NORTH·LONDON
HOSPICE

Outpatient & Therapies Service
BARNET **Bereavement Support** Patient
Community ENFIELD
Haringey **EDUCATION** **CARE**
Triage Service
North London Hospice
PALLIATIVE CARE SUPPORT SERVICES
24-hour advice line for NLH patients and professionals

OVER **90%**
SUPPORTED AT HOME

1756 **individual patients**
cared for by all NLH services this year

QUALITY ACCOUNT 2014-15

CONTENTS

OUTPATIENT AND THERAPIES SERVICE PATIENT STORY

"Everyone is lovely and very caring. "A" (nurse) is marvellous. My lung nurse, B, suggested that I come to the Hospice. I had heard of the Hospice. She knows I don't like hospitals. I don't like male nurses seeing to you when you are a woman – it's not right for someone of my generation.

I'm deaf so I don't have a lot to talk about so I was a bit worried about mixing with other people. From my first visit, "A" has been very kind.

I felt like the Queen when I first arrived – lots of people waiting around to greet me. I had my hair washed, a pedicure and a manicure. I was really pampered and couldn't get over it. The volunteers are all lovely and I've played dominos.

It would be nice if there were some magazines in the Open Space. Sometimes you are left on your own between appointments or waiting for your driver. Hospice drivers pick me up and drop me off.

I finish here in 3 weeks and I'm really choked about that. I've got used to coming. I really look forward to it and it makes me feel better. I was getting tearful and depressed at home. The best thing about coming is being able to get out. I don't get out much; my son just takes me shopping once a fortnight for an hour. I hate having to ask people to do things for me. Any problems, I have to sort them out for myself and I get very tired of having to keep struggling to get them sorted.

I would recommend the Hospice and am treated with respect and dignity."

North London Hospice (NLH) Response to this User Feedback:

Patients attend for a planned 12 week therapies programme. Following review, this is extended where appropriate. Patients are helped to move to other services prior to their discharge date. Following discharge all patients are welcome to attend on a drop-in basis.

Drop-in clients can access the following: a volunteer led activity e.g. quizzes, games, crafts etc; meditation; hair & beauty therapy; yoga. They can stay for lunch or enjoy some conviviality with volunteers. The drop-in service was instigated in July 2014 and all ex-patients were informed of this in writing and invited to attend.

NLH has a large team of volunteers and it is very unusual for a patient to be unattended at any point. NLH have reminded volunteers to be aware of patient's whereabouts at all times. In addition there is now a system of dedicated link volunteers who are assigned to individual patients attending the social programme.

EXECUTIVE SUMMARY

The Quality Account is produced to inform current and prospective users, their families, our staff and supporters, commissioners and the public of our commitment to ensure quality across our services.

North London Hospice is a registered charity (No.285300) and has been caring for people in the London Boroughs of Barnet, Enfield and Haringey since 1984.

It provides Community Specialist Palliative Care Teams, a Palliative Care Support Service (NLH's Hospice at Home service), an Outpatients and Therapies Service (formerly Day Services), an Inpatient Unit, an Out-of-Hours Telephone Advice Service, a Triage Service and a Loss and Transition Service (including Bereavement Service).

The following three priorities for improvement projects for 2015-16 are proposed:

Patient Experience Project: To pilot the use of real time user feedback in *order to seek their views whilst experiencing NLH care in order to be responsive to improve the individual's care experience.*

Patient Safety Project: To introduce a bespoke risk management database

Clinical Effectiveness Project: to scope the service provision for those living with and beyond chronic illness in North London Hospice Outpatients & Therapies Service

The 2014-15 priorities for improvement projects are reported and may have contributed in the following ways: a more social environment for IPU patients and visitors in the Living Room at Finchley; a 17% reduction in falls and a decrease in grade 3 and 4 pressure ulcers developed on the IPU; a 3% increase in dementia patients cared for by NLH and the introduction of palliative care outcome tools to enable us to better review the effectiveness of addressing patient's problems and concerns.

Key service developments are described. The extension and development of community service provision in Haringey following a partnership with 5 local palliative care providers. The collaborative project with Macmillan Cancer Support looking at greater choice and flexibility in provision of care to people at home. The provision of a flexible time limited individual programme for patients attending Outpatients and Therapies Service (formerly Day Services). Refreshed and upgraded patient rooms with improved clinical rooms and the creation of an 18th bedroom on IPU as part of the IPU refurbishment.

Service data is highlighted and discussed. IPU had 295 admissions this year and their average length of stay was 13.6 days. Bed occupancy increased this year to 81 %. 19% patients were discharged from IPU. The Outpatients and Therapies Service cared for a total of 243 patients. The community teams cared for a total of 1299 patients in their own homes and supported 59% of these patients to die at home where this was their preferred place of care. Palliative Care Support Service cared for 279 patients and provided a total of 14, 985 hours of one-to-one nursing care to people in their own homes.

NLH's user surveys revealed that 99% patients were satisfied with our service and 98% would recommend service to families and friends.

The Board of Trustees gives assurance to the public of the quality of North London Hospice's clinical services.

PART 1:
CHIEF EXECUTIVE'S STATEMENT: STATEMENT OF QUALITY

I am pleased to present North London Hospice's (NLH) fourth Quality Account which details the level of quality of care we have achieved in 2014-15 for 1756 patients and their families from our local communities of Barnet, Enfield and Haringey.

I am pleased to report that 98% of patients and 99% relatives who answered our user survey this year would recommend NLH service to a friend. Despite such excellent feedback we are always seeking ways to engage with users and see how we can improve their experience. Our Living Room project has focused this year on addressing social isolation reported by some of our Inpatients last year. The experience is now an*: "Enjoyable time spent with volunteer and enjoyed the music & table games & greatly enjoyed the courtyard."(*User quote).

We are very excited that in 2015-16, a new project will start that will involve trained volunteers interviewing our patients and relatives to see what changes we can make for them then and there to improve their experience. This will reflect two of our 8 core values "Focusing on the individual" and "Being Adaptive and Creative".

NLH's vision is that everyone in our diverse community affected by a potentially life limiting illness has equal access to the services and support they need to optimise their quality of life. NLH carries this out through:

- delivering specialist palliative care
- providing additional support and services to meet individual needs
- sharing our skills and experience to influence others providing care
- maximising and supporting community involvement

All staff work towards meeting this vision through NLH's strategic plan, linked individual staff reviews and department objectives.

This year has seen NLH extend its reach by delivering its day services (now called Outpatients and Therapies) closer to home with the delivery of services at two sites (Enfield and now Finchley). In response to commissioner feedback the service has broadened its referral criteria to include people experiencing challenges as a consequence of having had treatment and or survived a life threatening illness. This year, a new project with users will map existing service provision for our users and, if any gaps are identified, will consider how North London Hospice may be able to address this need.

This year has also seen NLH join a newly formed partnership to provide specialist palliative care services to people living in Haringey. As part of this we now employ the Haringey Community Specialist Palliative Care Team based in Haringey and provide a triage service for referrals.

NLH's education department have trained 223 staff of external organisations like Care Homes, Community Nursing Services, and trainee doctors. This year it has provided new training in communications skills and as part of NLH's Dementia Care Project has delivered dementia training to 83 staff.

NLH as an independent charity makes no charge to patients or their families for care given. It is a testimony to our local community that they continue to support the £6.2 million annual care costs. NLH receives 40% from NHS grants.

NLH Board of Trustees reviewed and approved this Quality Account on ....I, Pam Mc Clinton, confirm that to the best of my knowledge the information set out in the Quality Account is accurate. I welcome any suggestions or comments on this Quality Account and on our care.

Pam McClinton

INTRODUCTION

Quality Accounts provide information about the quality of the Hospice's clinical care and initiatives to the public, Local Authority Scrutiny Boards and NHS Commissioners. Some sections and statements are mandatory for inclusion. These are italicised to help identify them.

North London Hospice (NLH) started to produce and share its Quality Accounts from June 2012. This year's Quality Account (QA) and previous year's QAs can be found on the internet (NHS Choices and NLH website) and copies are readily available to read in the reception areas at the Finchley and Enfield sites. Paper copies are available on request.

OUR CLINICAL SERVICES

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

1. Community Specialist Palliative Care Team (CSPCT)
2. An Out-of-Hours Telephone Advice Service
3. Outpatients & Therapies (OP&T), formerly Day Services
4. Inpatient Unit (IPU)
5. Palliative Care Support Service (PCSS) - NLH's Hospice at Home service
6. Loss and Transition Service (including Bereavement Service)
7. Triage Service

For a full description of our services please see Appendix One.

PART 2:

PRIORITIES FOR IMPROVEMENT PROJECTS 2015-16

The following Priority For Improvement Projects for 2015-16 were identified by the clinical teams and endorsed by the Quality, Safety and Risk Group, Board of Trustees and local commissioners and Health and Overview Scrutiny Committees.

The priorities for improvement projects are under the three required domains of patient experience, patient safety and clinical effectiveness:

Patient Experience-Project 1: Listening and responding to current individual user feedback

NLH would like to pilot real time user feedback to identify what of their current service experience could be improve and act promptly to improve the individual's care experience. Trained volunteers will be used to interact (face to face or telephone) with users during the User Survey completion. The feasibility of using this method of user surveying was reviewed by Hospice UK with Marie Curie Cancer Care and NHS Improving Quality in 2014. Unexpected learning from this study highlighted:

- the value made through the volunteer-patient interaction;
- increasing patient reporting of concerns and wishes;
- the enjoyment of the social interaction.

Baseline:

We currently carry out a user postal survey each year over a 6 month period. Feedback is entered manually into a spreadsheet, analysed after collation of all the survey results, and action taken to develop and improve services where required. In 2014, NLH only received 16 completed surveys from IPU patients with the support of one volunteer. NLH would hope to increase both the number of volunteers involved and completed IPU patient surveys.

Outcome:

Users will be enabled to provide feedback on treatment, care and preferences relating to their current needs. Staff will receive prompt patient feedback so changes can be made to care delivered. Patients will be empowered by volunteers to raise concerns or requests. Patient's social/personal interaction time with volunteers is increased.

Timescale:

A pilot of IPU and OP&TS patients will inform initially potential prospective surveying to these patient groups and then progress to telephone surveying of community patients.

Patient Safety-Project 2: To introduce a bespoke risk management database

NLH is committed to improving the safety of all users of its services, including patients, carers and relatives, as well as all members of staff and volunteers. To support this plan we are working towards introducing a bespoke risk management database which will be developed for the Hospice by Sentinel. The database will provide:

1. A robust, accessible reporting and management system for incidents and complaints
2. A central register of compliments
3. A centralised service specific and organisational risk register
4. Triggers to manage Duty of Candour incidents

Baseline:

At the present time the Hospice has a number of in-house developed Excel spreadsheets which are used to capture the information within the four areas above. Whilst this provides the information needed to manage within these areas, it is a time-consuming process. On 1st April 2015, new regulations relating to "Duty of Candour' came into effect (Health and Social Care Act 2008 (Regulated Activities) Regulation 20. These require health services to notify any persons involved in a notifiable incident which has resulted in death, severe or moderate physical harm or prolonged psychological harm. NLH will carry out a staff questionnaire asking about their experience of incident reporting and whether they are aware of outcomes and learnings.

Outcome:

The new system will enable the Hospice to build on the progress we have made over the last few years in the management of incidents, complaints/compliments and risks, to improve the reporting of these at all levels as well as the monitoring of outcomes and learnings.

Timescale:

The new database is under construction with final amendments being made by the end of May 2015. All data from 1st April will be uploaded centrally by either Service Managers or members of the Quality Team who have been trained on the system by the end of the first quarter. Also during this quarter, individual members of staff will be trained and the system will be rolled out to all Services and staff.

Clinical Effectiveness-Project 3: Developing provision for those living with and beyond chronic illness in North London Hospice Outpatients & Therapies Service

NLH's Outpatients & Therapies Service (OP&T) is considering broadening its reach to include patients who continue to experience challenges as a consequence of having had treatment, and those who continue to live alongside a potentially life-limiting illness – 'survivors'.

Baseline:

Following the broadening of NLH's referral criteria to include the patient group above, NLH have been providing one to one support. NLH have recognised the need to consider other ways of delivering this support through group work or in partnership with other providers. This scoping exercise will map the local services that currently exist in the boroughs of Barnet, Enfield and Haringey, to understand the local resources, requirements and opportunities for service development.

Outcome:

Implement recommendations of Project. If a need is established, develop a service to enable patients to utilize their own coping strategies and self-management techniques, to improve their quality of life. Alternatively, establish a database of local services.

Timescale:

Recommendations will be made by April 2016

STATEMENTS OF ASSURANCE FROM THE BOARD

The following are a series of statements (italicized bold) that all providers must include in their Quality Account. Many of these statements are not directly applicable to specialist palliative care providers such as NLH.

Review of services

During 2014-15, NLH provided and/or sub-contracted 1 service where the direct care was NHS funded and 3 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 2014-15 represents 29 per cent of the total operational income generated by NLH for the reporting period 2014-15.

Participation in clinical audits

During 2014-2015, 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 2014-15 are as follows (nil). The national clinical audits and national confidential enquiries that NLH participated in, and for which data collection was completed for 2014-15, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry (nil). The reports of 0 national clinical audits are reviewed by the provider in 2014-15 and NLH intends to take the following actions to improve the quality of healthcare provided (nil).

