Meeting **Health Overview and Scrutiny Committee**
Date and time **Wednesday 17th May, 2023** **At 7.00 pm**
Venue **Hendon Town Hall, The Burroughs, London NW4 4BQ**

Dear Councillors,

Please find enclosed additional papers relating to the following items for the above mentioned meeting which were not available at the time of collation of the agenda.

Item No	Title of Report	Pages
10	NHS Quality Accounts 2021-22 • North London Hospice	3 - 46

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North London Hospice

QUALITY ACCOUNT

2022 – 2023

Draft V0.7

Our Vision, Our Purpose, Our Values, Our Strategic ambitions

OUR VISION

The best of life, at the end of life, for everyone.

OUR PURPOSE

North London Hospice - working together to provide palliative care and support, when and where you need us most.

OUR VALUES

C O R E

Collaborative and learning
Share learning, educate and work supportively together.

Open and honest
Be clear and transparent in the way we work and respond to others.

Respectful and empowering
Be kind, enable and value everyone's contribution.

Equal and Inclusive
Treat people fairly, be welcoming and involve them.

CORPORATE
strategic ambitions
OUR REACH
OUR DUTY
OUR COMMITMENT

Compliments from Our Service Users

Community Teams

“Thank you to the North London Hospice Community Team for responding so promptly to our needs, when we contacted you, we felt desperate as a family that my dad was in distress and in his final hours; it was your team that came within hours of a referral and eased his symptoms, calmed us down and gave clear instructions to the care home to manage his final hours. I cannot tell you the relief the team provided by attending in person and administering his “just in case medication”. I simply cannot fault the care or service and will be forever grateful for the empathy and kindness you displayed as a whole

Community Team and Patient and Family Services:

I just want to say a huge 'thank you' to all the staff for their care and compassion, not only to my husband but also to myself and our children. I am sure that his last few days were made so much more comfortable and bearable by being under your care. As well as the doctors and nurses, I would like to also thank the clinical nurse specialist and your bereavement service for their home visits and calls to me, they were always there when we needed them, and they both helped me through a truly heart-breaking time”.

Outpatients and Wellbeing Service:

“I have really struggled to walk and come to terms with the aftereffects of my cancer treatment. Your help and support have been absolutely invaluable, I feel much more positive now and know there is hope with improving my quality of life. I have very much enjoyed coming to the Outpatients and Wellbeing centre, it has been a great help not just physically but also mentally”.

Inpatient Unit Service

“My family and I came to the hospice for 3 days while our mum sadly passed away. At 2am we received a call saying she was deteriorating quickly and that we should come. we sat with her for the next 12 hours until she died. During the night the nurses not only took amazing care of our mum, but also of us. A lovely nurse offered us a cup of tea. I asked for green tea and she apologised for not having any. 10 mins later she appeared with tea for all of us, including a cup of green tea for me - it came from her own personal belongings!

There are so many things I remember from that terrible night but what I will always remember is the warmth from that cup of tea and what a difference that gesture made to how we felt.

The work you all do is incredible, you make a difference to so many people every day”.

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PATIENT STORY- The Journey of a patient and his family

My husband's experience of North London Hospice care

"He died at home in 2022. The time between his diagnosis and death was 6 weeks. I have little memory of that time. it is largely a black hole, though I do occasionally have flashes of sentences, images, sounds and these are increasing and will perhaps one day join up.

***I would like to know that we did the very best we could for him**.*

I think I contacted the hospice when his diagnosis was first made. This in itself was a shock as we had been sent to A&E by our GP from a routine appointment. I was telephoned at home later that night, having stayed with him until he was admitted. He had been told by hospital staff and it is likely that he had asked them to phone me. Whatever the circumstances, I know that I contacted Social Services about what help was available and I recall ringing the hospice for the same information. I remember that staff were incredibly helpful, and we were visited by a clinical nurse specialist (CNS) when my husband was at home, some 3 weeks after diagnosis. The CNS was excellent and spent a long time with him answering his questions and allaying his fears. I heard him comment that she was telling him things he had not been told before. What this indicated to us was that the CNS had a way of saying things that made sense to him and I felt that he was calmer and possibly even less afraid. The hospice staff were responsible for my husband's medication throughout this period, and it worked well.

Sadly, his health deteriorated quickly after a single dose of radiotherapy, and he was readmitted as an emergency. When it became apparent that no treatment was possible beyond palliative care, we decided to bring him home. Within 24 hours we had all the equipment we needed, and a care package was in place. Carers were supplied by the council who were also very good and visited after his death to offer their condolences. Staff from the hospice visited frequently to manage his medication and answer our questions. They were very supportive, and his care was excellent, as good as we could have ever hoped for and certainly better than remaining in hospital. At home we were able to include him in family life until the last 48 hours without pain or discomfort being an issue.

The family and I will be forever grateful to the hospice staff for the care and support they provided. we have raised funds at my husband's funeral so that others like us might benefit from this help when they need it most.

STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

It is with great pleasure that I introduce you to North London Hospice's 022-2023 Quality Account which has been developed in consultation with North London Hospice clinical service staff and managers, the Executive Team, and the Board of Trustees.

Last year saw more change as we continued to navigate the ongoing impact and legacy of the Covid-19 pandemic. This has required constant adjustments in response to changing guidance but has also presented opportunities to improve the quality and efficiency of our services from the lessons we have learnt along the way.

In this report we outline last year's contribution to our continuous journey of quality improvement. Over the past year we have worked to reduce clinical incidents, acquired pressure ulcers, falls and complaints. We have reviewed and updated guidance, and policies and procedures and have streamlined these to ensure they allow our staff to be effective practitioners. We have been reinvigorating our link nurse structure and continue to use multi-disciplinary groups to collaborate on finding robust improvements for our patient services.

We remain committed to ensuring that our clinical and corporate governance is safe, fit for purpose and supports delivery of the excellence that we strive for in all that we do. In 2022 we are investing further in our quality improvement agenda and new team members have joined us in the roles of Head of Quality and Assurance and Quality Improvement Lead.

In 2022 we have invested further into our quality improvement agenda through introducing a new Quality Manager and Head of Improvement Manager.

Key initiatives in the planning for 2023/24 include the rollout of our new patient records system allowing improved integration with primary care; and delivering year one of a new programme.

We have made our compliance with CQC regulations more robust, and updated, and improved on our processes for our regulated activities. We are subject to periodic reviews and have been consistently compliant with their standards for hospices for adults. Our Haringey site was inspected by the CQC in March 2023, and we received a "Good" rating overall.

We saw over 3,600 people use our services through our Health & Wellbeing Centre, our community services or on our Inpatient Unit.

We continue to deliver on, our Clinical, People, Finance, Communications and Marketing and Equality, Diversity and Inclusion Strategies and we have worked

tirelessly to enable staff to maintain our CORE values. These strategies continue to help us all to achieve more together than ever before.

We continue to work on our leadership walkarounds and improve on areas that benefits our service users. We have modernised our front of house and reception areas in 2022, to make it more user friendly and inviting for our visitors, and staff.

We have also continued to explore different care pathways that are responsive to the changing needs of our population, either from the impacts of the pandemic or the changes in needs of our community more widely.

Our financial position is robust, and we continue to plan our future for long term resilience to meet current and future needs for palliative and end-of-life care.

This year's Quality Account details some of this work and we are pleased to share this with you as we continue our journey of improvement in a post Covid-19 world.

Our report includes our progress on our priorities for improvements, on which we have made significant progress.

We would like to thank all our staff, trustees, donors, volunteers, and supporters for everything they do to continue to help us achieve our vision. We would also like to highlight the continued support we have had from our local communities who have enabled us to maintain the services we provide and without whose support we could not deliver the range and scope of services we do.

I can confirm the accuracy of this Quality Account and will ensure the quality of the care we provide is regularly reviewed and improvements are made as needed.

Declan Carroll

Chief Executive

Statement of Assurance from the Board of Trustees

The Board of Trustees has worked closely with the Hospice Leadership Team to gain assurance about patient and staff safety and wellbeing.

The board is fully committed to the provision of high-quality service at North London Hospice. We continue to provide challenge and guidance to ensure a robust clinical and corporate governance structure. As members of the Board, we aim to ensure that North London Hospice fulfils its vision, goals, and objectives to be an important part of the community we serve.

The board has received regular written reports from the executive team, and discusses and scrutinises these to challenge risk around patient safety.

Every two months the Clinical Governance and Assurance committee meet to review the progress against priorities, patient feedback, complaints, and risk and we discuss key performance indicators. The chair of the committee reports a summary to the Board of Trustees.

We aim to ensure that the organisation remains complaint with its CQC registration and activities, health and safety, employment law and other relevant legislation.

The Board recognises that not all the priorities for quality improvement aimed for in 2022/23 were fully achieved, but notes the good progress made in 2022/23 and supports the quality improvements planned for 2023/24.

Finally, we are as a Board extremely grateful to all our volunteers, staff, and community for their continuing efforts to maintain our standards of compassionate care and support at the end of life.

Liz Burgess- Jones

Chair of Trustees

Cate Woodward

Chair of Clinical Governance and Assurance

INTRODUCTION

The quality account provides an overview of our services, information about the quality of the hospice's clinical care and improvements to the public, local authority scrutiny boards and commissioners. This is our opportunity to share with you information about how well we have delivered services in the past year which are safe, effective and offer our patients and their support network a good experience. We also highlight our priorities for the coming year which is based on our strategic plan. Some sections and statements are mandatory for inclusion. These are italicised to help identify them.

