

**NORTH LONDON HOSPICE**

**QUALITY ACCOUNT**

**16-17**

**DRAFT FINAL**

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Page Number

# Executive Summary

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

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It is with great pleasure that I welcome you to North London Hospice's (NLH) 2016-17 Quality Account which has been developed in consultation with NLH users, clinical service staff and managers, the Executive Team and the Board of Trustees.

This year, NLH celebrates 25 years of providing inpatient care to the residents of the boroughs of Barnet, Enfield and Haringey. From our initial beginnings as a community team in 1984, we now have 196 staff supporting the delivery of specialist palliative care to 2274 people and their families. Care is provided within peoples own homes, care homes and through outpatient and therapies at our two sites in Winchmore Hill and Finchley and within our 18 bedded inpatient unit.

I am pleased to report that this year we achieved the Care Quality Commission rating of "Good" following three separate inspections of our Finchley, Winchmore Hill and Haringey services. 95% of our users would recommend our service to family and friends.

At all levels of the organisation, we constantly review our care and make plans for improvements that include listening to users when designing new or revising services. I am delighted to see how our quality projects this year have seen real improvements affecting both the user and staff experience: the successful setting up of a user group in Outpatient and Therapies service; the commencement of Schwartz Rounds to bring together our staff from all backgrounds (clinical and non-clinical) to talk together about the emotional and social challenges of caring for our group of patients; the evidencing in our clinical records of the Five Priorities of Care for the Dying, a national initiative that facilitates the needs and wishes of the dying person and those closest to them being central in both the planning and delivery of care wherever that may be; the introduction of the "Hello my name is..." national initiative that ensures staff name badges are clear to read and staff introduce themselves at every encounter with our patients and their families.

Next year's projects have also been discussed at our user Feedback Group and include: scoping our service provision to 'Hard to Reach Groups' of society to promote equal access to our services; the extension of a doctors' Journal Club to all professionals; the co-production of new Outpatient & Therapies services discussing with potential and actual users and referrers where there are gaps in services and what services need establishing; the development of patient falls management on the In Patient Unit so there is increased understanding by the whole multidisciplinary team and new national guidance is implemented.

Further developments this year have included our open gym, exercise group and introduction of Occupational Therapy within our Outpatient and Therapies service, the extension of our audit and educational programmes, the development of our community clinical nurse specialists to enable more detailed physical assessment and the prescribing of certain medication to facilitate more responsive symptom management and preventing hospital admissions. Increased collaboration has seen our clinicians providing training with older people services, renal, respiratory and care home teams.

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

Pam McClinton  
Chief Executive of North London Hospice April 2017

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## INTRODUCTION

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Quality Accounts provide information about the quality of the Hospice's clinical care and improvements 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 the 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 Winchmore Hill sites. Paper copies are available on request via our Patient and Family Feedback Lead.

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## OUR CLINICAL SERVICES

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The Hospice's services are provided by specially trained multi-professional teams, which include doctors, nurses, physiotherapists, occupational therapists, social workers, counsellors, clinical psychologists, 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)
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](#)

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## PART 2: PRIORITIES FOR IMPROVEMENT 2016-17

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The following priorities for improvement for 2016-2017 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: Listening to users through the creation of a user forum

**Baseline:** User feedback is received individually through surveying, patient stories, complaints, compliments and comments cards. One-off user focus groups have been held, but no regular user forum existed.

**Project aim:** To establish a User Group for the Outpatients and Therapies service

**Timescale:** To develop, consult and introduce the user forum by the end of March 2017.

#### **Project Delivery:**

- Project Group was formed from September 2016, including 2 service users and monthly meetings were held to formulate effective Feedback Groups (name decided by users for user forum/group).
- 4 open Feedback Groups were held from November 2016, each with a different topic of discussion ( what NLH has as a result of user feedback, name of OP&T site, review of new promotional patient information, 2016-17 Priority for Improvement Projects).
- Attendee numbers varied between 1-7. This is in line with the experience of such groups in other hospices.
- In one of the groups we asked patients and relatives to suggest a name for our centre at Barrowell Green. We discussed the issues and the results were presented to the Hospice's Executive Team who have in turn made some suggestions based on the Feedback Group's ideas which is back out to consultation with users prior to presentation to the Trustees.

**Outcome:** Agreed Terms of Reference put in place; users recruited; schedule of planned meetings for the year put in place; minutes of meetings held produced; identified with users forum members what success of forum would look like to them and monitor performance against these outcomes, patient experience areas for improvement (OP&T centre name and promotion of OP&T services) have an action plan established or being developed.

#### **Challenges to date:**

- Maintaining a level of service users attendance at Feedback Group
- Considerable work involved to maintain momentum
- Limited access to patient's email addresses to promote groups differently

#### **Conclusion/Ongoing Plan:**

Feedback Groups will continue and plans are in place to widen attendees to all NLH service users and hold on both sites.