To ensure that NLH is providing a consistently high quality service, it conducts its own clinical audits.

The provider reviewed the reports of 4 local clinical audits in 2014-15 and NLH undertook the following actions to improve the quality of healthcare provided.

NLH has taken or intends to take the following actions to improve the quality of healthcare provided:

Summary of completed Internal Audits 2014-15:

Audit Topics	Key Findings	Actions
Audit of anticipatory EOLC drug prescribing in community palliative care patients	44/ 45 (98%) patients prescribed anticipatory EOLC drugs. 35/ 44 (80%) patients prescribed anticipatory EOLC drugs by CSPCT. 2/44 (5%) patients received emergency out-of-hours (OOH) prescriptions. Of note the total cost of anticipatory EOLC drugs as per local guidelines is £26.23 versus the cost of an emergency OOH GP (BarnDoc) home visit which costs approximately £500. <u>Conclusion</u> Excellent results that reflect good prescribing both in terms of timeliness and adherence to guidelines.	Disseminate results to celebrate good practice Community Team to share results at GP Gold Standards Framework (GSF) meetings (all Community Team – ongoing 2014/15) Education Team and Consultants to disseminate results via external teaching sessions (ongoing 2014/15)
Blood Transfusion re-audit	Re-audit of the transfusion pathway documentation RESULTS: good New audit looking at the assessment of effectiveness of transfusion documentation- 7/23 pathways were fully completed. 2/23 were because the patients had died before the evaluations were due to be completed. The results indicate we need to identify why these new sections are not being completed despite training and make changes to improve practice in this area.	Share results and hold session on the blood transfusion assessment for IPU and Community Team Update the training tracker e-learning session to emphasise the assessment sections and to agree if blood transfusion e- learning module should be mandatory for Community Team Modify pathway - to provide clarity of who is responsible for the assessment documentation. -insert a section re transfer of ownership from IPU to named Community Team member Ensure blood transfusion is early part of junior doctors' induction both training tracker and face to face session with auditor.

Hand washing audit	Completed at Finchley and Enfield sites. **<u>Finchley Site Audit</u>** IPU self monitoring - 97% compliance *Kitchen and sluice– This part of observation needs to be extended to provide robust data.* **<u>Enfield Site Audit</u>** Self monitoring - 77% compliance <u>Discussion</u> This was considered a good result given it was the first audit of hand hygiene at this site. It revealed there was variable knowledge amongst the team regarding hand hygiene.	Share results to raise awareness - highlight good and poor practice and reminder of 5 moments of hand hygiene. Signs in kitchen to remind staff and volunteers to wash hands Ensure Uniform and Workwear policy reflect IPC requirements Re-audit at Enfield with observational data collection
CQC (against proposed Fundamental Standards)internal audit of services	49/55 standards met. 6/55 standards partially met.	<u>IPU:</u> Care plans to be integrated with iCare. Draft consent form to be completed Controlled Drugs and infection control audits to be completed. Staff competences adapted and introduced Staff PDRs completion. Recruit to establishment. Introduce outcome measures <u>OP&T:</u> Governance standing item to be introduced at operational meeting.- complete

Research

The number of patients receiving NHS services, provided or sub-contracted by NLH in 2014-15, that were recruited during that period to participate in research

approved by a research ethics committee was 0.

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 2014-15 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework.

What others say about us

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).

This registration system ensures that people can expect services to meet essential standards of quality and safety that respect their dignity and protect their rights.

The Care Quality Commission has not taken any enforcement action NLH during 2014-15.

NLH is fully compliant with "Essential Standards of Quality and Safety" (Care Quality Commission, 2010).

At both the Finchley and Enfield sites, the CQC carried out unannounced inspections as part of a routine schedule of planned reviews. Full details can be viewed at www.cqc.org.uk/node 293531 and www.cqc.org.uk/node/504055 respectively. They observed how people were being cared for, talked to staff and talked to people who used our services. NLH was found to be compliant in all of the areas assessed.

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 2014-2015 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.

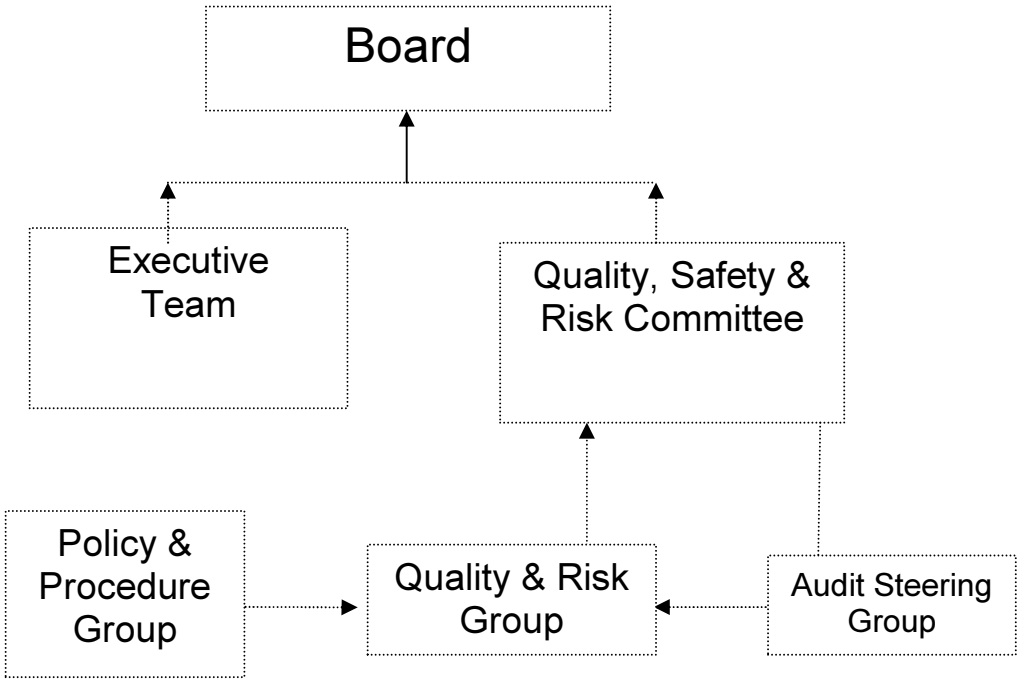
Information Governance (IG) refers to the way in which organisations process and handle information, ensuring this is in a secure and confidential manner. As part of the monitoring of the IG Standards within the Hospice NLH completed the annual IG Toolkit in March 2015 and received a score of 98%. In April 2015, NLH received confirmation that our assessment has been reviewed by the Health and Social Care Information Centre (HSCIC) and has been confirmed as Satisfactory.

NLH was not subject to the payments by results clinical coding audit during 2013-14 by the Audit Commission. This is not applicable to independent hospices.

PART 3: QUALITY OVERVIEW

QUALITY SYSTEMS

NLH has quality at the centre of its agenda. The Executive Team identified "Working together to make a difference to palliative and end of life care in our communities" as its overall strategic aim for 2015-18. There are specific aims and objectives around sustaining and ensuring quality outcomes.



See Appendix Three (page 50) for role description of above groups

KEY SERVICE DEVELOPMENTS OF 2014-15:

Extension and development of community service provision in Haringey

Palliative Care services in Haringey have undergone a period of significant change. Haringey Clinical Commissioning Group worked in collaboration with 5 local palliative care providers to develop a joint proposal for an Integrated End of Life Care system in Haringey that built on good existing palliative care practice in Haringey.

The rationale for joint integration of palliative care services has been advocated for a long time as an answer to meet patients' needs, reduce hospital admissions and also to reduce overall healthcare costs

The range of services commissioned are from one lead NHS provider North Middlesex University Hospital who is accountable for the delivery of all services and holds subcontracts with the other providers for specific parts of the pathway. The other four organisations working together with North Middlesex are as follows; NLH, Whittington Health, Marie Curie, and St Joseph's Hospice.

NLH's role in this partnership is the provision of a Community Specialist Palliative Care Service, an out-of-hours (OOH) advice line for Health care professionals and the development of an integrated Triage service with a single point of access for Haringey referrals. Following recruitment of additional Community Clinical Nurse Specialists the vision is to provide a responsive 7 day a week service and an OOH advice line for patients in Haringey and deliver a similar Community service as we do in the other two boroughs.

Haringey Community staff are now employed by the North London Hospice and are settling into new accommodation at the George Marsh Centre, St Anne's Hospital in Haringey. There is now a new Community Team Leader for the Haringey Community Team and this will support the on-going integration of staff within the organisation yet developing collaborative working with the other palliative care providers.

Enhanced community care provision in Barnet and Enfield

NLH is working in partnership with Macmillan Cancer Support to pilot a model of care that provides greater choice and flexibility following out of hospital care; a rapid response service that supports patients in a crisis; a service that has the ability to support patients earlier on in their pathway and the development of a befriending and good neighbour volunteer service that reaches out into the community

The Rapid Response Health Care Assistants for End of Life care who are part of the Macmillan Specialist Care at Home project have already made a significant impact on caring for patients and their families in the Community. Since August they have been called out to over 70 visits which range from sitting with dying patients for a number of hours or providing urgent hands-on care when patients and families are in a crisis, or being asked to take urgent 'bloods' for patients who have acute symptoms. This is a positive start and although it is in the early stages of evaluation, it is already demonstrating the need for a rapid response service for those patients who are in the unstable or dying phase of their illness in the Community.

Outpatients and Therapies Service (formerly known as Day Services) developments

NLH opened a new and different model of Day Services in Enfield in 2012 to provide a bespoke programme of care for patients with specialist palliative care needs and their carers. On referral following an assessment of need, a flexible time limited individual programme is agreed. Opportunity is provided for those who have completed their planned programme and have been clinically discharged from the service, to attend social drop in sessions.

In 2014 - 2015 in response to stakeholder feedback, the referral criteria were broadened to include those who continue to experience challenges (physical, psychological, emotional, spiritual), as a consequence of having had treatment and those continuing to live alongside a potentially life-limiting illness, 'Survivors'.

In addition, in June 2014 Day Services also reopened at the North London Hospice in North Finchley. Following a review of the service, the name changed to Outpatients & Therapies Service (OP&T) to better describe the service.

Cessation of use of Liverpool Care Pathway

NLH's adapted IPU version of the Liverpool Care Pathway (LCP) and its use in the community was stopped in the summer of 2014 following the recommendation of More Care Less Pathway (2013). The Five Priorities for Care of the Dying recommended in One Chance to Get it Right (Leadership for the Care of Dying People, 2014) are the basis of good palliative care and have always been central to NLH's care. On the IPU the adapted LCP has been replaced by the adapted Intentional Care Rounding tool which includes a minimum 2 hourly review and documentation of dying patients' needs which includes assisting with nutritional and hydration needs or the giving of mouth care if more appropriate. A new Care After Death document which was redrafted from the After Death Care section of the LCP has been introduced to ensure effective administrative tasks are completed, for example that involved professionals are notified of the death. These are linked to new Verification of Death and Care After Death of a Patient on the IPU policies. NLH's Practice Educators, through their work with over 40 care homes across six boroughs undertaking the Gold Standards Framework (GSF) Care Homes Programme, promote individualised care planning using the GSF Minimum Protocol as a guide.

Triage Service

From December 2014, the management of referrals was reviewed. All referrals for all services offered by NLH now come through Triage Service. Triage developed a direct contact with referrers, patients and/or their carers. Patients are receiving more timely and effective care from appropriate services through more integrated NLH service provision and improved signposting of referrals to other services.

Compassion in Practice

Compassion in Practice, the national strategy for nurses launched in 2012, is reviewed regularly by NLH's nursing and facilities group. It has led NLH to benchmark itself against national nursing and quality improvement initiatives. The following are some examples. The NHS Institute for Innovation and Improvement's Fifteen Step Challenge led to improvements in front of house volunteer training, as well as in presentation of areas on view to users and the public. A bid was made to Nursing Technology Fund. Though unsuccessful, this process highlighted NLH's clinical IT development needs which will be sought from other fundraising streams. User information boards introduced in front of house area. Comment cards were amended to include prompts for suggestions. Patient case studies are now presented at each

Board meeting.

Catering provision

NLH undertook a catering review which included a patient survey. Findings indicated a need to review the patients' menu (especially the supper menu) and the visitors' menu to increase variety. There had been a need to use some external agency staff which did not provide a consistent provision. It was therefore decided to outsource the catering service. In November 2014, Valeside, a specialist Hospice Catering provider working within 7 other Hospice environments, took over the catering provision at NLH. This action has enabled us to benefit from Valeside's experience gained over several hospice settings and has enabled us to improve the catering offer to our specialist client group.

IPU refurbishment

Patients and families have enjoyed the benefits of our newly refurbished Inpatient Unit (IPU), with patient rooms refreshed and upgraded to include improved lighting. Staff are finding the enlarged and re-fitted clinical rooms provide a more efficient working environment. The new hard flooring enables the Housekeeping team to ensure rooms are patient ready in a reduced amount of time. The creation of therapy rooms in our OP&T suite enabled us to convert an existing therapy room into an additional ensuite patient bedroom increasing our number of rooms to 18, allowing us to care for a greater number of patients and their families on the IPU

Nursing Workforce Competencies

The Education Department has been working with the IPU, Community Teams and OP&T Departments to develop nursing competencies for all NLH nursing and care staff. The purpose of the competencies is to aid the development of high quality nursing care. The competency model will be used alongside the nurses' Personal Development Reviews.