Our care is centred on the patient. We respect individuality and each person's dignity and right to privacy. We care for the whole person – their physical, emotional, spiritual, social needs and goals. The care includes support to those important to them, their families, and carers through an individual's illness and into bereavement. We care for people during the advanced stages of all life-limiting conditions, including cancer, heart failure, lung, kidney, and neurological diseases.

The North London Hospice started to produce and share its Quality Accounts from June 2012. The full year's Quality Account (QA) will be found on the internet (NHS website and NLH website) and copies will be readily available to read in the reception areas at the Finchley and Winchmore Hill sites.

OUR CLINICAL SERVICES

The hospice's services are provided by specially trained multi-professional teams, which include doctors, nurses, physiotherapists, occupational therapists, a paramedic, social workers, counsellors, clinical psychologists, spiritual care, and chaplaincy as well as a range of volunteer roles. NLH offers the following clinical services:

- Community Specialist Palliative Care Team (CSPCT)
- Out of Hours Telephone Advice Service
- Outpatient and Wellbeing (OPD&W)
- In-Patient Unit (IPU)
- Palliative Care Support Service (PCSS) - NLH's Hospice at Home service
- Bereavement Service
- First Contact Centre

Our funding of services

During 2022-23, NLH provided and/or sub-contracted two services where the direct care was NHS-funded and three services that were part NHS-funded through a grant.

NLH has reviewed all the data available to them on the quality of care in these NHS services.

The NHS grant income received for these services reviewed in 2022-23 represents 33% per cent of the total operational income generated by NLH for the reporting period.

SERVICE ACTIVITY DATA

NLH monitors the performance of different aspects of its services quarterly against some annual targets. Highlights of this year are included here.

Inpatient Unit (IPU)

	2021-22	2022-23
Admissions	346	284
Patient died on IPU	77%	75%
Patients discharged home	23%	64%
Length of stay	17.4 days	15.3 days
Closed bed days	156	645

Outpatient & Wellbeing Service

	2022	2023
Total Referrals	232	252
Total Number of Attendances	3402	1421

Community Teams

Place of death	2021-22	2022-23
Usual place of residence	75%	63%
Hospice	14%	12%
Hospital	11%	25%
Other	0%	0%
Percentage of patients achieving their preferred place of death	89%	85%

Palliative Care Support Service (PCSS)

	2021-22	2022-23
Number of patients support	442	394
Average hours of direct care per patient	28	32
Average number of patients supported per week	8.5	8
Average number of patients supported per month	37	33

REVIEW OF PRIORITIES FOR IMPROVEMENT 2022-23

The following priorities for improvement for 2022-2023 were identified by the clinical teams and were endorsed by the clinical governance and assurance committee, board of trustees, local commissioners and health and overview scrutiny committees. The priorities for improvement were categorised under the three required domains of patient experience, patient safety, and clinical effectiveness.
The three projects for the year outlined were:

- Managing Medication Authorisation and Administration Charts (MAAR) in the Community.
- A review of Health and Wellbeing Service Intervention Pathways.
- Nutrition management in our Inpatient Unit.

Priority One: Patient safety – Managing Medication Authorisation and Administration Charts (MAAR) in the Community

What we planned to do:

At North London Hospice we strive to collaborate with external stakeholders throughout the boroughs that we provide our services to.

Best practice is that the MAAR chart should be completed and signed by the prescribing professional either the GP, hospital or hospice doctor or non-medical prescriber and not prepopulated. The palliative care team continue to offer specialist advice regarding symptom management and guidance on how to complete MAAR charts but will no longer prepopulate a MAAR chart. This is the recommendation of the Pan London MAAR Chart Group.

Our clinical nurse specialists were completing the MAAR chart with the medications and doses and then the local GPs would sign the MAAR chart so the medication could be administered. We wanted to follow best practice and our

staff have collaborated with primary care teams and have delivered on this priority.

We wanted to ensure safe practice in line with national recommendations and introduce a change in practice. We planned to work with external colleagues, mainly GPs and district nurses to provide education and to support the change in the wider community.

Progress against the plan:

We wanted to deliver the following and carried out regular checks to see that the following deliverables were met.

- Provide information and educate NLH staff.
- Develop internal processes for advising on MAAR Charts including template letters and safety checks.
- Review the community operational policy.
- Provide information and education to GPs with the support of the borough end of life care leads, CCG end of life lead and NLH community teams.

Challenges to date:

Post COVID we have faced some challenges, one of which has been staff shortages as has been for most healthcare organisations, but our staff were determined to work on this improvement, to streamline the process and provide safer care for our patients.

This was also a significant change in practice for our Nurses and for GPs who were familiar with the current process, of nurses transcribing for the GP's before they added their signatures.

We were concerned about the increase in workload for the GP's, and that some would find it more difficult to achieve and would need extra support.

Going forward:

We will continue to monitor the use of the MAAR charts and audit our process, to ensure it is working effectively for all our service users.

Priority Two: A review of health and wellbeing service intervention pathways

What we planned to do:

The Health and Wellbeing team had a significant review of its service provision post-pandemic alongside the launch of the new Organisational Strategy 2021-2025. In order to support the objectives within this strategy our service model is

changing to a goal centred, intervention pathway approach, aimed at those with a treatable but palliative diagnosis.

Using a co-productive model, we planned to develop pathways of interventions for non-cancer diagnosis based on common symptoms and diagnosis. We planned to engage with patients and colleagues to identify the common themes of symptoms, to help develop a menu of treatment interventions alongside identifying trigger factors for referral into palliative care.

The Goal Attainment Scale (GAS-Light)– a framework to support goal setting, monitoring, and reviewing outcomes will be used, using the OACC suite to identify the point where GAS-light is to be introduced. We wanted to establish, improve, and show progress in the following areas:

1. To establish intervention pathways for:
   - Heart Failure
   - Respiratory Disease
   - Rare neurological conditions
   - Peripheral neuropathy (as an additional issue)
2. To establish trigger factors for when referral to palliative care for those with Heart Failure, respiratory disease or rare neurological disease should be referred to palliative care.
3. Pilot and evaluate the use of GAS- light in an outpatient setting.
4. To increase reach.
5. To provide self-management skills.

Progress against the plan:
We established regular meetings held with the Heart Failure team in the acute and community sectors. We strengthened good connections with Respiratory teams and continued to participate in pulmonary rehab.

Peripheral Neuropathy treatment was implemented for some patients via internal referrals.

We have a 30% increase in our referrals in non-cancer diagnosis.

Pathways and flow charts clearly defining the referral criteria for Outpatient and Wellbeing services were successfully completed and carefully integrated with the model used by the Compassionate Neighbour groups.

Challenges to Date:

The Goal Attainment Scale trial had some delays mostly due to low level of new referrals to the team. Goals are the main focus, but feedback initially is that GAS increases paperwork.

With staff vacancies it was anticipated that the project may be slowed down. The collaboration between the acute sector did slow the project down somewhat.

The referral and participation by patients were low, and we hoped that this priority for improvement would also help us increase on ways of getting more participation from service users.

Going forward:

We will continue to monitor the increase in our referrals and participation. We will continue to work closely with our external stakeholders as we believe this has benefited our patients who are referred to us.

Priority Three*:* Nutrition Development on the Inpatient Unit

What we planned to do:

- Improve patient feedback on nutritional care and overall catering feedback on the Inpatient Unit.
- Review the current nutritional assessment policy to ensure it meets the needs of our patients and staff.

Progress against the plan:

We established a nutritional working group that included all members of the multi-disciplinary team and included a Volunteer Dietician. We reviewed feedback from patients with varying nutritional needs and identified and analysed emerging themes. Feedback survey questions relating to Inpatient nutrition were modified to be more specific and surveying across patients was implemented over 12 months.

The groups junior doctor undertook an audit of the existing assessment tool, benchmarking it against national guidance and produced a teaching session encompassing nutritional practice and improvements moving forward.

We sought feedback from nursing staff on the tool and amendments were made to the policy to ensure the content and actions were more succinct. We have introduced a number of initiatives to support the nutritional needs and overall experience of nutrition on the inpatient unit.

The group developed the overall provision outside of usual mealtimes, a relative's menu was re-introduced providing support for families and carers.

The group introduced weekly catchups with the Inpatient unit chef so that feedback could be shared early in the patients journey and any concerns raised by patients, or the chef could be resolved immediately.

The daily menu was re-designed, and it was agreed that moving forward the menu would be returned to the patient when the meal was delivered so as to support patients with dementia or poor memory.

The alternative patient menu was re-introduced, and a provision was made available for relatives to heat patient food if they wished to bring food in.

A patient snack box was introduced so that patients have more choice of snacks day or night.

A new patient information leaflet was introduced with practical advice on how to manage nutrition and anxiety around loss of appetite. We have undertaken a review of our current policy to ensure it is relevant to our practice. We have added nutritional care plans to our inpatient unit patient electronic records system EMIS.

At the end of the year, we recorded that:

- 85% of patients provided positive feedback about the catering service, at the start of the PFI this was 55.6%.
- 85% of patients thought that the meals provided met their nutritional needs (at the start of the PFI this was 75%).

Throughout the plan progress against the outcomes were reported and monitored by quarterly reports to the Quality and Risk Group and quarterly progress reports to the Clinical Governance and Assurance Committee, a sub-committee of the Board.

Challenges to Date:

Some of the challenges we faced were dealing with the rollout of the new menu and our catering team. We also had some issues around the logistics management of the drinks trolley.

Going forward:

The Head of Inpatients has added a nutritional assessment care plan on EMIS, and this will be reviewed and audited one month post implementation.

The group is in the process of compiling information to update the policy prior to the end of year.

