2014/15	2013/14	2012/13	2011/12	2010/11
Inpatient Unit						
Total number of patients	174	202*	218	241	236	199
New patients	162	176	191	211	208	178
% Occupancy	61.1%	73.68%	72.8%	80.5%	71.6%	79.9%
% returning home	36%	40.1%	30.3%	35.7%	34.1%	31.4%
Average LOS	15.6	14.8 days	15.9 days	14.2 days	12.9 days	16.2 days
Day Hospice						
Total number of patients	97	123	139	136	125	99
Sessions held	231	254	310	302	364	349
Attendances	1753	1623	1961	2205	2011	1844
Average length of care	201.4	181.6 days	243.5 days	225 days	239.6 days	189.5 days
Community Service						
Total number of patients	1020	1008	988	976	970	970
Total contacts face to face	No longer in MDS	7972	8474	4850	5698	5904
Total contacts telephone	No longer in MDS	12372	11150	10219	10242	10789
Average length of care	130.4	109 days	99.7 days	95.2 days	90.4 days	101.5 days
Family support						
Total number of clients	170	189	193	181	298	382
Total contacts	1172	1355	1204	1034	1804	1693
Average length of care	283.1	248.2 days	215.8 days	159.7 days	133.2 days	127.2 days
Outpatients	103	72	151	149	144	145

- A correction has been made to the 2014/15 total number of patients due to the total number of admissions reported in error

Appendix 2

Results of 15/16 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 with regards to falls although slightly higher with pressure ulcers and considerably higher with medication errors. However, it has now been agreed that Medication Incidents will only be reported to HUK if they have reached the patient as this is the definition used by participating units and therefore these figures should reduce considerably. All medication incidents will continue to be recorded internally regardless of whether they reach the patient or not and monitored monthly by MMG.
Accountable Officer	• Documentation now being created to evidence changes to the appointment of the CDAO. • AO report to be included on the quarterly CGC agenda. • Medication to be prescribed by drug, not brand. If brand is important this to be added in brackets. • Prescribing audit to be completed.
Controlled Drugs	• Approved signatories' (including doctors) list now up to date. • All nurses have been reminded that corrections in CDRs should be signed and dated. • Doctors have been reminded that prescriptions should not be altered or additions made (they should be re-written). • The name of the Nurse and name of witness are documented in destruction book (not initials) and are signed by both.
Dorset Network Audit on face to face contact with patients	• Some months have shown a higher percentage of delays although this was due to lower staffing levels. No patients came to any harm from this delay. • Documentation improved.
Prescription Pad Security	• To be included in the Medicines Management policy. Information displayed in Sisters communication book. PharmacyFax bulletin highlighting security requirements displayed prominently on the Controlled Drug cupboard door. • Sister ensures all information is recorded. Due to low usage, a weekly audit is carried out. • Sister has compiled a list of practitioners authorised to prescribe on their FP10s. • Trained nursing staff record destruction of drugs.
Discharge Planning	Eight patients had delayed discharges totalling 253 days: o Family unable to cope with patient at home due to patient's dementia and also increased care need. Standard CHC application submitted and approved. o Admitted originally for EOLC but not at end of life. Patient declined to engage in discharge discussions and also refused to sign consent form for 4 days and had capacity to do so. Delayed allocation to Social Worker despite numerous phone calls and letter from Dr. No reply to letter. RIP on IPU. o Admitted for symptom control. Had fast track funding on admission. Patient's condition was varied. Unable to find suitable nursing home. Decided at MDT meeting that due to patient's deteriorating condition patient to remain at JWH for EOLC. o CHC in place but unable to find care. o Re-ablement support in place but unable to commence on discharge date.

	○ CHC in place prior to admission. Discharge planned to care home. Wife decided she would like patient to be at home instead. Discharge due to family delays. Discharged home with live in carer. ○ Standard CHC application completed and approved 11 days later. Patient decided on a suitable Nursing Home and was then discharged. ○ Admitted originally for EOLC but not EOL on admission. Already known to Social services (SS). IMCA had to be involved as patient lacks capacity. For a number of weeks unable to find 24/7 care and were still awaiting brokerage search results. Letter from Dr regarding delays in discharge. Assessed by care agency and costings for care finally agreed for 24/7 care, QDS double up care and night care. Funding declined for care at home and Nursing Home placement agreed.

Infection Control Audits Actions 15/16

Bed and Mattresses Mattresses numbered 1 Mattress cover found to be beginning to become unusable. All beds clean and in good working order.	• Now easily identified • One on order to replace.
Catheters Only one concern in 2015 that one patient had a sample sent off, nothing was grown however the patient continued on antibiotics. Insertion remains for rationalised reasons	• This had only occurred once since catheter audit has commenced in May 2012 (4 years) • Continue to observe
Decontamination All areas clean at time of audit minimal items were dusty	• Audit findings shared with nursing staff and hotel services.
Sharps Temporary closure: not closed Needle safe integral part of nursing culture.	• Added to teaching sessions, and reiterated in training sessions
Commodes Commode underside always cleaned effectively Foot plates not cleaned to correct standard	• Storing cleaned commode with seat upside down is being effective. • Reminding all staff of cleaning foot plates as well as all of commode
Hand hygiene North 92% compliance South 88% compliance Central 96% compliance	• No hand cream available, this is a hospital that the well-being centre is based, have emailed the lead this is a minimal issue. No hand poster in place, this has been rectified. • No hand gels in place, this has now been rectified. Hand cream not available in all rooms. Is available in one central point. • 1 Fit bit in place when checked. Asked to remove at time of audit, have not observed it since.