PARTNERSHIP WORKING

In addition to the clinical service provision, NLH works with voluntary and statutory agencies within the locality in the following ways:

1. NLH is actively involved in local End of Life Boards which work in partnership to achieve local end of life strategies and share best practice.
2. Clinicians attend General Practice Gold Standard Framework meetings which review the care of end of life patients being cared for by individual practice teams.
3. NLH is part of PallE8 a specialist palliative and end of life care expert group for North Central and North East London.
4. NLH is a member of Enfield Dementia Action Alliance
5. NLH is providing specialist palliative care input into Barnet Clinical Commissioning Group (CCG) 'Frail Elderly Multi Disciplinary Team (MDT)'. The initial pilot demonstrated

effectiveness at reducing unnecessary admissions and improving coordination and quality of care. NLH's involvement is to continue.

6. NLH participates in London Cancer's Psychosocial Forum and is involved in the Carers stream. NLH facilitated an event in February on "Illness and Its Meaning" for forum professionals.

7. NLH User Involvement Lead is a member of Enfield Healthwatch's Reference Group

8. In 2013, NLH embarked on some early work with local hospices to benchmark IPU incident data for falls, pressure ulcers and medicine errors. Challenges identified at this stage were around consistency between hospices of how such data is collected and the lack of data analysis resources within small independent hospice organisations. This inter hospice group has however proved invaluable in sharing good practice. Hospice UK (previously Help The Hospices), the national organisation for hospices, has initiated a national benchmarking exercise which NLH joined and has been sharing data in 2014-15. Similar data challenges remain to our local early benchmarking as well as a new challenge of how to interpret differences with small individual hospices' data. NLH plan to employ a new post of data analyst to support this and similar work.

9. NLH's Assistant Director-Quality is working with the Royal College of Nursing (RCN) on two streams: on a Task and Finish Group developing a national nutritional and hydration care resource for nurses and health care assistants (following the recommendation of More Care Less Pathway) and representing the RCN in the Royal College of Physician's review of the National End of Life Audit for Hospitals.

10. NLH is part of the Barnet Integrated Locality Group which aims to deliver care using an Integrated multi-disciplinary approach. Currently, NLH is there in a specialist advisory role to help shape the needs of the model.

11. NLH is working in partnership with Macmillan Cancer Support in its community care provision as detailed.

12. NLH is working with North Middlesex University Hospital, Whittington Health, Marie Curie Cancer Care and St Joseph's Hospice in provision of services in Haringey, also detailed previously.

13. OP&T has developed links in Enfield with two local primary schools, Firs Farm and Highfield. Choirs from both schools have sung to patients at OP&T for the last two years in the run-up to Christmas. Pupils and staff from both schools have also participated in two very successful Art Projects with OP&T patients, facilitated by our Art Therapist and a Volunteer. The project enabled Year 5 and 6 pupils to gain an understanding of different people's lives and experiences, helped dispel anxiety or fears they may have about death and dying and gained an understanding of the services provided by a hospice. NLH patients reported thoroughly enjoying working with the children and found the project 'energizing'. Schoolchildren have raised funds for the Hospice, e.g. running a cake stall at school. Parents have also raised funds and some have expressed an interest in volunteering.The Schools' Art programme continues with a new project in Finchley in April 2015. This will be a collaboration between NLH and our neighbour, the Dwight School.

14. The NLH Education Department works with the University of Hertfordshire, providing placements for their student nurses. One of our Practice Educators sits on the University's Fitness to Practice panel, which assists the university when a student nurse's fitness to practice is called into question e.g. if their behaviour or health raises a serious or persistent concern.

15. Involvement in Pan London End of Life Network meetings. There are several strands to the Network and NLH has particularly been involved in the London Social Care Partnership and have contributed to the development of a charter that local authorities are being asked to sign up to - to deliver standards around commissioning, training and service content around end of life. Skills for Care are also part of the Network and NLH are on the Volunteer Sector Executive Group. The purpose of this group is to identify how there could be a useful and coherent contribution by the very large and diverse voluntary sector around end of life. Initially, it has tasked itself to influence the response to bereavement in the work place across all sectors.

16. The Enfield Community Team Social Worker is now the secretary of the Association of Palliative Care Social Workers and NLH organised a session on the subject of "Mediation in End of Life Work".

EDUCATION AND TRAINING

NLH delivers for external professionals

- A bi-annual 'Introduction to Palliative Care' course aimed at trained nurses and allied health professionals and runs over four days.
- A bi-annual 'Introduction to Palliative Care' course aimed at Health Care Assistants and Support Workers and runs over two days.
- Monthly syringe driver training, assisting nursing homes and district nurses to become familiar with the new CME T34 syringe driver.
- Three times a year we run a session for King's College Medical students, providing them with an insight into palliative care and the role of the hospice.
- As a Gold Standards Framework regional centre for end of life training for care homes, the Hospice has completed three training programmes for over 50 care homes in the boroughs of Barnet, Enfield, Haringey, Tower Hamlets, Hackney, Newham, Camden and Islington. For the homes in the three boroughs we serve, we are now providing facilitation to help them become accredited GSF homes.
- Bespoke training for care homes.

New this year:

- We have run a new course this year, 'End of Life Care and Dementia' that has been attended by 30 internal and 53 external delegates.
- The Hospice now runs Sage & Thyme, foundation level communication training that has been attended by 28 internal and 47 external delegates, held on alternate months.

NLH provides a variety of training placements for:

- Speciality Registrars from Local Educational and Training Board (LETB) - Health Education North Central and East London and Senior House Officers from Barnet General Practitioner Vocational Training Scheme
- Student nurses with the University of Hertfordshire
- Social work student placements with London South Bank University

- Half & one day hospice placements for final year medical students
- Chaplaincy placements
- Work experience for 16 and 17 year-olds wishing to apply for nursing, medical or allied health professional training.
- Erasmus students (European students), one of which said:
  "I feel very privileged to have been given this opportunity to work at the Hospice. For me, it's about the personal relationship between a medical professional and a patient, providing care at a hospice you really feel that personal link ... I now know that palliative nursing is what I want to do with my life."

Induction and Mandatory Training for NLH Staff and Volunteers:

NLH provides an induction programme for NLH new staff and volunteers as well as annual mandatory training. To make this training more accessible and flexible, much of it is now done by e-learning. Additional internal training is also provided for staff.

CARE ENVIRONMENT

On a daily basis the Facilities Team at NLH seek to create a welcoming, pleasant and comfortable care environment, which makes patients, and their visitors feel at ease. Safety and cleanliness are at the centre of our routines. During our most recent Care Quality Commission (CQC) inspection of the Finchley site one of our patients stated, "They clean everything every day and even that is done with care." Another said, "The cleanliness is excellent, the floors are always being mopped and the sinks are cleaned too." The CQC inspector noted the patient rooms and clinical areas were clean and free from clutter. As a team we are delighted that patients are satisfied with the levels of cleanliness in the Hospice. Alongside the need to have a clean environment is our desire to maintain a homely and relaxed atmosphere, little touches such as the volunteer flower ladies who look after our plants and arrange flowers make this achievable.

SERVICE ACTIVITY DATA

NLH sets itself annual targets on activity, some of which are included in the following tables in brackets e.g. first table IPU admissions (NLH target 330). The targets relate to 2014-15 activity only.

In Patient Unit (IPU)

The figures for the IPU have been provided in line with the Minimum Data Set information collected by the National Council for Palliative Care. This data relates to completed admissions by end of March 2014.

ALL ADMISSIONS	2011 TO 2012	2012 TO 2013	2013 TO 2014	APRIL 2014 TO MARCH 15			
				BARNET	ENFIELD	HARINGEY	TOTAL
Admissions to the IPU:							
Patient Admissions (NLH target 330)	304	313	314	166	108	21	295
% Patients with cancer	90%	89%	86%	91%	97%	100%	93%
% Patients with non cancer	10%	11%	14%	9%	3%	0%	7%
Completed in patient stays:							
Total of Completed Stays	327	357	345	162	99	27	288
Total number discharged home (inc care home)	82	89	82	23	24	8	55
Discharged to acute	12	4	7	2	0	1	3
% patients returning home	25%	25%	24%	14.2%	2432%	29.6%	19.1%
Total number of patients who died	233	264	256	139	75	20	234
% patients who died	72%	74%	73%	85.8%	79.8%	70.4%	80.9%

Average length of stay (NLH target 14)	14	12.6	13.3	14.6	15.1	12.3	14.(13.6*)
Day Cases	4	9	8	1	1	0	2

*Average length of stay includes one patient who was in the Hospice for 120 days who died in April 2014 and another patient who stayed for 130 days and died in January 2015. If these patients are excluded from the figures the average length of stay is 13.6

Analysis:

There were slightly fewer admissions this year with 295 versus 314 in 2013-14. Of these admitted patients there was an increase in patients cared for with a cancer diagnosis (86% in 2013-14 to this year's 93%) versus those with a non cancer diagnosis. There was an increase in the percentage of patients who died during their admission to the IPU with 80.9% of completed stays ending in the death of the patient. However nearly 1 in 4 (19.1%) patients was discharged home. The average length of stay remains fairly constant when adjusted as discussed above.

Comment:

The fewer admissions this year (versus previous years) and not reaching NLH's target of 330 IPU admissions, could be attributed to a decrease in available bed days due to IPU refurbishment, more patients staying longer including two patients staying 120 days and 130 days.

The increase in patients dying during their admission may be attributable to an ongoing trend of patients referred being sicker and fewer patients admitted for respite care.

Bed Usage

ALL ADMISSIONS	2011 TO 2012	2012 TO 2013	2013 TO 2014	APRIL 2014 TO MARCH 2015			
				BARNET	ENFIELD	HARINGEY	TOTAL
Bed Occupancy (NLH target 75%)	73%	73%	73%	45.5%	29.4%	6.3%	81.3%
Closed bed days: Refurbishment							596
Closed bed days	156	85	116				75

9% of beds were closed for refurbishment during the twelve months

Analysis:

Bed occupancy percentage has increased from 73% in the last three years to 81.3% this year. As described under Key Service Developments of 2014-15, the IPU underwent a

significant refurbishment which involved all rooms and in patient areas. This accounted for 596 closed bed days. In addition this year there were 75 closed bed days which is less than in 2013-14 and 2011-12 but the same as 2012-13.

Comment:

The bed occupancy increase may be due to the newly refurbished rooms being easier to clean, the hygiene technician's spread of hours of work having been increased and taking more planned admissions at the weekend.

The reason for closed bed days prior to the refurbishment (between April-September 2014) were deep cleaning requirements of rooms where patients with MRSA have been cared for. Other issues included electrical and plumbing issues and electric hospital bed equipment failures.

Outpatients & Therapies Service

	2013 TO 2014	APRIL 2014 TO MARCH 2015			TOTAL
	ALL PATIENTS	BARNET	ENFIELD	HARINGEY	TOTAL
Total number of Patients	184	115	108	20	243
Patient Attendances (NLH target 1665*)	927	490	721	105	1316
Patient Did not Attend		280	513	97	890
% patients with cancer	88%	75.3%	90.9%	95.75%	82.9%
% patients with non cancer	12%	24.7%	9.1%	4.25%	17.1%
Nursing and Therapies session (NLH Target 3300)	621	280	477	62	819
Complementary Therapy session-patient	1638	386	594	116	1096

Description of Data Fields:

Nursing and Therapies activities are any other care provided by Hospice staff and volunteers including Physiotherapy, Spiritual Care, and Nursing; Psychological Therapy (includes Psychology, Art Therapy and Music Therapy).

Analysis:

There has been an increase in total number of patients seen in OP&Ts from 184 in 2013-14 to 243 and a similar increase in patient attendances. More patients were cared for with a non cancer diagnosis 17.1% compared to 12% last year. There has been an increase in Nursing

and Therapies sessions and a decrease in number of complementary therapy patient sessions compared to last year.

Comment:

The number of patient attendances (1316) did not reach its NLH target of 1665 despite a OP&TS Service Promotion programme amongst health professionals. The service wanted to offer more complementary therapy sessions than the existing volunteer complementary therapist model could offer so the Board agreed to appoint a new funded Complementary Therapy Coordinator. The post holder took up post in February 2015 and will enable the organisation to develop the service through amending the level of post registration experience that Complementary Therapy volunteers require as the post holder will provide mentoring, training and supervision of the volunteers. The coordinator will also maintain a caseload, providing a sustained level of service availability.