The hospice undertook a re-tender of its catering facility and in the future, we will be able to offer both patients and relatives a range of high-quality ready meals for out of hours use.

Themed catering days have been introduced so that patients and carers can celebrate cultural days and special occasions, such as the coronation in 2023.

We will introduce a patient drinks trolley, giving patients the opportunity to have a complimentary drink and a social chat. The drinks trolley will be delivered by our fundraising team, and then the drinks round will be delivered by our volunteers.

LOOKING FORWARD: PRIORITIES FOR IMPROVEMENT 2023-24

The following priority for improvement projects for 2023-24 have been identified by the clinical teams and approved by the clinical governance and assurance committee and the Board of Trustees. The progress against the outcomes outlined against our quality priorities above will be reported and monitored by quarterly progress reports to the Quality and Risk Group and quarterly progress reports to the Clinical Governance and Assurance Committee, a sub-committee of the Board. The priorities for improvement projects are detailed under the three required domains of Patient Safety, Clinical Effectiveness and Patient Experience:

Priority One 1: Managing Complaints and Concerns

How we identified this project:

We identified an increase in the number of complaints across all services. The organisation receives complaints about clinical and non-clinical aspects of its business. We want to ensure our process on complaints and how we handle them are robust.

What we plan to do:

Update our policies, processes, and systems around how we handle complaints within the organisation. Allow the organisation to improve on its learning from complaints we receive.

What the outcomes will be:

We will see a decrease in the number of complaints we have in all areas, have better customer service and improved care for our service users and staff.

Priority Two: Urgent care Pathways

Advance Care Planning is an essential part of recording future wishes to enable patients to experience a person-centred death in their preferred place. The preferred tool for documenting Advance Care Planning in London is the, recently rolled out, Universal Care Plan. The North London Hospice Advance Care Planning policy was updated in 2022 and has not yet been implemented. We are working towards implementing this in 2023.

How we identified this project:

Advance Care planning is a cornerstone of current end of life care. Early clarity of patient wishes allows the various teams across North London Hospice to work effectively together to deliver care that reflects patient preferences. We realised

compliance with organisational policy & regional expectations also need to be met.

What we plan to do:

We plan to:

- Audit against ACP policy to establish the availability and quality of Advance Care Plans on discharge from IPU.
- Describe the current quantity, quality & documentation of ACP conversations during IPU admissions.
- Implement training & processes to improving the recording & sharing of advance wishes & treatment escalation plans during an IPU admission.
- Train & empower all members of the multidisciplinary team to participate in Advance Care Planning.

What the outcomes will be:

All Urgent Care Plans should be updated. We intend that all patients discharged from IPU should have been offered either creation or update of a pre-existing Universal Care Plan, to reflect their wishes. These conversations will be documented. All discharge summaries should include information on CPR status and UCP.

Priority Three: Implementing the Patient Safety Incident Response Framework (PSIRF) into our quality framework.

How we identified this project:

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. It is to replace the current Serious Incident Framework.

What we plan to do:

- We will review our current systems and processes to understand how developed they currently are to respond to patient safety incidents. This includes understanding our patient safety incident profile, improvement profile and available resources.
- We aim to engage with the Integrated Care Board (ICB) and collaborate with other organisations journeying into PSIRF.
- Roles and responsibilities for investigating incidents and incident training relevant to all levels will be reviewed and defined.
- An organisational patient safety incident response plan will be written using the NHS PSIRF preparation guidelines and a new policy introduced to replace the Serious Incident Reporting Policy.

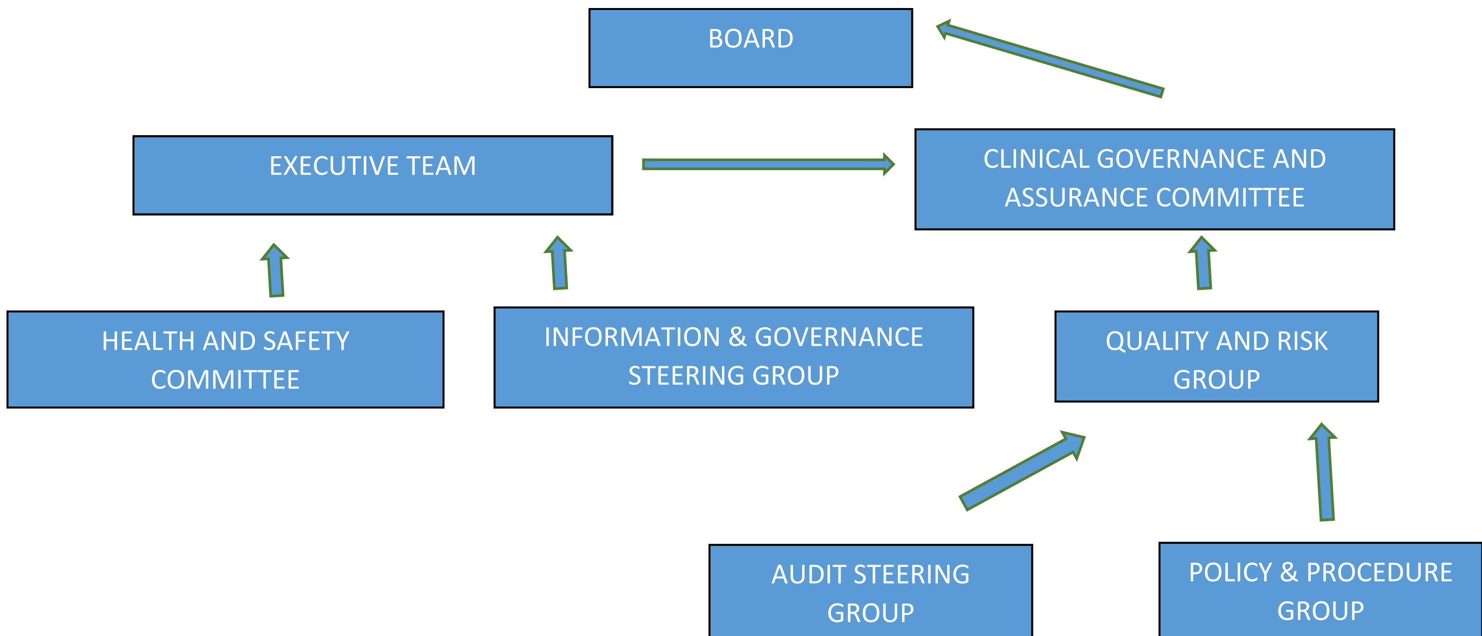
What the outcomes will be:

The patient safety incident response will be embedded within a wider system of improvement, with staff gaining further knowledge and confidence in the incident investigation process and prompt a cultural shift towards systematic patient safety management. Where possible by compassionately engaging with those affected by incidents, we hope to gain a vital insight into how to improve care we deliver and ultimately make it safer for patients. By adopting a proportionate response investigation framework our resources will be better placed and improvement activity will be accelerated on areas that will most benefit the most.

PART 3: QUALITY OVERVIEW-

QUALITY SYSTEMS

NLH has quality at the heart of everything it does as depicted in the diagram of reporting and quality assurance arrangements below:



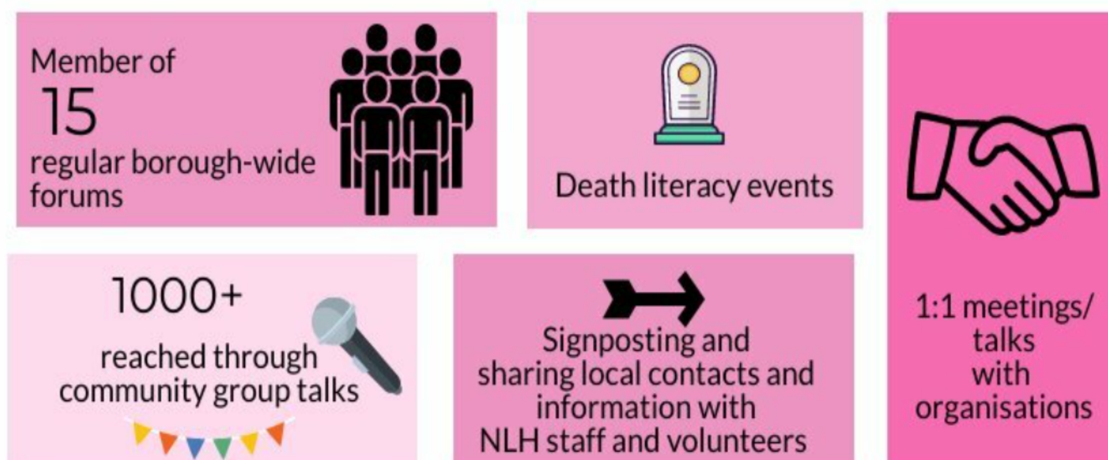
NLH strives to see quality improvement across its services, and this Quality Account represents a small reflection on some of the initiatives we undertake.

KEY SERVICE DEVELOPMENTS OF 2022-23:

- We have developed our workforce (staff and volunteers) to ensure we have the right people, with the right skills to meet the needs of our service users. We are looking at ways to include a more diverse range of volunteers.
- We deliver high quality safe care, ensuring a culture of learning development and improvement.
- We have modernised our front of house and reception areas in our Finchley head office site. This was a major project, but disruption was kept to a minimum and did not impact on patient care. Our last investment in this area was in 2013 - as we have expanded our services and reach and want to meet our new ambitions in our Strategic Plan. Areas for refurbishment include the reception, lounge, café, toilets, Room of Quiet and multi-purpose rooms. It will also provide more private meeting spaces alongside the lounge area. The space is ergonomically

designed and includes energy efficient materials that are also of a sustainable nature.