Appendix 3
CCG Contract Monitoring Requirements 2015-16

Area of Practice	Quality Requirement	Threshold
Risk Assessments and Screening	% of Falls assessments completed within 24hrs of admission	95% + = Green 90 -94% = Amber Under 90% = Red
	% of Nutrition assessments completed within 24hrs of admission	
	% of Pressure Ulcer assessments completed within 6hrs of admission	
Infection Control	Percentage of patients screened for MRSA	
	MRSA Bacteraemia	0=Green 1 or above=Red
	Clostridium Difficile	
	MSSA	
	E-coli	
	Norovirus	
Pressure Ulcers	Number of all provider acquired Pressure Ulcers	
	Number of all provider inherited Pressure ulcers	
Medication Errors	No Harm (Level 0)	
	No Harm (Level 1)	
	Low Harm (Level 2)	
	Moderate Harm (Level 3)	
	Severe Harm (Level 4)	
	Death (Level 5)	
	Number of medication errors relating to controlled drugs	
Falls	No Harm (Level 1)	
	Low Harm (Level 2)	
	Moderate Harm (Level 3)	
	Severe Harm (Level 4)	
	Death (Level 5)	
Incidents (please note these numbers include med errors, PUs, falls also shown separately above)	Number of incidents by harms;	
	No Harm	
	Low Harm	
	Moderate Harm	
	Severe Harm	
	Death	
Referrals	No. of new referrals	
	% non-malignant referrals per quarter	
Statistics - IPU	IPU occupancy (excluding respite)	1,482 bed nights p.a.
	% IPU occupancy (excluding respite)	
	Number of IPU referrals unfulfilled	
Length of Stay (IPU) (excl hospice respite)	Total days stayed	
	Total number of patients	
	Average length of stay	
	Number of patients staying more than 30 days	
	No.of days for patients staying more than 30 days	
Pts on an EOL pathway who have an appropriate personalised care plan	Number of deaths recorded (IPU)	
	Number of IEOLCP recorded	
	% of deaths on IPU with IEOLCP recorded	
ACP undertaken whilst with the Service	No. of pts with an ACP undertaken whilst with the service	
	% of total with ACP undertaken whilst with the service	
Statistics - Community	Community FTF contacts	1,934 p.a.
	Community Tel contacts	3,156 p.a.
	Community Total contacts	5,090 p.a.
GSF meetings	No. of GSF meetings attended by WHT staff	
	% of GSF meetings attended by WHT staff	
Statistics - Wellbeing	Daycare (social respite) actual attendances	1,527 p.a.
	Wellbeing actual attendances	509 p.a.
Friends and Family Test	Implementation of staff friends and family test	
	Early implementation of FFT in all outpatient and day case departments 1 January 2015	
	FFT response rates; inpatients	Q3-24%;Q4-30%

	FFT - "Extremely likely to recommend service to Friends & Family"	*80% + = green* *70 -79% = amber* *69% & below= red*
	FFT decreasing negative responses	<1.5%
End of Life	% of people supported to die in their preferred place (PPC)	75%
Complaints	Number of complaints received	N/A
	Percentage of complaints acknowledged within 3 operational days	95% & + = Green 90 -94% = Amber Under 90% = Red
	Percentage of complaints responded to within agreed timescales (20 working days)	
	Number of complaints referred to the Ombudsman	
	Date when last complaints summary published on website	N/A
Staffing	Staffing Levels Publicly displayed	Yes/No
	Clinical Staff turnover	
	Clinical Staff appraisal rate	95% & + = Green 80 -94% = Amber Under 80% = Red
	Clinical Staff Mandatory training rate	
	Clinical Staff Sickness rate	
	Percentage of eligible staff Annual Flu Vaccination	
	Workforce Assurance Framework	
Safeguarding	Percentage of eligible staff trained in L1 Safeguarding Children	95% & + = Green 90 -94% = Amber Under 90% = Red
	Percentage of eligible staff trained in L2 Safeguarding Children	
	Percentage eligible staff trained in L3 Safeguarding Children	
	Percentage staff trained in Safeguarding Adults	
	Percentage staff trained in relation to Mental Capacity Act and DOLs	
Duty of Candour	Number of times duty of candour used	N/A
Mixed Sex accommodation Breach	Number of non-clinically indicated mixed sex accommodation breaches	0 = Green 1 + = Red
Confidentiality / information security	Number of Incidents and breaches	0
Serious Incidents	Number of serious incidents relating to Pressure Ulcers	
	Number of serious incidents relating to Falls	
	Number of serious incidents - other	N/A
Never Events	Number of Never Events	0
Service Provision	Service Availability / Service Updates	
	Support provided to non-cancer networks	
	Specialist sessions for non-cancer diagnosis	
	Outcomes	
Safety	CAS Alerts	
	NICE Technology Appraisals & Clinical Guidance	
	RCA	