Community Teams Highlight information

	2011 TO 2012	2012 TO 2013	2013 TO 2014	APRIL 2014 TO MARCH 2015			
				BARNET	ENFIELD	HARINGEY	TOTAL
Total number of Patients	1237	1265	1251	588	517	194	1299
% Patients with cancer	79%	76%	80%	81%	83%	85%	83.5%
% Patients with non cancer	21%	24%	20%	19%	17%	15%	16.5%
Completed periods of Care	864	930	851	525	447	84	1056
Patients discharged from the Service	147 17%	158 17%	179 21%	93 18%	102 23%	20 24%	215 21.5%
Number of Patients who died within the Service	717 83%	772 83%	672 79%	432 82%	345 72%	64 76%	841 79%
Died (%) at home (care home)	56%	55%	58%	56%	64%	59%	59%
Died (%) hospice	24%	22%	21%	22%	14%	9%	18%
Died (%) hospital	19%	20%	20%	17%	21%	23%	19%

Died (%) other	1%	3%	1%	5%	1%	8%	4%
Average number of Visits and Telephone Calls made by the Community Team to each patient during office hours							
Visits	5	5	5.1	5.2	6.	3.2	5.2
Phone calls to Patient/Family	16	12	12	14.6	16.5	8.8	14.9
Phone calls to other professionals	9	12	8	10.8	10.4	5.5	9
Average number of Telephone Calls made out of hours and at weekends to each patient							
Phone calls to Patient/Family	0.5	3	2	0.4	0.3	0.1	0.3
Phone calls to other professionals	0.6	1	1	0.3	0.5	0.1	0.4

Analysis:

The total number of patients cared for by the community team has increased to 1299 from 1251 in 2013-14. There has been a similar percentage of cancer patients (83.5% v 80%) versus non cancer this year compared to last year. The home death rate of patients cared for by the community team is 59%. The average number of visits per patient has remained fairly constant at 5.2 with a higher percentage of phone calls to the patient/family (14.9 versus 12) and professionals (9.8% v 8.5) than in the previous two years.

Comments:

This shows demand for the service continues to increase. The improvements in activity have been achieved despite significant vacancies. It is recognised that community staff prioritise patient care need over the other components of the specialist role e.g. audit and teaching. As vacancies are recruited to, this will be readdressed. Staff have worked smarter with the use of a first assessment pro-forma and experienced administrators are working more proactively to support the Community Nurse Specialists (CNS). The home death rate is increasing year on year and may be attributed to the PCSS and increased awareness of the team and external partners of advanced care planning.

Palliative Care Support Service (PCSS)

	2011 TO	2012 TO	2013 TO	APRIL 2014 TO MARCH 2015

	2012	2013	2014	BARNET	ENFIELD	TOTAL
Total number of Patients (NLH target 400)	188	241	278 (277)	134	145	279
% Patients with cancer	82%	83%	81%	81%	82.4%	82%
% Patients with non cancer	18%	17%	1 (19%)	19%	17.6%	18%
Total hours direct care (NLH target 14589)	8339	9497	16244 (14278)	6286	8699	14985
Home death rate						97.5%
Average hours direct care per patient	44	39.25	58.4 (51.55)	47	60	53.7

Please note in 2013-14 the difference in figures provided in brackets and out of brackets demonstrates the influence of one complex patient cared for on the |PU that also required PCSS nursing care hours. Total year figures are provided out of brackets.

PCSS CARE PROVIDED FOR EACH BOROUGH APRIL 2014 TO MARCH 2015			
	BARNET	ENFIELD	TOTAL
Total hours of care	6286	8699	14985
Health Care Assistants	5813	7578	13391
Registered Nurses	473	1121	1594

Analysis:

It is noted that similar number of patients (279 v 278) were cared for by PCSS this year compared to 2013-14 but more hours of direct care were given (14985 v 14278)

Comment:

This service is delivered within separate NHS commissioned budgets from Barnet and Enfield. It is considered that the complexity of patients referred and the realisation of the volume of

hours of care required to support a patient at home is increasing. This explains the decrease in numbers cared for but the increase in total hours. The high home death rate of 97.5 % (n=158) demonstrates the impact that funds allocated for hands on nursing service contributes to enabling patients to die in their preferred place of death where that is home. The community district nursing services appear to have embedded the use of the service for palliative care crisis and end of life care in their practice.

Supportive Care Team

	APRIL 2014 TO MARCH 2015			
1. Spiritual Care Team (IPU)	BARNET	ENFIELD	HARINGEY	TOTAL
Number of clients in the In Patient Unit	166	108	21	295
Number of clients seen by the Spiritual care Coordinator	123	77	22	222
Number of contacts by Spiritual Care Coordinator	330	215	45	590
Average number of contacts by Spiritual Care Co-ordinator	2.7	2.8	2.0	2.65
Number of clients seen by the Spiritual Care chaplains	101	85	22	208
Number of contacts by volunteer IPU chaplains	696	549	135	1380
Average number of contacts by volunteer IPU chaplains	6.9	6.5	6.1	6.6

	APRIL 2014 TO MARCH 2015			
2. Social Workers Team (IPU and Community)	BARNET	ENFIELD	HARINGEY	TOTAL

Number of clients seen by Social Workers	290	209	58	557
Number of face to face visits by Social Workers	624	352	126	1102
Number of Telephone Contacts by Social Workers	1803	872	194	2869
Average number of contacts by Social Workers	8.4	5.9	5.5	7.1

3. Loss and Transition Service (including Crimson Volunteers)	APRIL 2014 TO MARCH 2015			
	BARNET	ENFIELD	HARINGEY	TOTAL
Number of clients seen by Staff	206	167	26	399
Number of visits made by Staff	505	375	62	942
Average number of visits by staff per client	2.5	2.25	2.4	2.4
Number of clients seen by Volunteers	61	48	12	121
Number of Volunteer Sessions	571	499	83	1153
Average number of sessions by Volunteers per client	9.4	10.4	6.9	9.5

Client=patient or significant others

Analysis:

This is the first year that full data is available so comparison is not possible with previous years.

Comment:

This data shows the significant contribution the Supportive Care Team make to the multidisciplinary care provided by NLH to its users. This ranges from specialist professional support provided by the Spiritual Care Coordinator, Specialist Social Work staff as well as Loss and Transition Staff who offer bereavement support for more complex situations. The team has the expertise to provide more complex psychosocial interventions to patients and families; this includes young people and children in the patient's family. The Social Work Team saw 557 clients with an average of 7.1 contacts. The Spiritual Care Team provides a safe space for patients and family members to explore many of the deep and difficult

questions associated with dying. They make no assumptions about a person and there is no expectation that a person is or ought to be religious. The key question is: how does this person make sense of their illness? What do they need in terms of support? The team never provides 'ready made' answers, but accompanies each person on their journey to find their own answers. Respect, compassion and genuineness are key to this person-centred expression of Hospice care. 295 clients were seen and received on average 2.65 contacts by the Spiritual Care Coordinator and 6.6 by the volunteer IPU chaplains. The Loss and Transition service (see appendix 1 for service role description) saw 399 clients with an average of 2.4 visits by staff and 9.5 sessions by trained volunteers.

SERVICE USER EXPERIENCE:

NLH remains committed to listening to the views of patients, relatives, carers and friends across all of its services. Since 2011 NLH has been sending out Annual User Surveys. Comments cards remain in use. In the autumn of 2014, NLH started to log compliments making data available to meet CQC pre inspection requests. Since 2012 NLH has been gathering patient stories to add richer narrative data to our user feedback. These have enabled us to gain more up to date feedback and as they are not anonymised and enables us to take immediate positive action where needed. This is known as real time reporting and is an area we plan to develop further in 2014-15 with new external funding for real time reporting software and devices.

The following are key performance measures NLH rates itself against.

QUALITY AND PERFORMANCE INDICATORS	QUALITY AND PERFORMANCE INDICATOR(S)	THRESHOLD	OUTCOME 2012-13	OUTCOME 2013-14	OUTCOME 2014-15
Service User Experience	% of patient/carers satisfied with the service	80%	100% (n=87) rated care as satisfactory and above	99% (n=102) rated care as satisfactory and above	99% (n=117) rated care as satisfactory and above
Service User Experience	% who would recommend service to friends & family	80%	98% (n=85) would recommend service to friends & family	98% (n=103) would recommend service to friends & family	98% (n=119) would recommend service to friends & family
Relatives Experience	% of patient/carers satisfied with the	80%	100% (n=138) rated care as	99% (n=116) rated care as satisfactory	98% (n=107) rated care as satisfactory

	service		satisfactory and above	and above	and above
Relatives Experience	% who would recommend service to friends & family	80%	99% (n=216) would recommend service to friends & family	98% (n=119) would recommend service to friends & family	99% (n=104) would recommend service to friends & family

Surveys:

239 (31%) survey responses (similar to previous years) were received from the total of 761 sent to:

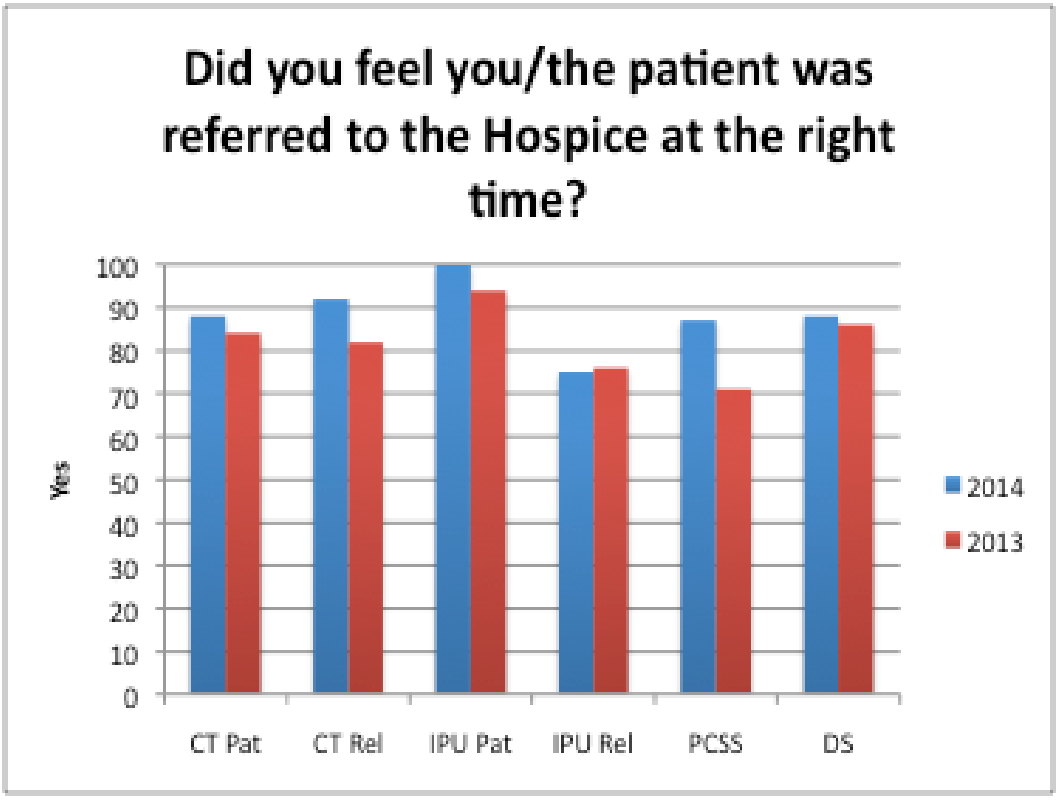
- Community Team patients (CT)
- Relatives/carers of Community Team patients (CT Rel)
- Inpatient Unit patients (IPU)
- Relatives/carers of Inpatient Unit patients (IPU Rel)
- Relatives/carers of patients who used the Palliative Care Support Service (PCSS)
- Day Services (DS) patients

As in previous years, the results have been calculated using the answer Yes/Agreed in any degree (including Sometimes/Somewhat).

Key Performance Indicators

The following three Key Performance Indicators are measured in our annual surveys:

Key Performance Indicator 1


Did you feel you/the patient was referred to the Hospice at the right time?
Yes
100
90
80
70
60
50
40
30
20
10
0
CT Pat
CT Rel
IPU Pat
IPU Rel
PCSS
DS
2014
2013

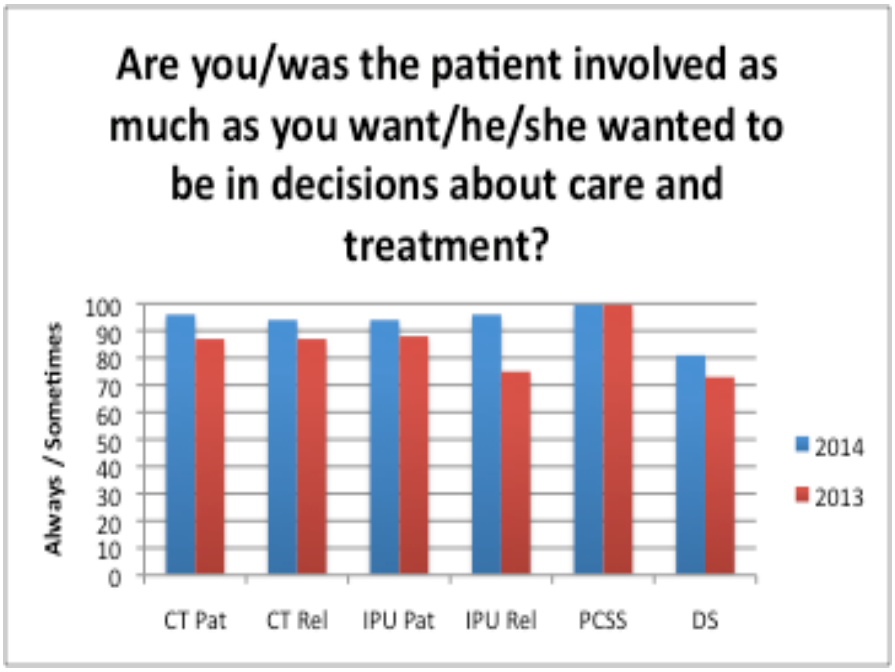
2014

CT Pat	88%	N=64
CT Rel	92%	N=47
IPU Pat	100%	N=16
IPU Rel	75%	N=21
PCSS	87%	N=26
DS	88%	N=30

Analysis:
100% of IPU patients felt they were admitted at the right time, whereas 75% of IPU Relatives felt the admission came at the right time. The remaining 25% all felt that their relative had not been admitted soon enough. 2 Community patients and 2 Community relatives felt that they/the patient had been referred too soon.