Ways Community Development engages:



Compassionate Neighbours

This year we have monitored the Compassionate Neighbours model. The referral criteria for external organisations were refined from 'chronic' to 'life limiting' to align with those of the Hospice and this has improved the appropriateness of the referrals received.

We have supported patients and community members, carers and people who were wanting to engage within community members experiencing similar issues of ill health and/or bereavement. The groups remain volunteer led.

The connections with local partnerships continue, particularly in Haringey where we have good links with social prescribers and the Haringey Memory Service.

Compassionate Neighbours in numbers 2022/2023

	2021/2022	**2022/2023**
Compassionate Neighbours trained	91	39 (total:271)
Referrals received	84	165
Referral source ratio (internal: external)	58:42	72:28
Introductions/matches	67	100
Number of new group activity launched	N/A	7

This year has seen the sign-off and implementation of the organisation's first community engagement strategy. This has included:

- Recruitment of the Community Engagement Coordinator to increase capacity within the team.
- Recruitment and training of Volunteer Ambassadors and Compassionate Neighbours to further increase capacity and organisational reach.
- Development of a project plan to track progress and measure impact.
- Development of Compassionate Neighbours groups as part of the Outpatients and Wellbeing Service.
- Analysis of the available Census data on ethnicity and faith groups to better understand the makeup of our boroughs.
- Communications on the intranet to launch the strategy and share key information and events. A 'week in the life of' article in Life Magazine (Q4).
- Development of creative opportunities to bring communities together to talk about death, dying and loss.
- Organising an Active Bystander training workshop to support staff and volunteers to take positive action to prevent or reduce harm to others when they encounter prejudice and discrimination.
- Relaunch of Life Stories (oral storytelling) service.

Community Development	**Total**
No. of 1-1/small meetings (with a representative/s of an organisation)	17
No. of planned/targeted community group talks and events	9
No. of people reached through planned/targeted talks or events	380
No. of external events attended.	11
Volunteer Ambassadors recruited	9
Number of large network meetings attended	20

IPU

Over the past year we have explored and implemented changes to the storage of equipment on the unit to decrease clutter on the unit and ensure a safer working environment for patients and staff.

The IPU team have continued to work with the facilities team to ensure that the ward environment is safe and secure. The largest project has been the introduction of a new call bell system on the unit. This is fully integrated with the ability to be individualised for patients, which includes a falls alarm system that

is worn like a watch and a large red button accessible for most patients including those with upper arm mobility issues, sight issues and fine motor skills.

Moving forward individualised equipment will be fed into the nurse care planning process to give clear information and guidance to staff and patients alike. The system can be used to help with measuring dependence and nurse activity with specific patients, this will drive decisions on nurse staffing levels and skill mix.

We have worked with our Learning and Development Team in response to complaints and incidents to ensure that we provide a productive learning environment, learning from Incidents in order to prevent future incidents – examples are MND training, Verification of Death update and training and a revised Single Nurse Administration training day.

We continue to work with local Tissue Viability, Bladder and Bowels Services and Dementia Services to help to improve the quality-of-care patient receive both as an inpatient and for those on discharge. Plans for 2023/24 would include moving into other areas that are highlighted as areas of need.

Local Clinical audits

North London Hospice recognises that audit has two main drivers-Quality Improvement and Quality Assurance. The hospice plans its annual core audit activity, overseen by the Clinical Governance and Assurance Committee (CGA) but remains dynamic with audits added to the programme in response to new risks and concerns. In 2022-23 the audit programme had over 18 audits which covers a range of areas to ensure compliance with local and national standards and identify opportunity for continuous improvement. The audit topics include:

- **Clinical** including deprivation of liberty safeguards, falls prevention, bedrails, nutrition, medical gas, venous thromboembolism (VTE) assessment and prophylaxis.
- **Infection Prevention and Control (IPC)** practises across all services. This includes a monthly hand hygiene audit and an annual audit using an Infection Prevention Solutions audit tool covering waste management, sharps management, clinical environment, equipment, and clinical practise.
- **Medication audits** with annual audits of the accountable officer, medicines management, controlled drugs, non-medical prescribing. All medication audits have met the requirements of all relevant legislation and a thematic review is undertaken annually. Monthly drug omissions audits initiated as part of the introduction of a new drugs chart have continued this year.
- **Record keeping** including Outcome Assessment and Complexity Collaborative (ACC) measures in community, consent, ethnicity, multi-disciplinary team (MDT) meetings, inpatient paper care plans and assessment tools.
- **Information governance** audits include Data security and Vantage permissions/ security.

- **Other audits** have included a process audit of the management of complaints and concerns.

  Examples of Improvement as a result of audit

  The multi-disciplinary audit steering group meets every other month, and under the guidance of Quality and Risk Committee oversees audit activity, reviewing audit reports and ensuring results are turned into action plans, followed through and re-audit completed. Some examples of changes made this year following audit include:

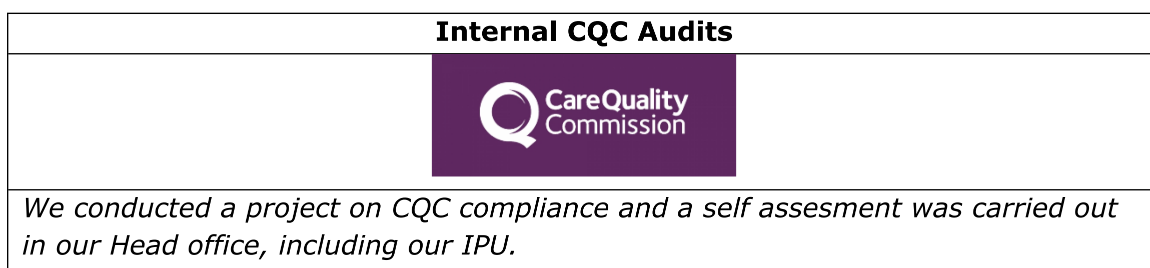
- Development of medical gas (focused on oxygen) educational material within mandatory training and a formal oxygen administration competency across all relevant clinical staff groups.
- Review of content of environmental risk assessment for community as low completion rates linked to a disengagement with the risk assessment tool and concerns over its purpose with a more standardised approach developed to alerts to keep our staff working in the community safe.
- IPOS community task and finish group established as peer review community record keeping audits demonstrated while performance status and Phase of Illness OACC measures were well embedded into practise, the use of IPOS had not been standardised.
- Bedrails assessment now has a 7-day EMIS worklist to ensure it is reassessed weekly.
- Paper care plan and assessment audit on the in-patient unit gave valuable insight into current practise and indicated some template redesign when migrating from paper to electronic records on EMIS. Nausea and vomiting and constipation care plans were occasionally overlooked therefore spot checks on care plans have been introduced to ensure patients have all their care needs defined to ensure they consistently receive the highest standard of care.
- Customisation of asset module within Vantage including automated notifications, to allow service managers to oversee their equipment servicing dates and ensure contingency planning to minimise disruption to patient care.
- Policy being written for patients retaining own controlled and non-controlled drugs as a result of both planned audit and an incident where the organisations process for managing own drugs was unclear. Cold Chain Policy written after audit found a gap in documentation of process required to ensure temperature control for safe and effective medicines.
- Complaints policy audit led us to modify the leaflet to ensure the complainant is given the opportunity to provide feedback on the outcome and awareness that support for those with communication or sensory needs is available.

- An Infection Control Framework is being written which will be rolled out across all Hospice Departments to improve integrated working and collaboration between all services. Review of Equipment policy to include the requirement for each team to hold a decontamination schedule and checklist suitable for their needs and raising the training and local profile of Infection Prevention Control champions to ensure in-patient and community services can clearly evidence decontamination standards and ensure they are safe.
- Under the lead of a new Accountable Officer adjustments made in how we store, record, and keep our stakeholders updated with medicines. The controlled drug register has been revised and changed ahead of reprint again based on incidents and staff feedback to improve patient safety.
- A quality improvement project on the development of a new drug chart has been implemented, the drug chart has been amended following a review of incidents to help prevent reoccurrence and improve patient safety.

During 2022-23, there were 0 national clinical audits and 0 national confidential enquiries covering NHS services that NLH provides. During that period NLH did not participate in any national clinical audits or national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in. The national clinical audits and national confidential enquiries that NLH was eligible to participate in during 2022-23 are as follows (nil).

The national clinical audits and national confidential enquiries that NLH participated in, and for which data collection was completed for 2022-23, 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 (nil).

The reports of 0 national clinical audits are reviewed by the provider in 2022-23 and NLH intends to take the following actions to improve the quality of healthcare provided (nil).



Internal CQC Audits
We conducted a project on CQC compliance and a self assesment was carried out in our Head office, including our IPU.

What we did well
The results of our audit showed that we had many areas of good compliance and practice.
We were very caring towards our patients and their family. cared well for our patients, in the IPU.
Our learning and development team were effective and our mandatory training within the organisation was 96% for our staff which included our trustees and executive team. Our staff had regular appraisals and clinical supervision, which helped them carry out their duties.
We carried out inductions for all of our staff when they commenced employment within our organisation, which included our volunteers. The results also showed we were caring towards our staff and volunteers.

We had good governance structures, and policies in place, and staff followed these. We reported incidents through our governance structures and had regular meetings to learn from any incidents. We had the correct policies in place to help us safeguard our patients and we carried our risk assessments for all our patients. Our patients told us that they were well cared for in many aspects of their care such as with managing their pain and meeting their emotional needs. They had care plans in place, and we involved them in making decisions with their care. Our staff used evidenced based practices, and followed national guidelines to give the best care to our patients.