Comment:
An improvement in these results is shown in all groups compared to 2013 results, except for IPU Relatives where this is slightly lower at 75%, (n=21). The relatively low IPU Relative response has been raised with the community and hospital teams that refer patients to NLH to try and improve this and also highlighted to NLH's own triage department.

Key Performance Indicator 2



2014

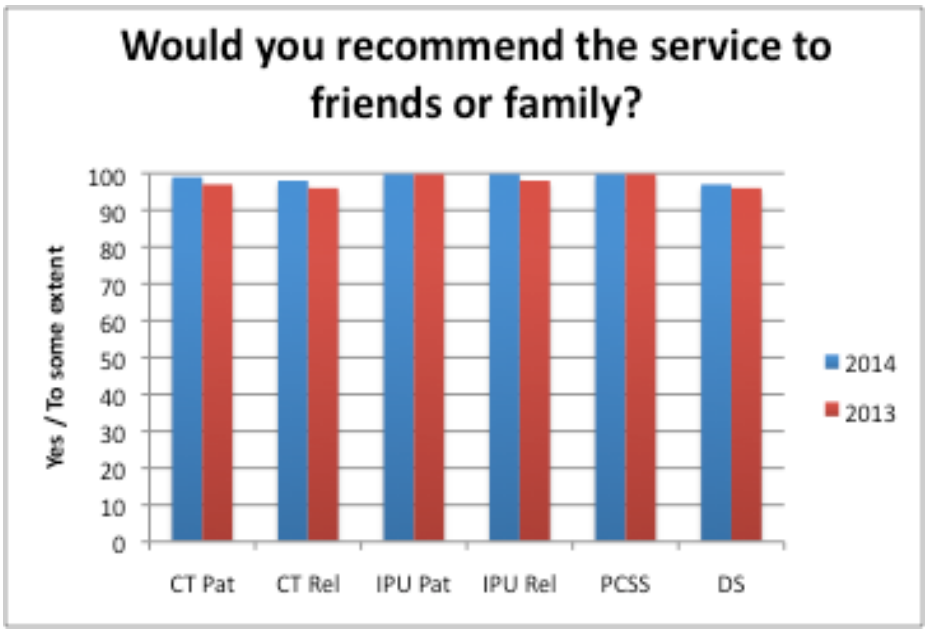
CT Pat	96%	N=67
CT Rel	94%	N=51
IPU Pat	94%	N=15
IPU Rel	96%	N=26
PCSS	100%	N=31
DS	81%	N=25

Analysis and Comment:
2014 has seen an increase in positive responses. One DS patient and one CT relative responded 'Never', however we cannot determine if they felt they wanted to be more or less involved.

The Day Services' team expected their result of 81% to be higher as all patients are informed about what is on offer on their first visit. There is currently no specific leaflet available as it is being updated to reflect the change to Outpatient and Therapies. The team will improve collaborative decision making around planned programme relating to goals.

Key Performance Indicator 3 - NHS Family and Friends test

This question is for all acute providers of adult NHS funded care, covering services for inpatients and patients discharged from A&E. The Hospice has included this question to all services since the first surveys in 2011.



	CT Pats	CT Rels	IPU Pats	IPU Rels	PCSS	DS
2014 n=	74	49	15	26	29	30

Analysis and Comment:
The average of all services has increased from 98% in 2013 to 99% this year. CT Patients, CT Relatives and DS Patients all had one reply of 'Not Sure' to this question.

Survey Comments:

"I was never in this situation before so I would not have a clue how to go about it without help; I could have written pages about the help we got. But I

am not in the right state now, but thanks for everything that the PCSS has done for us: we value every minute of it and appreciate much."

"Patients' food needed a greater variety and improved quality and presentation. Closer monitoring of agency staff, regarding drug rounds, e.g. I found on a couple of occasions, tablets trying to be given when patient had just woken up, and wasn't quite with it. This was unsuccessful and distressing. This was not the norm. It only happened twice while I was there"

North London Hospice (NLH) Response to this User Feedback:
Catering provision is now provided by Valeside, a specialist Hospice Catering provider. Only 19 hours of agency nursing staff were used in 2014-15. NLH has recruited additional nursing bank staff in order to mitigate the use of agency staff.

"The volunteers are highly motivated, caring and outstanding!"

"It has felt very important to find the Hospice. - I now feel I have somewhere "I" not just my cancer is being taken care of. Sadly hospitals don't really understand the importance to feel emotionally held."

"I didn't know what to expect because I didn't know they [Community Team] existed until about 2 weeks ago. I am very impressed & I think they do an amazing job and I am very grateful."

Comment Cards & Emails:

Total received 101

Finchley based services: 80

Themes: High quality of care, kindness of staff, suggestions for fundraising, 2 separate comments about noisy relatives.

"Thank you for all your help with my dad. You made us all welcome. Thank you for making us feel that it was a home from home. Thank you all for the care you showed my dad and my family."

"Families of 10-25 at a time, taking over, being loud, rude and inconsiderate, eating fish and chips and generally encroaching upon the grief of others are really upsetting and all but negate the otherwise excellent service of the Hospice (patient visitor)."

North London Hospice (NLH) Response to this User Feedback:
All visitors can use the space provided - Front of House (FOH) Volunteers /FOH Co-ordinator will manage the area. This is a scenario we use in the FOH training and volunteers should be able to take steps to manage this situation. It will be discussed in the next FOH meeting.

Enfield based Services: 21

Themes: Good welcome, friendly, kind, negative comment about meditation session, positive comments about the Ceremony of Remembrance

"To all the wonderful and caring people who since my coming to the Day Service Unit at Enfield. I was made so welcome by all of you, smiling all of the time, making me feel so good from day one. Thank you is so small a comment to you all on my visits, you will always be very special to me. For all that you wonderful people did during my time with you, your kindness, and wonderful way you have treated me. Thank you Joe, John for bringing me from door to door, not forgetting Peter."

"I went to the meditation group a few times which I quite enjoyed but the last time I went, there was quite a lot of religion involved which I didn't like so I'm trying the art instead"

North London Hospice (NLH) Response to this User Feedback:
Review meeting held with meditation group lead.

"I have had an excellent time. I was grateful to attend the physiotherapy and art therapy sessions. Thank you."

"Last week, before I came here, I just wanted to end it all – there was no point in carrying on. I told my CNS and she thought I should come in here – thank goodness she did."

Example: My wife had been in Chase Farm and came home. It was the weekend and she was in pain. …Everywhere was shut… I was so worked up and then rang NLH. The lady there said I sounded so stressed that she was coming straight out to see me, which she did. You assessed the situation and set up the syringe driver for my wife – the weekend service was brilliant. You made a real difference even though you were only involved for an hour or two – my wife died later that night. I can't tell you how much I appreciate what you did. I could only have called an ambulance and my wife didn't want to go back to hospital."

The comments are passed to Service Management Teams (SMTs) at the end of every quarter for responses and actions.

Case Studies

By giving people the opportunity to tell their own story, we can hear about their experience as a whole and it is often the smaller details that give us greater insight into what makes a difference to patients and families in our care.

Total number of case studies collected in 2014-15 is 22

IPU: Case Study 9 – *"Lovely building, nice food but always cold, relaxing, nice staff, fantastic care, new rooms less cosy and more clinical: reassuring: if I want something I only have to ask: Staff are excellent, volunteers lovely: The cleaners are so nice, they say "Good morning, how are you, did you sleep well?"*

Day Services: Case Study 8 – From patients: *"caring, nice to chat and meet other people instead of looking at 4 walls, lovely volunteers, From a carer : nice to have time to get my eyes tested, go to the bank etc, knowing patient is well looked after."*

Community Team: Case Study 11 – *"Lack of information given, both oral and written*

Care is good from everyone, whoever we speak to. CNS does all the leg work and knows what we need before we do!

She (CNS) does her role with a constant compassion, professionalism and with a huge heart. She always treated us like people she was interested in rather than patients she looked after."

Day Services & IPU Case Study: 1 – *"Lovely volunteers, have some live music, like to sit in the courtyard."*

The case studies are given to SMTS at least at the end of every quarter for responses and actions.

North London Hospice (NLH) Response to this User Feedback:
CT Case Study 11: Staff to be reminded of the Information Policy and Procedure which defines the information to be given out at specific events in the patient's pathway. The admin team are to ensure that packs of leaflets are available for staff to access.

See Appendix… for IPU Case Study example

NLH is committed to listening to the views of patients, relatives, carers and friends across all services. We will continue to ensure that staff across the organisation consider these views when evaluating and developing services.

COMPLAINTS

Quality Performance Indicator	Threshold	Outcome 2011-12	Outcome 2012-13	Outcome 2013-14	Outcome 2014-15
Number of Complaints (NLH targets less than 30)	25	31	19	34	18

Quality Performance Indicator	Outcome 2011-12	Outcome 2012-13	Outcome 2013-14	Outcome 2014-15
Investigations completed, complaint upheld/partially upheld	21	13	18	12
Investigations completed, complaint not upheld	4	1	7	0

Analysis:

18 complaints were received in 2014-15. No complaints were referred to The Parliamentary and Health Service Ombudsman. 14 related to clinical care given and 4 related to our charity shops. Of the 14 clinical care complaints, the common themes were:

- communication (2)
- managing expectation (2)
- care quality (10).

The following are some examples of actions taken following completed investigations (12) this year:

- The scope of the out-of-hours service provision is to be clarified in the Community Team Leaflet.
- Additional training for IPU volunteers, specifically around boundaries

In light of the complaints about communication received in 2013-14, the Learning and Development Steering Group have reviewed the communication training needs of NLH staff and recommended that all staff should undertake Sage & Thyme training and all nursing staff Band 6 and above should undertake Advanced Communication Skills training. 28 NLH clinicians have received Sage and Thyme training this year.

This year we have separated critical feedback from Formal Complaints.

PATIENT SAFETY

Incidents

	2011-12	2012-13	2013-14	2014-15
Total number of Incidents	207	279	250	216
Total Number of Clinical Incidents	147	168	173	152
Clinical Incidents as a percentage of total number of incidents	71%	60%	69%	70%

Analysis:

- There is a decrease in the total number of incidents for 14-15 (n=216) data compared to 13-14 (n=250) and 2012-13 (n=279).
- There are a similar number of percentage of clinical incidents of total number of incidents of 70% for 14-15 () data compared to 69% in 2013-14.

- Comparison of patient related incidents:
    - Increases noted in
        - contact with a hazard from 0 to 1
        - premises and estates from 0 to 1
        - confidentiality from 1 to 2
    - Decreases noted in
        - Admission/discharge and transfer to 3 from 5
        - drug errors reduced to 19 from 25
        - 10 errors were missed administrations
        - 1 error involved giving a prescribed medication that was not needed at the time
        - 1 wrong medication to wrong patient
        - 1 anticipatory prescription not done so delay arose when medication needed
        - 4 right drug but wrong preparation
        - 1 wrong drug administered but immediately noted and changed
        - 1 under dose of right medication given
    - Patient information reduced to 2 from 4
    - slips/trips and falls reduced to 49 from 61

A new "safeguarding" category was introduced into the incident categories this year to aid closer monitoring through governance where learning from individual cases is examined and shared. There were 6 such cases. All cases were discussed with NLH's safeguarding lead (or deputy in absence) and NLH and statutory processes were followed.

Comparison of category of clinical incidents

	2013-14	2014-15
Major	6	5
Moderate	60	53
Minor	62	68
No effect	45	26

Of the five major clinical incidents:
1 missing clinical notes of a patient.

1 RN in a care home refused to repeat a prescribed medication for a patient distressed in last few hours of life
1 patient admitted to IPU with a grade 3 pressure sore
1 patient admitted to IPU with a grade 4 pressure sore
1 patient disclosure of safeguarding issues

Falls:

	2011-12		2012-13		2013-14		2014-15	
Number of Patient related Slips/Trips/Falls (% of all incidents) (NLH target less than 65)	57	28%	60		61	24.4%	49	22.7%
Falls per 1,000 occupied bed days	12.9		13.45		13.7		9.75	

Analysis:

The number of falls per 1000 occupied bed days this year has fallen compared to previous years. This is despite having one patient who fell 9 times in quarter 1 of 2014-15 (18 % of all falls).

Comment:

Higher incidences of falls in hospices are recognised due to the deteriorating condition of hospice patients. Confusion, unsteady walking, deteriorating continence and patient's personal struggle to accept the limitations of their illness are common contributory factors. NLH has safety measures in place to prevent and minimize the impact and frequency of these and is committed to ensuring best practice. This year the introduction of Care Rounding reported on page… may have contributed to a reduction in falls. NLH's Falls Policy and Procedure and Bedrails Policy were reviewed this year alongside a new assessment process combining manual handling and bed rails assessment and an amended falls assessment tool and patient information leaflet. NLH's physiotherapist now reviews all falls incidents. This ensures a consistent objective review of falls incidents, monitoring of adherence to policy and procedure and ensures patients reviewed by physiotherapy service.

Pressure sore monitoring and reporting

Summary of pressure sores reported April 2014 to end of March 2015

	2013/14		2014/15	
	UNAVOIDABLE	AVOIDABLE	UNAVOIDABLE	AVOIDABLE
Developed Grade 3 more than 72 hours of admission	9	0	6	0
Pressure Sores developed Grade 3 more than 72 hours of admission per 1000 Occupied Bed Days*	2.02	0	1.3	0

*Occupied bed Days April to March= 4727

Explanation:

NLH's services and governance systems scrutinise pressure sores that develop 72 hours after admission to NLH IPU. It is agreed nationally that the most likely cause of such pressure sores relates to care provided within the healthcare setting the patient is in i.e. NLH. The identification of such sores is reported through NLH's incident process as well as externally to local tissue viability nurses and Safeguarding teams. NLH has introduced in-depth case review called "Root Cause Analysis" or abbreviated commonly to "RCA" which are undertaken in house and scrutinised by NLH's governance systems described in Part 3-Quality Systems and Appendix Three. A judgement was made by the investigator leading the RCA as to whether the pressure sore development was considered avoidable or not. Please see Appendix 4 for definition of avoidable and unavoidable pressure sores.

Analysis:

There have been less grade 3 or 4 pressure ulcers this year compared to 2013-14. 5 of the above were grade 3 pressure sores. 1 was a grade 4 pressure sore. All were reviewed and deemed "unavoidable". This could be equated to a decrease in admissions however there has also been an increase in IPU bed occupancy.

Comment:

This year, through the Hospice UK In Patient Unit Quality Metrics work, we have been able to benchmark acquired grade 2 and above pressure sores incidence with other similar size hospice IPUs. The available data for the first three quarters show NLH IPU population has a lower incidence of avoidable pressure ulcers (0 vs 3.8, 6.9 & 9.9 per 1000 OBDs) in Quarters 1/2/3 when compared to similar size hospice IPUs. However, NLH has a higher incidence of total pressure ulcers per 1000 OBDs of hospice acquired grade 2 and above pressure ulcers (4.5 compared to 2.7 in quarter 3). NLH are not able to ascertain why this is so but will continue to monitor and ask the question 'why?'

Infection Control

QUALITY AND PERFORMANCE INDICATOR(S)	NUMBER 2011-12	NUMBER 2012-13	NUMBER 2013 –14	NUMBER 2014-15
The number of patients known to be infected with MRSA on admission to the IPU	2	4	3	7
The number of patients known to be infected with Clostridium Difficile, Pseudomonas, Salmonella, ESBL or Klebsiella pneumonia on admission to the IPU	0	0	2 with known Clostridium Difficile	1 patient known to have Vancomycin Resistant Enterococci
Patients who contracted these infections whilst on the IPU (NLH target 0)	0	0	0	0

NLH notes patient's infective status on admission and tests where clinically indicated. The clinical team agrees, on an individual basis, what is the most appropriate treatment plan, if any, depending on the patient's condition. During 2014-15 there were no cases noted where patients contracted reportable infections whilst on the IPU.

PRIORITIES FOR IMPROVEMENT PROJECTS 2014-15

The following priorities for improvement for 2014-2015 were identified by the clinical teams and were endorsed by our internal governance structures.

The priorities for improvement are under the three required domains of patient experience, patient safety and clinical effectiveness:

Priority One: Patient Experience: "The Living Room Project"

Initial Plan:

IPU Patient A: *"The worst bit is being stuck in my room but I do get taken out for walks around the grounds in a wheelchair and I do have lots of contact with staff and volunteers."*

IPU Patient B: "I have previously been in another hospice where there was a Day Centre in the building and I could join in. It makes the place seem more lively and better than being in my room all day. It takes my mind off the pain. If I sit up I'm in pain so I can't sit and read or type for very long but if I was interacting with others I'd be more distracted and not thinking so much about how I'm feeling. I'd like to play board games. I feel a bit isolated in my room although I am used to being on my own."

We received feedback from a number of IPU patients, indicating that patients who were active and mobile were feeling isolated, lonely and bored. People staying in the IPU could previously attend the Day Centre during their stay but this service was moved to the Hospice site in Enfield during 2012. Inpatients said they would like more interaction with other patients/visitors which was reiterated by patients who attended Day Services at our Enfield site. They said that they found great benefit from meeting and being able to chat with other people in a similar position.

We wanted the newly refurbished reception area at our Finchley site to be used by patients and visitors however they wished. We also wanted to bring in local community groups to see the work of the Hospice and offer them fundraising and volunteering opportunities as well as encouraging them to contribute to social events or activities for the benefit of our users.

User feedback was a key factor in determining how the space would be used in the future and what would be provided there.

This was our original project plan:

TIME	ACTION PLANNED	STATUS
March 2014	Log of events in place. 6 in office hours events planned by steering group. Staff informed of project & engaged	Achieved
June 2014	6 in office hours events held and user feedback gained to develop future events programme	Achieved
September 2014	Regular events delivered according to user feedback need. Physiotherapy exercise/class started. 3 community groups to have visited and discussed how they can work collaboratively with the hospice and its users in the Living Room	Partly Achieved
December 2014	Plan for out of hours events agreed	Not Achieved
March 2015	7 further community groups to have visited. Community groups interacting with users in Living Room	Not Achieved

March-June 2014 Actions:

Steering group cascaded project plan to staff and users

Log of events commenced

Communal dining of IPU and OP&T patients and visitors with volunteers and staff commenced.

Daily (weekdays) Tea at 3pm started

Other events held:

- 8 x singers
- 1 x Magician
- Television brought out for Wimbledon/ World Cup.
- 2x Comedy DVDs played

Feedback:

"Didn't know you had events like this: lovely, a nice diversion, surprising"

"Should have more light music"

"Something to take our minds of the stress"

July-September 2014 Actions:

Tea at 3pm continued

OP&T commences social group on Thursdays

Events – 1 singer

4 Community Groups visited the Living Room

- Hornsey Girls School
- Chase Community School
- Barnet Lions
- Heroes for Helen

During this period the Inpatient Unit was undergoing refurbishment with a number of bedrooms closed. Therefore there were less visitors and access was often difficult. Because of this we offered fewer entertainment events but we continued with the weekday Tea at 3pm.

Feedback: "*Enjoyable time spent with volunteer and enjoyed the music & table games & greatly enjoyed the courtyard*."

October - December 2014 actions:

Weekend Tea at 3 commenced.

Events: - 2 music events

4 Community Groups visited the Living Room

- Sainsbury's (Head Office)
- Sainsbury's (Golders Green branch)
- Metaswitch
- Local Cubs

Feedback: "*So unexpected - didn't know something was going on. Just came out for the tea. I love this space - love to come out here."*

January-March 2015 actions:

Daily Tea at 3

Events – weekly informal harp/xylophone/piano music provided by OP&T volunteer

2 Groups visited the Living Room

- St James (Corporate Supporters)
- Representatives from Fortismere School

Feedback: "*The Living Space is nicely laid out with comfy chairs – there's no need to spend lots of money making it any better."*

End of Project Review:

Tea at 3. This gives patients and visitors an opportunity to come out of their rooms and mix with others in the Living Room space, with a complimentary hot drink and a tasty morsel. A dining table is laid out with a lace tablecloth, pretty china and homemade cakes. If there is no entertainment scheduled, volunteers will sometimes put the radio on for background noise, following positive user feedback. Tea at 3 is now firmly established and happens every day. On most days there are family members and visitors present, often along with the patient. The event is well publicised and volunteers make sure that visitors are aware of it.

"*Tea at 3 is a good idea. When I went home after my first stay here, I was thinking about coming back sometimes to have the Tea at 3."*

"The tea is very much appreciated. Lovely cake and company."

Entertainment. Music events and other entertainment are well received and we will continue to provide this. Sometimes the number of people in the audience is very low or even non-existent (depending on the patients we have at the Hospice), which we have to bear in mind when inviting artists. Following user feedback we have been trying to increase activity in the area. We have also received feedback that some people would prefer quieter spaces and not everyone wants to be 'entertained'. We are now more mindful when organising events that we also need to provide quiet places for those who require them.

"*We weren't ready for a magic show or anything similar really. We opted not to watch."*

OP&T. Volunteers encourage patients in the IPU to join in the social activities that happen every Thursday. There is a meditation group, informal art group and informal music group. We now also have a few patients that come on a Wednesday for social interaction although it is not as busy as Thursday. Patients and carers are interacting with others which encourages inpatients and their families to join in when they are able. Because of this, people from the Inpatient Unit are now using the Living Room throughout the week, not just when OP&T are operating.

"*You get fed up sitting in your room, you need something else as stimulation. I like to talk, not to play scrabble or games, just to mingle with other people. The more you mingle, you hear about other people's ailments, sometimes worse than yours and that makes you feel that things perhaps aren't that bad."*

Community Groups. We have yet to see these groups engaging with

patients and families although they are encouraged to use the area whilst these events are happening. When a school or other group is providing entertainment, then the interaction is more obvious.

Exercise class. Due to staff changes, the planned exercise class has been postponed until a new permanent member of staff has been appointed.

Challenges:

- Providing a variety of events
- Providing events out of office hours
- Facilitating IPU patients to eat together in the Living Space
- Encouraging groups to use the area and engage with patients and families

Unfortunately, despite requests via Twitter and Facebook, it is proving difficult to provide regular entertainment. We will continue to look for suitable entertainment as it is so popular.

We are currently providing entertainment on weekdays only. We made one attempt on a Sunday but as only Front of House volunteers are on duty at weekends, they have no-one to liaise with, apart from IPU staff who are busy with patient care. Despite our best efforts to ensure the event ran smoothly, it caused many problems so it was decided that we would not pursue weekend entertainment for the moment. We will look at this again at a later date. Tea at 3 is popular at the weekend.

For inpatients, outpatients and visitors, having lunch together remains popular. We had hoped to be able to offer this throughout the week, not just on the two social activity days, but currently there is still only one volunteer who seems to be able to facilitate this. This is an area that will continue to be looked at.

Conclusion:

The Living Room Space is now becoming much busier and during the day it is rare to find it empty. OP&T have brought more people and activities into the space. The two days when the OP&T Social programme is running have brought about the most change.

Because they are now meeting in the Living Space, patients from the IPU are getting to know each other and socialising, sometimes in their rooms.

We have seen many instances of patients being taken in their beds into the Living Space and the courtyard, sometimes more than one at a time, with interaction between the families.

The Living Room offers much more than space for patients and their family members to access hospice services. It allows them to offer support, care and help to one another. Many patients have commented on the positive emotional and human impact of being with others, sharing ordinary non-health-care related activities which, even for a short while, expands their world beyond sickness, back into something they want and recognise.

The work that has developed over the year will be sustained by the Front of House Co-ordinator and User Involvement Lead. We will now focus on the user experience within our open spaces at our Enfield site.

The Living Room project certainly seems to have fulfilled its mission of giving IPU patients a chance to socialise and alleviate isolation. In addition to this, other visitors are enjoying the space and using it as they wish.

"This place is lovely and the staff are all wonderful. I'm so amazed with the room and the open space. When you first come in, it's so comforting."

Patient Story: Patient has been staying in the Inpatient Unit for a couple of weeks and likes to spend time socialising in the reception/living room area.

"When I was in the Royal Free Hospital and they told me that I could come to the Hospice, I imagined that there would be dark, little cubicles there, religious statues and candles.
I got out of the ambulance and thought to myself, ' Heavens, this cannot be' – I was so surprised. I wondered what my room would be like – everywhere looked so comfortable. The staff were so friendly. You never see a nurse here with a long face. I'd not been in 5 minutes when someone came in and said "Hello". How did they know who I was so quickly?

I came out into the open area to have a look round and someone explained the outside area. The staff were very helpful and understanding. I was very hesitant and apprehensive and feeling quite 'down'. I had a few tears and said some prayers – my faith is pretty strong. After 3 or 4 days I began to relax and my spirits lifted. Being at the Hospice has given me my confidence back and I feel able to face tomorrow, when I have an appointment at the hospital.

When I first came in, the doctors took all my tablets from me. I have to take my medication on the dot or some of my symptoms start up so I rang the bell and asked for my pills that were due. Someone came along and said that they were looking at my medication now and it would be along in a moment. 10 minutes went by and still no tablets so I rang again. I got the same answer and I said that I wasn't asking for anything I shouldn't be having.

Eventually after another 10 minutes my tablets were brought to me. Luckily that hasn't happened again as I need to keep my symptoms under control.

Once I was in reception and thought I'd better go back to my room as it was time for my pills. Someone said that I should stay where I was and the nurses would come and find me and they did!

One day I went into the Room of Quiet to pray but there was a group of people talking outside so it wasn't quiet and I could hear every word. I gave up and went back to my room – that was disappointing.