Our senior leadership teams were approachable and always available for staff, and patients and their families to speak to.
If and when anyone complained, we handled these quickly and effectively to ensure people were satisfied with the outcomes.

Some examples are listed below:
SAFE:

- Implementation of electronic care plans in our inpatient unit.
- Updating older policies to ensure staff have proper procedures to follow.
- Continuing to update our risk registers and risk assessments.
- Ensuring that our HR processes are in line with government regulation.
- A deep dive of our policies and standard operating procedures

EFFECTIVENESS:

- Procuring a new patient call bell system in the IPU.
- Ensuring that our services are accessible to service users with disabilities.
- Making sure that our safeguarding systems remain robust, and training is available for staff through our training systems.

RESPONSIVE:

- We have made sure that our services are responsive to service users of different faiths, cultures, abilities, and the care they receive meets their needs.
- Standardised pain assessment.

• We have audited our discharge process and began to review the referral pathways to our inpatient services. *WELL-LED:* • Reviewed the research strategy and we have continued to participate in research projects that help us to maintain best practice. • We have reviewed our CORE values and asked staff how they felt they were working and helping us to achieve our aims to be an outstanding organisation. • Involvement of Trustees in Leadership walkarounds has been a success, utilising their expertise to steer improvement based on real time observations and discussions with staff.
Where can improvements be made We recognised the need to involve our staff in audits, and research to enable them to improve on the quality of care they provide to service users. We recognise that we need to ensure that any actions are completed so staff have clear processes to follow. We also noted that we could be more robust in our IT training and practices throughout the organisation.

Quality improvement and innovation goals agreed with our commissioners

North London Hospice income in 2022-23 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework.

What others say about us

The Care Quality Commission (CQC) monitors, inspects, and regulates services to make sure they meet fundamental standards of quality and safety. They consider five domains of service provision:

• Is the service safe? • Is the service effective? • Is the service caring? • Is the service responsive?• Is the service well led?

They publish their inspection performance ratings and reports to help the public.

North London Hospice is required to register with the Care Quality Commission and its current registration status is unconditional. North London Hospice has the following conditions on its registration (none). The Care Quality Commission has not taken any enforcement action against North London Hospice during 2022-23 as of 31 March 2023. North London Hospice has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

NLH’s three sites were separately inspected in 2016. NLH was found to be compliant in all the areas assessed and each site was rated “Good” in all domains. Our Director of Clinical Services maintains regular contact with our CQC inspector.

Our Haringey site was inspected in March 2023. We received a rating of Good and we await publication of the report at the time of this quality account. We had already started working on some of the improvements of our internal inspection and some of these were discussed on the day of inspection. We have devised an action plan to ensure that all suggestions from the CQC are carried out so we can continue to make improvements towards providing the highest quality of care.

There were only three main areas for improvement noted to us from the CQC.

1. Some complaints should be recorded as incidents. – Although we report all complaints, we did not always log them as incidents. We have made system changes to our incident reporting system to enable a direct link between the complaints and incident module and invested further training in managers to ensure they can identify where a complaint should also be logged as an incident.
2. Local departmental risk registers should be maintained to help us improve on our risk management framework. Although we do have local risk registers, we recognised that not all were available for those who needed them. We have completed the work on risk registers and strengthened our process on the assurance we have around risk.
3. Ensure that community incidents that involve third party stakeholders are reported as incidents. Although we were always reporting back to stakeholders with issues we found, we were not always logging them on our incident reporting system. Further training around incident reporting and management is planned for 2023.

A new Head of Quality, supported by a new Quality Improvement Lead and Quality Administrator in the last twelve months have been working on a clear action plan to further strengthen our incident reporting system and complaints system to facilitate ease of reporting, extraction, and accessible display of meaningful data to drive improvement. We have developed a better governance structure and are in the process of updating our governance framework. The engagement of the executive team has allowed us to act quickly and efficiently on the improvements we needed to make to ensure CQC compliance.

Research

Over the last year we have achieved our ambition of becoming research active hospice. We are developing a Research Strategy focusing on external partnerships and collaborations and encouraging research engagement and participation. The hospice has been involved in several ethically approved research studies:

We have set up our research steering group and have commenced the governance framework for this. We have met with the National Health institute of research (NIHR) team and are working on best practice and ethical management of any research we ask our service users to participate in.

1. We have been accepted to participate in the second research trial of Clinically Assisted hydration in the patients last days of life (Chelsea II). The study is open to all patients admitted to our IPU at the end of life and commenced in September 2022.

2. We also participated in a small research project carried out with our pharmacist undertaken by Reading University. The aim of the study was to gain and understanding of the behaviours and barriers around medicines reuse, particularly for those working directly with patients in a care home or hospice setting.

3. We are also included in a research pilot with the NHS Blood and Transplant service for eye donation and patients who die in the IPU hospice environment may be included. This mainly focuses within our IPU area, but community patients may also be included if they meet the criteria.

We will continue to expand on research governance and participation in research pilots and trials in 2023-24.

DATA QUALITY

NLH did not submit records during 2022-23 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data as it is not applicable to independent hospices.

Information Governance (IG) refers to the way in which organisations process and handle information, ensuring this is in a secure and confidential manner. The Data Security and Protection Toolkit is an online self-assessment tool that must be completed annually by all organisations that have access to NHS patient data and systems. It enables these organisations to measure their performance against the National Data Guardian's 10 data security standards and to provide assurance that they are practicing good information governance ensuring data security and personal information is handled correctly.

The hospice completed its 2021/22 toolkit submission in June 2022. The 2022-23 submission will be completed by June 2023.

NLH was not subject to the payments by results clinical coding audit during 2022-23 by the *Audit Commission*. This is not applicable to independent hospices.

Quality Improvement projects (QIP) informing service developments in IPU

Adding Electronic care plans to our IPU

We have added electronic care plans to our EMIS patient care records on the IPU moving towards a paperless medical records system. This is in line with the organisational clinical objective to continue to ensure we are using technological and digital developments to support safe and effective patient care.

Part of this project was to optimise quality in terms of content, usability and process design of assessments and care plans during migration process from paper to electronic.

The anticipated benefits of migrating the care plans to EMIs are expected to be:

- Improve Accessibility. Continually keeping paper records filed and organized so they are easily accessible can be a timely task. A standardised, clear electronic template allows care plans to be easily retrieved and updated as required.
- Improved co-ordination of care, with patient focus at the center.
- Development of reporting parameters and data quality that measure the effectiveness of our services for more informed and tailored decisions.
- Cut costs on paper and supports the hospice's strategy to reduce waste by printing less.
- Improve data security with risk of loose paper being misplaced.

- Remove requirement to store paper notes taking up space both active patients and those archived.
- Increase staff satisfaction with a well-designed system aimed to support staff in making timely, efficient, and accurate assessment and care plans.

The care plans have been implemented with minimal disruption and with safety and continuity of care at the centre.

Responding to Urgency of Need in Palliative Care (RUN-PC) Triage Tool & Triage Process

This year we have further developed the RUN-PC Triage tool, continuing to improve on how we triage and assess our patients who are referred for palliative care treatment. We have improved on how we use the triage tool and improved the process and efficiency of what we discussed in our bed meetings, to aid how we referred and discharged our patients safely and efficiently.

We will develop this further by doing a deep dive into our discharge processes, and the way we discharge our patients. We will further develop our discharge pathways for our patients, so they are discharged back to the community safely and effectively.

Community and outpatients

Improving our shared Community and Outpatient Multi-disciplinary Team meetings.

We have completed a quality improvement programme on how we communicate between our community and outpatient multi-disciplinary teams. We wanted to ensure that our patients were known to both teams and ensure patient safety through this combined sharing. We have completed this and updated our processes, have improved communication, and aided holistic care for our patients. These meetings have also helped our staff satisfaction and how they learn from each other.

PARTNERSHIP WORKING

North Central London Clinical Commissioning Group (ICB)

NLH has worked with our North Central London (NCL) commissioner to support the priorities for improvement through our work with GPs on the MAAR charts and our work with our outpatient and wellbeing services' on developing care pathways.

Ongoing partnership working

We have continued to work in partnership with Noah's Ark, the Enfield Community Heart Failure team and Enfield Pulmonary rehabilitation service. We are also working with the North Central London Cancer Alliance on the Personal Cancer Care Programme.

Partnership working continues with the Barnet Patient Engagement Group and colleagues in Jewish Care, Healthwatch Barnet, Barnet Carers, Age UK, Dementia services, Multifaith forum and GP Patient Engagement to encourage a local conversation about preparing for end-of-life decisions and care. This year, once again, NLH worked closely to produce a public engagement campaign for Dying Matters Week.

Partnership working with Marie Curie Hospice Hampstead

We have continued to meet regularly with the senior management team at Marie Curie in Hampstead to share experiences and consider opportunities for collaborative working.

Enfield Respiratory Team

We continue to provide input into their 'Pulmonary Rehabilitation' courses exploring advanced care planning and the role and services of North London Hospice.

Partnerships Community Borough teams

Our community teams have regular meetings with Partnerships Community Borough Teams. These include:

- Regular meetings with district nursing to discuss care plans for people under joint care.
- GP meetings.
- Neurological meetings.
- Heart failure meetings.
- Enhanced health for care homes meetings.
- Multi Agency Care and Coordination (MACCT) case by case as needed.

LEARNING AND DEVELOPMENT

It was a very positive year for L&D team. Quick recruitment to the vacant post meant the successes of the previous year could be built upon and the eventual removal of covid restrictions meant that training could return to a more stable plan, and training in care homes could be resumed.