When people are on their mobiles in the rooms and the door is open, it is very disturbing. Sometimes bereaved families congregate outside my room and there are children running up and down the corridor.

I like coming out into reception and talking to the receptionists.
I saw some nurses sitting at the tables, having their lunch and I thought that was a good idea and something I could do. The food is nice but never hot. The soup is always cold. I've had a cooked breakfast twice and both times it was cold.

The volunteers are very nice, even if they give me a soup spoon to eat my porridge with or forget my tea! And no-one tells me off for keep ringing the bell.

I enjoyed the harpist the other day. Would like to see a string orchestra and a film – perhaps a history of the Hospice. I wasn't going to come out for the afternoon tea today as there was a film starting on the telly, but I decided to after all.

In the open space the chairs are too close together for private conversations but it's a good idea to be able to wheel beds out into the garden.

I find it very relaxing at the Hospice and want to stay a little bit longer."

North London Hospice (NLH) Response to this User Feedback:

The following actions have been taken to address some of the points raised in this case study:

- teaching regarding importance of timing of Parkinson's medication incorporated into the ward rounds and MDTs
- continue working with the living room group to develop activities in the living room space
- New catering company engaged
- Re: Noise outside the Room of Quiet – the reception volunteers are

given training which includes scenarios about how to assess the impact excess noise might be having on other users and offering them alternative, quieter places to sit.
- Chairs too close together – We have now purchased some high back furniture which improves privacy in the area. Also the furniture can be moved around or meeting rooms can be made available for private conversations.

Priority Two: Patient Safety: To ensure fundamental care needs are met and evidenced through structured intentional care rounding and improved documentation on IPU.

The priority for improvement project, commenced in the autumn of 2013 on introducing Intentional Care Rounding (IC) on IPU (see page 43), was extended for 2014-15 as NLH had seen benefits in patients identified at high risk from falls and pressure sores.

NLH wanted to introduce this initiative to:

- Reduce incidence of falls. NLH Quarter1 2013-14 figure =17.5 falls per 1000 Occupied Bed Days* (OBDs) (n=19/13) was taken as a baseline. The objective was to reduce falls to range between 6.5 (NPSA benchmark*) and 12.5 falls per 1000 OBDs.
- Improve documentation of continued patient monitoring
- Food and drink being within reach and received where appropriate or mouth care offered when oral nutrition was not appropriate. The objective was that there would be 100% documentation of this.
- Pressure area positional changes. The objective was that there would be 100% documentation of appropriate position change.
- Consider the benefits of IC for all patients including patients in their last few days of life.

* Occupied bed days: bed is occupied by a patient at midnight

* NPSA benchmark: National Patient Safety Agency national benchmarking figure for NHS falls

<u>How we hope to achieve this</u>

The IPU team planned to continue with the momentum of introducing IC gained in the autumn of 2013 (to a staff selected high-risk group of patients). In the spring of 2014, a revised checklist was to be created (which will be relevant to the care needs of patients in their last few days of life also) so IC could be introduced for all IPU patients.

In 2014-15, NLH adapted IC checklist was to be piloted in one of two teams

on the IPU. The use of the checklist in achieving the above stated objectives was to be monitored and the value of IC for all patients on IPU evaluated in the spring of 2015.

TIME	ACTION
April 2014	Adapted tool introduced to IPU staff and planned Red Team (9 beds) three month pilot
May 2014	Pilot commences with quarterly review
August 2014	Review of pilot. The IPU was refurbished June-September 2014. This required beds to be closed in rotation; this meant that a full pilot was not achieved for the Red Side of the Unit Beds 9-17. However the Care Rounding Tool continued to be used for patients assessed as a high risk of falls or Waterlow greater than 10. The Care Rounding Tool was adapted to include assessment of agitation on 01/07/2014 and the Unit is now using Version 2.1. A review was completed in October 2014 that showed a reduction in falls comparing reported fall for Q1 and Q2 2013 but an increase in reported Grade 2 pressure ulcers, that were a combination of patients admitted with the ulcer, acquired prior to 72 hours of admission and those acquired on the unit. All have been identified as unavoidable.
October 2014	The Pilot has commenced on the Red Side of the Unit Beds 10-18, with patients at risk on the Blue Side also included. The Care Rounding Tool version 2.1 will be kept in the patient's room for completion
December 2014	Review of Pilot. Introduction of Care Rounding tool for every patient admitted to the unit from January 2015
March 2015	Final Review

<u>Final Pilot Review.</u>

A selection of patient records where reviewed as part of the final review of the introduction of Intentional Care Rounding on the Inpatient Unit. Each patient record that was reviewed had IC documentation in place for each day

of the patient's stay on the unit. The intended review areas including the patient's access to food and drink and mouth care showed adherence to completion of all tool prompts. However, the review of the documentation identified that not all records were 100% complete. The review highlighted that during the late shift between 8pm and 10pm completion of the documentation was more sporadic. Staffing requirements on the IPU for the late shift are now being reviewed.

Slips, Trips and Falls

In 2013/14 there were 61 patient related slips, trips and falls on the Inpatient Unit, representing 13.2 falls per 1000 occupied bed days. This figure has reduced in 2014/15 to 49 patient related slips, trips and falls equating to 9.75% falls per occupied bed days. 2014/15 has seen a 19.7% reduction in falls compared to 2013-14 data. In the first quarter of the year one patient had 9 repeated falls recorded throughout the admission despite close monitoring.

Pressure Care

There has been a decrease in Grade 3 pressure sores developed after 72 hours of admission to IPU from 10 in 2013/14 to 5 in 2014/15. However, there has been an increase in Grade 2 pressure sores developed after 72 hours of admission from 4 in 2013/14 to 5 in 2014/15.

Following the final review the IC document will be further amended so that it is documented whether the patient was in bed or sitting in a chair when the documentation was completed in order to monitor the length of time patients are sitting out of bed.

It appears that the Intentional Care Rounding is having a positive impact on the incident of slip, trips and falls and there has been a decrease in the number of grade three acquired pressure ulcers. The IC documentation will be updated and its use will continue on the IPU with ongoing monitoring of its use by the IPU Nurse Management Team.

Priority Three: Clinical Effectiveness:

Project One: Dementia care

At NLH we want to make a real difference to the lives of people with dementia and their carers by building on the National Dementia Strategy (2009) and the Prime Minister's challenge on dementia (2012).

There is a real opportunity to build on this nationally led momentum to improve our services and extend our reach to a wider community. This will impact on our IPU, supporting people in the community and providing specialist training and education to care homes.

Baseline:
Currently we accept referrals for patients with dementia as their primary diagnosis in addition to those with dementia as a non primary disease. Up until now, there has been no NLH Strategy in relation to meeting/responding to the increasing needs of this patient group. One of NLH's palliative care consultants has been funded to attend Barnet CCGs frail and elderly MDT pilot where a significant number of patients have dementia.

A review of NLH patient primary disease activity has revealed that in 2013-14, 60 patients, out of a total of 1409 patients seen across the Hospice, had dementia. This represents 4% of patients. Across the services, 11 of the 60 patients were seen by two services. Below is the breakdown of patients cared for by each service:

- IPU 5
- Day Services 0
- Enfield CNS 28
- Finchley CNS 26
- PCSS 12

It can be seen that the majority of patients with a dementia diagnosis are cared for by our community services.

We hope to achieve this by doing the following:

- Providing dementia awareness sessions for all staff and volunteers.
- Providing different levels of dementia training for staff according to identified needs.
- Training key NLH staff to become Dementia trainers who can then deliver further training.
- Delivering external dementia training to care homes and district nurses.
- Working in partnership with the Enfield Dementia Action Alliance initiative.
- Using the Kings Fund Dementia Friendly Assessment Tool to enable us to assess our current environment and help identify areas that need modification. We will then use this information to inform the IPU refurbishment plan. The assessment tool can then be repeated to ensure we have addressed the issues relevant to our care setting.
- Trialing a clinical assessment tool on the IPU for monitoring dementia the symptoms of dementia patients on the IPU who are unable to communicate verbally.

TIME	ACTION	April 2014 - March 2015

April 2014	Commence development of programme of 3 levels of dementia training for staff	Two of the three levels of dementia training for staff have been delivered in February & May 2014. These sessions are to be repeated in February & March 2015. Level 3 training completed in March 2015.
	NLH Dementia Group to attend Dementia Awareness Train the Trainers Course	Dementia group have now attended Train the Trainer Course
	NLH develop partnership with local and national cross sector dementia initiatives e.g. Enfield Dementia Action Alliance	NLH attend meetings of Enfield Dementia Action Alliance on a regular basis - meetings have not been attended this quarter due to clashing with other events. NLH have kept up to date with the minutes of meetings and hope attendance will be possible in the coming quarter
	NLH consultant to become Dementia Champion and attend Dementia Champion Training	Achieved and 2 practice educators have now trained as Dementia Champions and ways to incorporate Dementia Friends into existing training are being explored
	IPU Team to use Dementia Friendly Site Assessment Tool to self assess IPU and develop action plan	Completed
September 2014	NLH consultant to deliverer teaching on IPU Assessment Tool for people with dementia prior	Delayed as below, but due to commence in March/April 2015

	to trial of tool	
October 2014	Trial of IPU Symptom Assessment Tool for people with dementia	This pilot has been delayed due to staff changes on IPU, but is due to commence with new IPU leads in March/April 2015
January 2014	Effectiveness of Assessment Tool evaluated	Delayed, as above
March 2015	NLH Dementia Group to have delivered Awareness Training Sessions at 3 levels to staff and volunteers	Achieved Dementia training has been attended by 43 internal & external delegates over this year Additional and new Dementia Friends Sessions to run from April 2015 for internal and external delegates including local lay community

Of NLH's 1756 individual patients cared for in 2014-15, 122 patients' primary diagnosis was dementia. This is 7% of the total number of patients cared for. This is an increase from last year of 3%. Perhaps if this is an early outcome of raised awareness of the needs of EOL dementia patients for specialist palliative care services. NLH remains committed to responding to the needs of dementia patients. NLH's Dementia Champions will continue to review and develop the organisations approach. It will continue with its dementia training and are persuing funding opportunity from Hospice UK around Hospice Enabled Dementia Care

Project Two: Introduction of a suite of outcome tools

Project Two was amended from the introduction of the Holistic Needs Assessment (HNA) Priority for Improvement in light of two factors that are influencing the approach that the Hospice needs to take to the use and introduction of a patient outcome tool.

In June 2014, Hospice UK in collaboration with The Dame Cecily Saunders Institute introduced the Outcome Assessment and Complexity Collaborative Suite of Outcome Measures. The measures have been identified in order to support hospices in the commissioning environment and to provide opportunities for benchmarking hospice services.

NLH commenced the Specialist Palliative Care at Home project in conjunction with Macmillan on April 2014. As part of the project the service is being evaluated by Nottingham University. A number of outcome tools form part of the evaluation of the project, which will take place between January and December 2015.

It is believed the introduction of the primary alternative outcome tool, The Integrated Palliative Care Outcome Scale (IPOS), will still enable the organisation to achieve:

- Improved understanding of patient stress/need
- More accurate record of patient stress identified by patients and carers in care plans
- Systematic way of ensuring patient defined need is included in MDT meetings – ensuring that the results of the completed patient outcome are taken into account in the decision making process
- A clearer mechanism for internal referral from staff qualified to assess psychosocial need (nursing and medical staff) to Supportive Care staff specifically trained to work with greater complexity in this area.
- A mechanism that will assist Clinical Supervision Development, i.e. to help practitioners identify psychosocial complexity and their need for support to address this.

The organisation will now implement, rather than pilot, the following tools across all services/teams:

- Integrated Palliative Care Outcome Scale (IPOS)
- Phase of Illness
- Palliative Performance Scale (PPS)

Revised Action Plan:

COMPLETED BY	ACTION
September 2014	• Meeting of the Priority for Improvement Project Group to discuss the rationale for the change • Evaluation work stream for the Specialist Care at Home Project Established

October 2014	• Meeting to ascertain the IT requirements for implementation of the outcome tools
November 2014	• Commence briefing and training with staff • Commence IT development
December 2014	• Continue training and use of tools
January 2015	• Commence use of tools across the organisation • Training completed with the Barnet and Enfield Teams and the Macmillan Project as planned. • The Haringey Team joined the organisation in December and they are continuing to familiarise themselves with iCare, will look to introduce to them from April 2015 • Due to the current staffing issues on IPU, IPOS was not rolled out in January - aim to be training IPU in April/May 2015
March 2015	• Review progress with implementation • Provide final report

The outcome tools have been introduced with patients receiving care within OP&T and from the Barnet and Enfield Community Teams. The multidisciplinary staff training ensured that both clinical staff and supportive care staff were able to contribute to how the tools would influence practice and benefit patient care. Systems for administering the tools and recording have been established. The IPOS is recorded on the electronic patient database so the Multi Disciplinary Team has the ability to review patient goals and monitor if appropriate internal referrals have been made.

The roll out of the Outcome Tools within the IPU has been delayed, it is anticipated implementation will commence in May 2015. Also at this time, the Haringey Community Team will commence use of the Tools.

The next steps is to start to evaluate/analyse the data that has been captured in relation to our effectiveness at addressing patients' problems and concerns and keeping pace with best practice guidance from the Outcome Assessment and Complexity Collaborative .