Positives for the year included mandatory training compliance averaging 94% and a wealth of additional internal courses, ranging from assertiveness, coaching, and mentoring, customer services and clinical skills training being offered. Continued direct mentoring, preceptorship, support, and reflection opportunities were also offered by the team. A poster sharing the successes, struggles and learning from the cohort of Trainee Nursing Associates was also accepted for display at the Hospice UK Conference. The Hospice additionally supported one of the nursing associates to attend and share their growth and learning with others and was a very positive induvial experience. The addition of

the career development fund also supported new learning opportunities for staff. This includes the commencement of a master's degree, a social work apprenticeship and a RGN top up degree apprenticeship.

A number of external courses, including our accredited but also bespoke courses, were delivered virtually and in person. All received outstanding feedback including "really good training by really experienced trainers, I feel motivated and engaged", "the best training ever, it was excellent" and "the training was amazing, and I feel more confident to deliver end of life care". As well as contributing to income generation for the hospice, these also developed long standing partnership such as with Barnet and Southgate College but also created new, with for example the Enfield Learning Disability Team on 'No Barriers Here'.

An unforeseen challenge was the need to change the new e-learning system due to the financial difficulties of the company. A new provider has however been found and we aim to have smoothly transitioned to new e-learning system by June.

We look forward to the new financial year with an abundance of learning opportunities in our 23/24 prospectus and our largest cohort of ECEPC learners. A NLH staff conference is planned for May, and we are excited to have also appointed a new team member who will specifically support the learning and development of our clinical staff and allow us to welcome more students into the hospice.

In figures; 114 mandatory and non -mandatory training sessions took place for internal staff and 106 external courses were delivered to 1074 learners. Mandatory training compliance averaged at 94% for the year.

SERVICE USER EXPERIENCE

North London Hospice welcomes feedback from all service users about their experience of our services. Negative feedback enables us to reflect and consider what we could have done differently. It is only through valuable feedback that we can understand and improve the care and service we provide. All complaints and concerns received are considered in line with policy. This includes an apology, investigation, an outcome, and actions put in place from lessons learnt.

The hospice has a range of feedback resources which are used to capture service user experience. Verbal or written suggestions, compliments, patient/carer stories, routine patient and carer surveys, concerns, and complaints. Feedback is shared with staff and reviewed by services and through NLH governance groups.

All feedback is collated and analysed for themes and used to identify improvements and implement change. We adopt a user centred approach and endeavour to drive a culture of continuous improvement through understanding the needs and preferences of our service users.

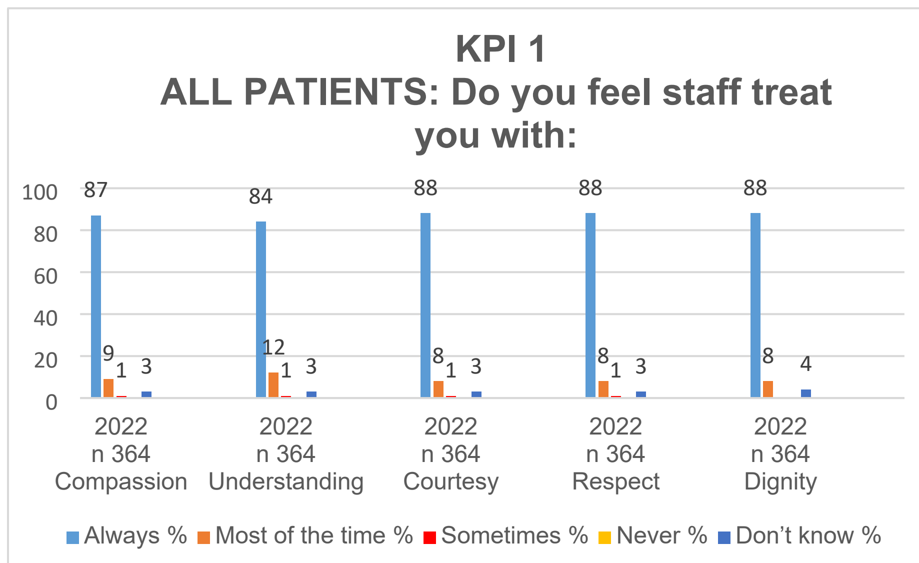
2022/23 User Surveys

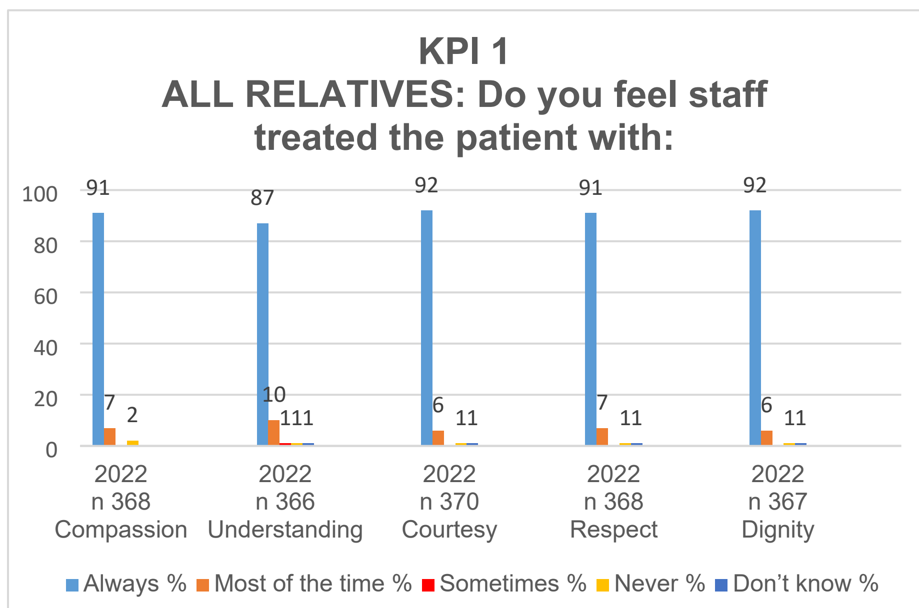
Experience surveys were sent from April 2022-March 2023

- Community patients and bereaved relatives
- Palliative Care Support Service, bereaved relatives (PCSS)
- Inpatient unit patient and bereaved relatives (IPU)
- Outpatients and Wellbeing patients (O&W)

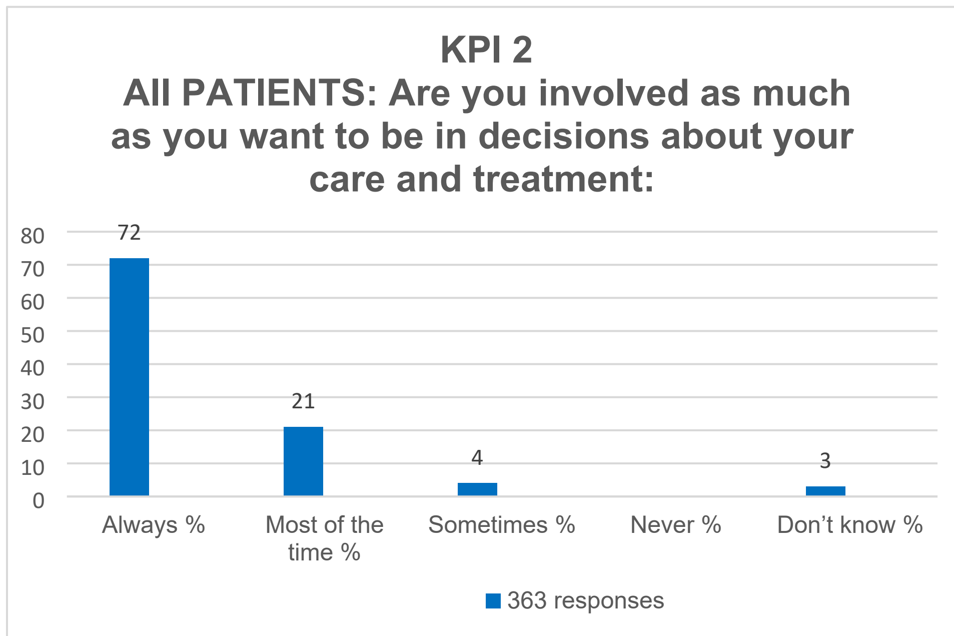
Results: Key Performance Indicators

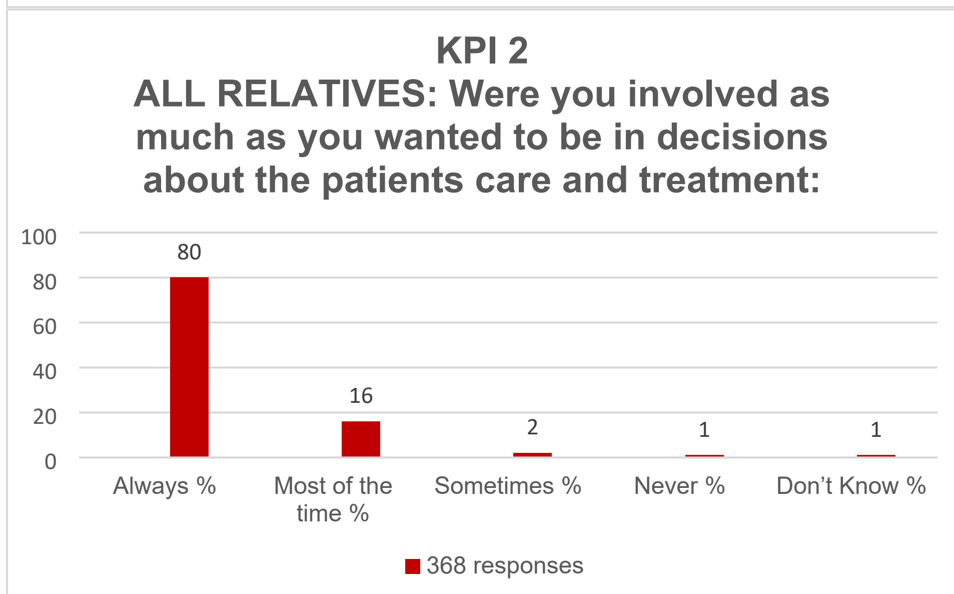
Key Performance Indicator 1: Are you/was the patient treated with compassion, understanding, courtesy, respect, and dignity?

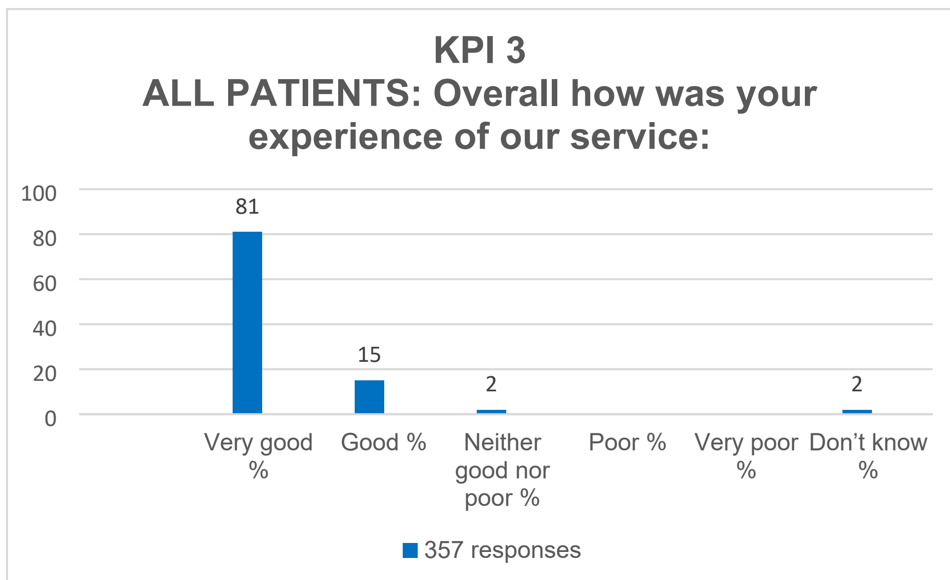


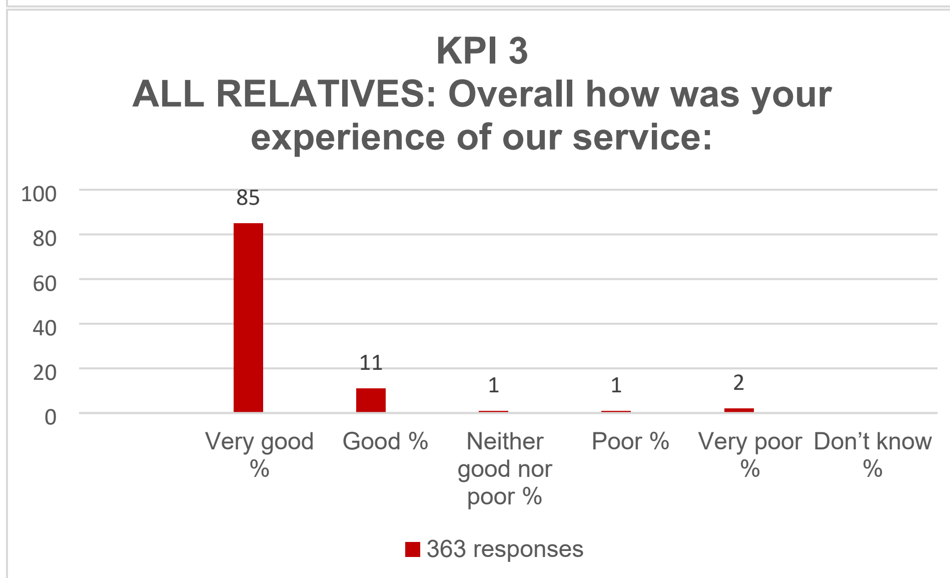


Key Performance Indicator 2: Are you involved as much as you want to be in decisions about your care and treatment?









Compliments:

This year we recorded 207 written compliments. Themes were care for patients, relatives, and carers, above and beyond, kindness of staff and overwhelming support during difficult times. Below are examples of compliments received from our patients, families, and carers.

Complaints and Concerns

We received **21** formal complaints in 2022-23 compared with **15** in 2021-22.

1 not upheld, 8 partially upheld, 12 upheld. We received 5 concerns.

A thematic analysis showed that there is some consistency of themes with previous years, i.e. communication and staff attitude across all services.

Lessons learnt included more open communication with all service users, volunteers and between healthcare and non-healthcare professionals as we all support inpatient, community patients and retail supporters.

Organisational wide communication training including situational role play based on actual complaints recorded will be rolled out in 2023.

To the many nurses, doctors, assistants, cleaners, and volunteers who cared for our father. We are more grateful than we can ever express for the skill and tenderness you showed him and for the two days he was with you. Thank you, we plan to fundraise for you in a number of ways.

In-Patient Unit compliment

To everyone at North London Hospice, thank you so much for making it possible for my partner to pass away peacefully at home. With your wonderful support I was able to fulfil her wishes. You are a fantastic organisation, and I will try to repay a small part of what you gave us by giving you my support.

Community team compliment

I would just like to say an enormous thank you to the staff, at the North London Hospice. At 8:45 on a Saturday evening you helped me with medication for my mum
Your kindness to us was so very much appreciated and you looked after Mum with kid gloves over her final week.
Please accept the enclosed donation on behalf of our wonderful Mum With appreciation and very best wishes,
PCSS compliment

PATIENT SAFETY

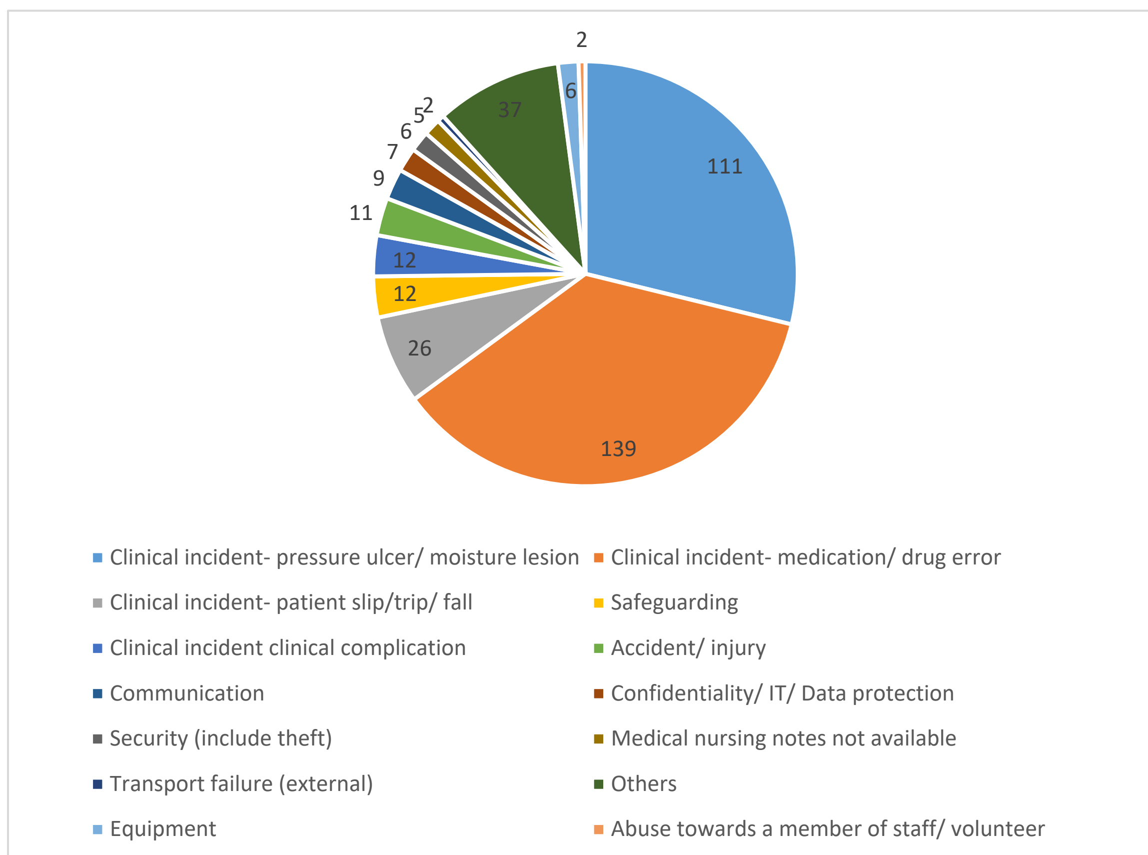
North London Hospice promotes a no blame open reporting culture encouraging the reporting of clinical and non-clinical incidents and near misses. We are committed to investigating and learning from our incidents as we drive for continuous improvement. The quality and risk group review the themes, trends and improvements relating to incidents, with a quarterly report produced.

Table 1 Total number of incidents reported on Vantage 2020-23

	2020-21	2021-22	2022-23
Total number of incidents	417	368	383

Table 1 shows a small increase in the number of incidents was reported this year from the previous year. This number reflects all incidents across the organisation both patient safety and non-patient safety incidents. The quality team have been working to raise the profile of incident reporting and this may explain the small rise.