NLH STAFFING

NLH employs a total of 172 regular staff and 45 bank staff. It benefits from the efforts of approximately 750 volunteers who are used as required in clinical and non-clinical roles. The Hospice has many staff working part time or flexible hours.

	2011-12	2012-13	2013-14	2014-15 April-March
Staff joined	17	38	52	54
Staff left	21	16	30	50

Comment:

Of the 54 starters this year, 33 have been clinical staff and 21 non clinical. Of the leavers 28 have been clinical and 22 non clinical.

The following significant staff improvement initiatives have been put in place this year.

- Staff Performance Development Review process and documentation continue to be rolled out across the whole Hospice, with a revised 'short form' version for certain roles (e.g. Shop Manager). Both the process and the documentation are being revised in light of user feedback.
- Embedding Staff Care, the new HR MIS, across NLH departments and activities.
- NLH's Management Development Programme (MDP4) continued (Year 4) to concentrate on specific skills. A survey of managers will be conducted to gather views on possible content for MDP5 in 2015.
- Review of all Human Resources policies and procedures.
- Information and Consultation Forum formed and involved as the consultative body in two cases of staff transfer under "Transfer of Undertakings (Protection of Employment) Regulations 2006" (TUPE) provisions; efforts are now underway to establish the Forum as a self-managing body meeting on a regular basis.
- NLH staff satisfaction survey (not undertaken since 2012)
- Staff Handbook revised and re-issued.
- Recruitment, Induction & Probation Handbook (guide for managers) compiled (nearing completion).

- The Bradford Score system adopted and sickness absence closely monitored/managed to try and improve attendance.

NLH BOARD OF TRUSTEES QUALITY ACCOUNT COMMENT

NLH Board of Trustees Quality Account Comment

The Board of Trustees of the North London Hospice warmly welcomes the fourth Quality Account. The report reflects the continued commitment to ensuring that everyone who requires access to Hospice services experiences skilled, respectful and effective care.

The year has seen a number of achievements in terms of service developments and capacity to extend the reach and impact of high quality care delivered by experienced and dedicated staff in our inpatient, day and community services. We are delighted to have extended our model of service to reach more service users in Haringey and also to have developed a productive partnership with Macmillan Cancer Support.

Once again, the Board is assured by the progress made against the priorities identified for this year. The Living Room Project in particular has had a positive impact on the experience of patients in the Inpatient Unit at the Finchley site, creating a comfortable, welcoming space that is increasingly used by patients, their families and friends. Focussing on safety, Intentional Care Rounding has introduced even more effective and systematic approaches to ensuring that patient needs are met in a timely, effective and responsive manner in the inpatient unit. This is reinforced by the introduction of consistent Outcomes Measures, that will assess service effectiveness at meeting patient's problems and concerns.

The Board welcomes the priorities identified for 2015/16 covering the domains of user feedback, improving risk management and extending the reach of services in our Outpatients and Therapies Service in Enfield and in Finchley. Volunteers will be central to the real time user feedback pilot, that seeks to be more responsive to the needs of users, and thus improving their overall experience of care. The risk management database will provide a more robust reporting system that will facilitate improved learning and responsiveness around issues of quality, safety and risk. The Board is especially supportive of the developments proposed in relation to the

Outpatient and Therapies services, welcoming approaches that will extend access to high quality services to a wider client group.

This report illustrates that the Hospice continues to serve the local community that supports its work so generously and consistently. It also illustrates the Hospice's commitment to extend its services to more people who can benefit from the high quality of care provided in all of its settings.

John Bryce
Chair
North London Hospice Board of Trustees

STATEMENTS FROM COMMISSIONERS, HEALTHWATCH, HEALTH OVERVIEW AND SCRUTINY COMMITTEES

Barnet Health and Overview Scrutiny Committee

APPENDIX ONE: OUR CLINICAL SERVICES

1. Community Specialist Palliative Care Teams (CSPCT)

They are a team of Clinical Nurse Specialist, Doctors, Physiotherapists, Social Workers who work in the Community to provide expert specialist advice to patients and Health Care Professionals. They cover the boroughs of Barnet, Enfield and recently they have taken on the Borough of Haringey. They work closely with, and complement the local statutory Health and Social Care services such as General Practitioners, District Nurses, Social Services, Hospital teams and other Health and Social care Professionals.

The service emphasis is based on:

- Care closer to home
- The facilitation of timely and high quality palliative care

This is achieved by providing:

- Specialist advice to patients and Health Care Professionals on symptom control issues
- Specialist advice and support on the physical, psychological, emotional and financial needs of the patients and their carers.
- An out of hours telephone advice service

Community patients are given the out of hours (OOH) number for telephone advice out of office hours. Local professionals can also access this service out of hours for palliative care advice as needed. Calls are dealt with between 1700-0900 by a senior nurse on the IPU. At weekends and bank holidays, a community Clinical Nurse Specialist deals with calls between 0900-1700 hours. Currently this level of OOH care is only provided in Enfield and Barnet (see plans to develop in Key Service Developments section).

2. Outpatients and Therapies -OP&T (formerly Day Services)

The service offers a planned bespoke programme for patients and their carers as follows:

- Nurse-led assessments and clinics; clinical interventions such as

transfusions;

- Psychological Therapies (Psychology, Art Therapy and Music Therapy);
- Physiotherapy;
- a range of Complementary Therapies (Acupuncture, Massage, Reflexology, Reiki);
- Informal Art and Music groups;
- Meditation and a Carers' Group;
- Hairdressing and Beauty Therapy.
- Macmillan CAB service available. Patients and carers can informally attend for volunteer-led social support, following assessment. Nutritious, low cost lunches and snacks are on offer on both sites.

OP&T is offered on both Finchley and Enfield sites and currently open four days a week. North London Hospice aims to eventually offer a five-day a week service to include an expanded Outpatient Clinic Service, as well as developing the therapeutic activities and interventions on offer.

3. Inpatient Unit (IPU)

NLH has 18 single en-suite rooms offering specialist 24-hour care. Patients can be admitted for various reasons including symptom control or end-of-life care. As the unit is a specialist palliative care facility, it is unable to provide long-term care.

4. Palliative Care Support Service (PCSS)

Most people would like to be cared for and finally to die in their own homes, in familiar surroundings with the people they love.

The Hospice's Palliative Care Support Service enables more people to do this.

The service works in partnership with the District Nurses and Clinical Nurse Specialists providing additional hands-on care at home for patients.

5. Loss and Transition Service (including Bereavement Service)

The Loss and Transition Support Service supports:

- Individual North London Hospice patients in coping with the emotional and psychological effects of loss of health.
- Their families/close friends in coping emotionally with their roles as carers and adjustment to change over time.
- Bereaved families/close friends in expressing their grief and eventually to make the transition to a new way of living.

The support is provided by volunteers who we have trained in support skills on our Oyster Training Programme or who are qualified counsellors. This

service is in addition to that provided by our Specialist Palliative Care Staff (nurses, social workers and doctors) and is offered pre-bereavement and for up to 14 months after bereavement. This service will be developing a range of support groups on both sites. Regular Ceremonies of Remembrance and the annual Light Up A Life event commemorate those who have died.

6. Triage Service

The Triage Service comprises a team of Specialist Nurses and administrators and is the first point of access for all referrals to NLH.

The Triage Service works in partnership with other hospice services, other Primary and Secondary Care Teams and other Health and Social Care Providers.

The team provides specialist palliative care to referrers and patients with any potentially life limiting illness. Haringey are a signposting service for patients in the last year of life.

APPENDIX TWO: INFORMATION GOVERNANCE

Information Governance

Information Governance (IG) refers to the way in which organisations process and handles information, ensuring this is in a secure and confidential manner. It includes information relating to our service users as well as personal information held about our staff and volunteers and corporate information e.g. finance and accounting records.

IG provides a framework in which North London Hospice is able to deal consistently with, and adhere to, the regulations, codes of practice and law on how information is handled e.g. Data Protection Act 1998, Confidentiality NHS Code of Practice.

For the Hospice, the purpose of the annual assessment is to provide IG assurance to:

1. The Department of Health and NHS commissioners of services
2. The Health and Social Care Information Centre (HSCIC) as part of the terms and conditions of using national systems, including N3.

The Hospice is measured against four initiative sets and 27 standards. The four sets are:

1. Information Governance Management
2. Confidentiality and Data Protection Assurance
3. Information Security Assurance
4. Clinical Information Assurance

The last assessment was completed in March 2015 with a score of 98%. In April we received confirmation that our assessment has been reviewed by the HSCIC and has been confirmed as satisfactory.

APPENDIX THREE: HOSPICE GROUPS THAT OVERSEE AND REVIEW QUALITY WITHIN NLH

Hospice Board

The Board is accountable and responsible for ensuring NLH has an effective programme for managing risks of all types and ensuring quality. In order to verify that risks are being managed appropriately and that the organisation can deliver its objectives, the Board will receive assurance from the Quality, Safety and Risk Group for clinical and non-clinical risks. It reviews NLHs Balance Scorecard bi-annually.

Executive Team (ET)

ET will review NLH's Balance Scorecard quarterly.

Quality, Safety and Risk Group (QSR) is a subcommittee of the Board and provides assurance that an effective system of control for all risks and monitoring of quality is maintained. It reviews NLH's Balance Scorecard quarterly and ensures action plans are delivered as indicated. The committee also reviews the results of audit work completed on the Hospice's Audit Steering Group and the policy review and development work completed in the Policy and Procedure Group.

Quality and Risk (Q&R)

Q&R reports to the QSR with overarching responsibility for ensuring that risk is identified and properly managed. It will advise on controls for high level c risks and to develop the concept of residual risk and ensure that all Directorates take an active role in risk management and that this includes the active development of Risk Registers.

Q&R is also responsible together with QSR to ensure that the treatment and care provided by the Hospice clinical services is subject to systematic, comprehensive and regular quality monitoring.

Audit Steering Group (ASG)

ASG is responsible for providing assurance of all audit activity through reports to Q&R and QSR. ASG presents its Audit Plan and Audit Reports and recommendations to Q&R and QSR for approval and will also ensure that any risks identified during an audit process will be added to the appropriate

Service Risk Register.

Policy and Procedure Group (PPG)

PPG group ensures the review of all NLH policies and procedures. It reports to Q&R and QSR.

APPENDIX FOUR: DEFINITION OF AVOIDABLE AND UNAVOIDABLE PRESSURE SORES

Avoidable Pressure Ulcer:

"Avoidable" means that the person receiving care developed a pressure ulcer and the provider of care did not do one of the following: evaluate the person's clinical condition and pressure ulcer risk factors; plan and implement interventions that are consistent with the persons needs and goals, and recognised standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate."

Unavoidable Pressure Ulcer:

"Unavoidable" means that the person receiving care developed a pressure ulcer even though the provider of the care had evaluated the person's clinical condition and pressure ulcer risk factors; planned and implemented interventions that are consistent with the persons needs and goals; and recognised standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate; or the individual person refused to adhere to prevention strategies in spite of education of the consequences of non-adherence."

Department of Health, Patient Safety First (2014)

APPENDIX 5 PATIENT CASE STUDY

From the wife of a former Barnet Community Team patient.

"We first got involved with A..., our Community Nurse Specialist, through the hospital. Initially home visits weren't necessary but after a couple of months we needed her to visit.

My husband was happy for the Hospice to be involved but he was adamant that he didn't want to go into the Hospice. He thought that I would like the support that they could give. The support was excellent and it was so comforting to know that help was on hand 24 hours a day.

My husband found A... helpful. He was a proud man and very independent. He was glad of her help for me. Ayesha would always offer to come round and would give us the name of the person who was on duty at the weekend, should we need to call. She told us about things like an attendance allowance which we didn't have a clue about.

We were involved in all decisions – A... would say 'This is the next step' and then ask us what we thought. She weighed up my husband and gave just the right approach. I felt I could ask A... any question and always understood her answers – she was very good.

The Hospice helped a great deal with my husband's drugs. I could ring anytime and that gave me confidence. Someone would always ring me back. It was so important that my husband was not in pain.

A... was very helpful with my husband's medication, especially in getting the right dose. Once she was involved the GP took more notice and listened to her. It had been a nightmare up until then as the dose would be changing every couple of days or sometimes daily. I used to dread getting prescriptions. Faxes would go missing, prescriptions not there, that sort of thing. If my own GP wasn't there, the locum would always query the high dose and then I'd have to start all over again.
On a couple of occasions I was horrified by the GPs attitude.

My husband had a syringe driver fitted and then the District Nurses got involved – they all seemed to work well together.

We really appreciated the support from the Hospice and my husband passed away at home which is where he wanted to be. He didn't want to go to hospital.

I would totally recommend the Hospice. My husband could have come in but he chose not to. You don't have to be in the Hospice to get the great treatment.

I had such confidence in the Hospice – they met my needs and reassured me. I was delighted to have them involved.

I have been offered bereavement support and A... said that she would come and see me again if I needed her. I couldn't have been more pleased."

ACCESSING FURTHER COPIES

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

Or
ww.nhs.uk/aboutNHSChoices/professionals/healthandcareprofessionals/quality-accounts/Pages/quality-accounts-2013-2013.aspx

HOW TO PROVIDE FEEDBACK ON THE ACCOUNT

North London Hospice welcomes feedback, good or bad, on this Quality Account.

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