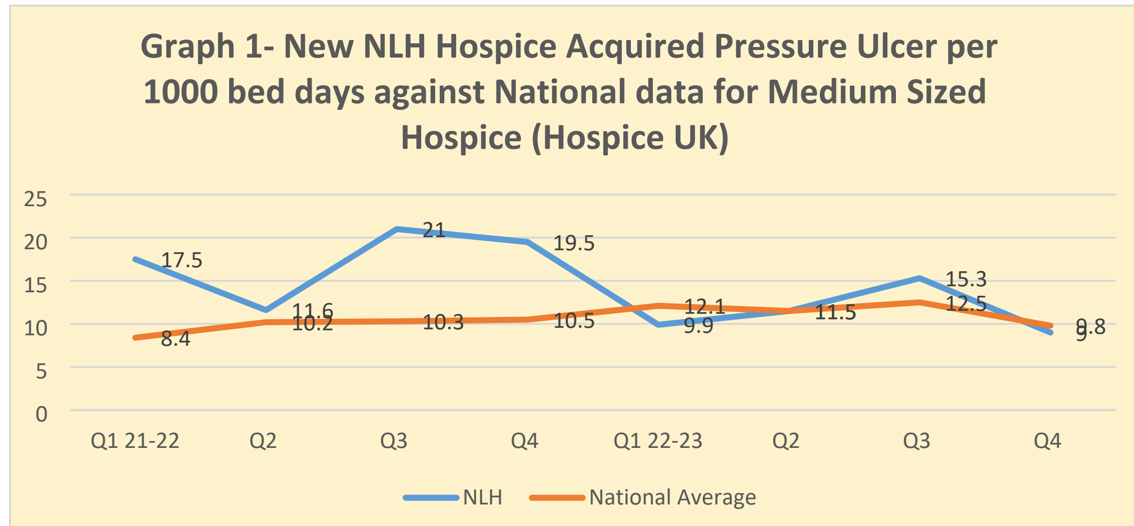
Chart 1 below shows the categories of incidents reported during 2022-23



Pressure Ulcers 2022/23

We report on newly acquired pressure ulcers and those that are present on admission and not attributed to the hospice hence our greater numbers of incidents reported.

Graph 1 below shows a reduction in North London Hospice new pressure ulcers reported per 1,000 bed days over the past year bringing it closer in-line with the national data for similar sized hospice (Hospice UK Benchmarking reports) was 46.



This reduction in pressure ulcers may be contributed to the review of the SSKIN (Skin, surface, keep moving, incontinence, nutrition, and hydration) charts and introduction of SSKIN bundle this year to support care. RCAs (Root Cause Analysis) are undertaken for hospice acquired Stage 3, 4, ungradable and deep tissue injury pressure ulcers. They demonstrate care undertaken with thought given to maintaining patient comfort, and in accordance with their wishes.

Medication incidents

Last year we reported 94 medication incidents on IPU compared to 63 this year. All medication incidents across the organisation are closely monitored and reviewed for learning, which includes learning from those that were not patient-related (pharmacy dispensing issue etc). There was no medication incident resulting in patient harm with a change in clinical status.

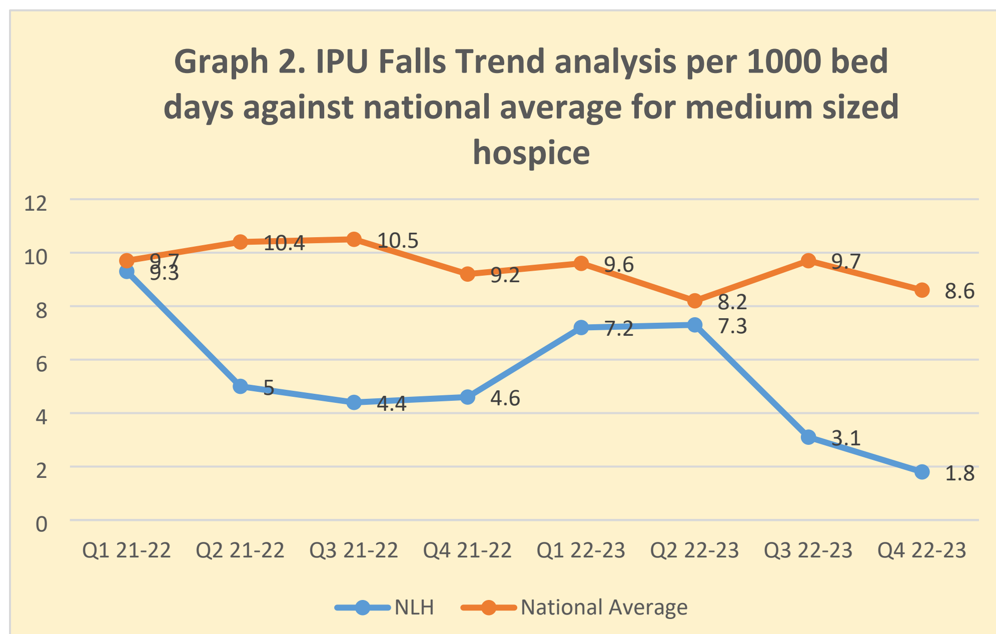
The overall data for this year indicated that the new drug chart was implemented safely and has been successful in its aim to reduce in incidences at point of administration. As our review and improvement activity continues, further changes have been made to the drug chart based on medication incident trend review e.g. missed signature due to layout led to a redesign.

Towards the end of the year, we launched new single nurse administrator training (SNAT) including the legalities and internal processes of controlled medicines as an initiative to reduce drug errors further. To drive the medication safety agenda at ward level one of the nurses has become a IPU medication champion.

There were 15 incidents are not attributable to NLH and involve external health care professionals reported by our community services which is an increase in 6 from last year. We are committed to providing feedback any incidents to our partner organisations to collaboratively improve patient safety and aim to strengthen this process moving forward as part of our PSIRF priority for improvement.

Patient Falls

There was a decrease in trends in the number of patient falls overall this year from 24 to 20. All incident's reports were either no harm or low harm. The hospice demonstrates its commitment to keeping our patients safe with every quarter the number of falls per 1000 beds being below the national average as reported by Hospice UK benchmarking.



National benchmarking with other hospices (this covers In-Patient Unit incidents only)

Patient safety is a key domain of quality in hospice care. Quality indicators are useful to demonstrate safe and harm-free care. North London Hospice uses Hospice UK Clinical Benchmarking toolkit to benchmark against three core patient safety metrics: falls, pressure ulcers and medication incidents.

Newly acquired Pressure ulcers IPU Only

	2021-22	2022-23
Number of pressure ulcers	72	46
Pressure ulcers per 1,000 occupied bed days	17.2	11.1
Hospice UK Benchmarking Pressure Ulcers per 1,000 occupied bed days (for hospices of the size of NLH)	9.5	11

Falls IPU Only

	2021-22	2022-23
North London Hospice Number of patient related slips, trips, and falls	24	20
North London Hospice Falls per 1,000 occupied bed days	5.7	4.8
Hospice UK Benchmarking Falls per 1000 occupied bed days (for Hospices of the size of NLH)	9.9	9

Medicine Incidents IPU Only

	2021-22	2022-23
Number of medicine incidents	81	63
Medicine incidents per 1000 occupied bed days	19.3	15.2
Hospice UK Benchmarking Medicine incidents per 1,000 occupied bed days	11.9	11.4

Duty of candour

NHS England requires providers to indicate how they are implementing duty of candour. The duty relates to the culture as well as the practice of being open and transparent with service users and relevant stakeholders, regarding care

and treatment. In the case of any serious clinical incidents reported then it will be subject to duty of candour. There were no duty of candour incidents reported during 2022-23.

APPENDIX: MANDATORY STATEMENTS

The North London Hospice Quality Account is required to include the following mandatory statements despite not being applicable to the work we do.

Participation in clinical audits and research

During 202-22, there were 0 national clinical audits and 0 national confidential enquiries covering NHS services that NLH provides. During that period NLH did not participate in any national clinical audits or national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that NLH was eligible to participate in during 2021-22 are as follows (nil). The national clinical audits and national confidential enquiries that NLH participated in, and for which data collection was completed for 2021-22, 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 (nil). The reports of 0 national clinical audits are reviewed by the provider in 2021-22 and NLH intends to take the following actions to improve the quality of healthcare provided (nil).

The number of patients receiving NHS services, provided or sub-contracted by NLH in 2021-22, that were recruited during that period to participate in research approved by a research ethics committee was nil.

There were no appropriate, national, ethically approved research studies in palliative care in which NLH was contracted to participate.

Quality improvement and innovation goals agreed with our commissioners

NLH income in 2021-22 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework.

Care Quality Commission

NLH is required to register with the Care Quality Commission and its current registration status is unconditional. NLH has the following conditions on its

registration (none). The Care Quality Commission has not taken any enforcement action against North London Hospice during 2022-23 as of 31 March 2023.

NLH has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

DATA QUALITY

NLH did not submit records during 2022-23 to the secondary uses service for inclusion in the hospice episode statistics which are included in the latest published data as it is not applicable to independent hospices.

ACCESSING FURTHER COPIES

Copies of this Quality Account may be downloaded from www.northlondonhospice.org

HOW TO PROVIDE FEEDBACK ON THE ACCOUNT

Please contact Qualityteam@northlondonhospice.co.uk

This year's Quality Account has been prepared by our Head of Quality, with support from teams across the Hospice. The Hospice Leadership Team has been closely involved in setting our priorities and leading improvements within the Hospice. The Board of Trustees has endorsed our Quality Account for 2022/23.