## Priority Two: Patient Experience: Introduction of elements of 'Hello my name is...' national initiative on IPU

**Baseline:** IPU Staff had a mixture of name and ID badges and some staff introduce themselves to patients and families. In the User Survey 2015, patients and relatives reported a reduction in staff introducing themselves and explaining their role. In a complaint a relative highlighted that they could not clearly identify staff members. It was decided whilst introducing new name badges that they should be of a dementia friendly design. The plan was to purchase dementia friendly 'Hello My Name Is...' name badges to support the ongoing work of creating a dementia friendly environment that was started last year.

**Timescale:** Project implemented by March 2017

**Project Delivery:** Meetings with IPU and Front of House staff and volunteers (including housekeeping and maintenance) were held to involve staff in the purpose and process of the project. Name badges were purchased to ensure primarily the clarity of staff's name, the largest black font of person's first name on the largest sturdy badge was selected. The colours selected were mindful of dementia patient's colour sensitivity and to keep with NLH's corporate colours. The badges have been distributed to staff from June 2016 and the experience of using them and feedback received have been discussed regularly in staff meetings and posters displayed.

### Outcomes:

- Improved scores in response to the question in the IPU user survey 2017 - "Do staff introduce themselves and their roles (to patients)" to "always" by 80% of patients. - cannot be measured until March 2018
- 100% IPU staff and volunteers to be aware of the project and its rationale, and be using the standard new "Hello My Name Is..." badge.- Monthly audits of whether staff are wearing the badges and are they introducing themselves has started. To date of 13 staff members checked, 23% were not wearing their badges. The cause identified was that these staff were new and had not yet been issued one. Of 6 volunteers asked 50% of volunteers were not wearing theirs, 2 had not been issued badge as new starter and 1 volunteer did not have it with them. In response a process has now been established to identify early ordering of badges for new starters and the availability of temporary badges.
- No further complaints or concerns raised by users from 2017 regarding staff not introducing themselves.
- IPU Manager "Feedback from patients has been positive. They can see the name clearly and find comfort in being able to respond to the nurse by name."

### Challenges to date:

Staff feedback has raised the question whether the badge should include the staff member's surname or role on the badge. This was reviewed and the decision was made to keep the current format so that clarity and visibility of the name was maintained.



### **Conclusion/Ongoing Plan**

The use of "Hello My Name Is" will continue on IPU and Front Of House at the Finchley site. It is hoped that external funding can be sourced to spread this initiative out to all staff and patient facing volunteers in 2017.

### **Priority Three: Clinical Effectiveness: Introduction of Schwartz rounds**

**Baseline:** Group supervision had been established for all front-line clinical staff for the previous two years.

**Timescale:** By end March 2017.

#### **Project Delivery**

Two Schwartz Rounds have taken place. The first round there were 58 attendees and 38 at the second. Of the 58 evaluation forms analysed from the first round, 55 described the session as excellent and 3 as good. The second round showed similar feedback. The panelists have included Chief Executive Officer, Medical Consultant, Health Care Assistant, Ward Doctor, Social Worker, Community Clinical Nurse Specialist and Triage Service Lead. The facilitators have attended all training programmes and completed online modules overseen by The Care Foundation. Attendees have commented on the impact of deeper reflective practice and shared learning and greater understanding of the personal impact of the work.

#### **Outcomes:**

Register of attendance available and evaluation feedback form is shared with The Care Foundation to measure performance and identify areas of development.

#### **Challenges to date:**

Working the programme across three sites; this is now being addressed by delivery at the two largest sites. Availability of staff due to part time working and shift patterns and service needs.

#### **Conclusion/Ongoing Plan:**

The rounds will continue 6 weekly and is now an established programme

## Priority Four: Clinical Effectiveness: NLH improving its evidence of the implementation of the national initiative “Five Priorities of Care”

**Baseline:** The Five Priorities of Care (One Chance to Get It Right: Improving Peoples experience of care in the last few days and hours of life. Leadership Alliance for the Care of the Dying People 2014) have been identified as:

1. The possibility that a person may die within the coming days and hours is recognised and communicated clearly, decisions about care are made in accordance with the person’s needs and wishes, and these are reviewed and revised regularly.
2. Sensitive communication takes place between staff and the person who is dying and those important to them.
3. The dying person, and those identified as important to them, are involved in decisions about treatment and care.
4. The people important to the dying person are listened to and their needs are respected.
5. Care is tailored to the individual and delivered with compassion – with an individual care plan in place

These priorities are well known, by specialist palliative care services like NLH, as core components of everyday palliative care best practice. NLH recognised, however, that its documentation may not have been able to consistently evidence that it was delivering this best practice. Therefore this project was identified by both IPU and Community Service as an improvement area. The Community Service also agreed to work with its respective borough community services to support their own implementation of this initiative.

**Timescale:** Project implemented in NLH services by October 2016.

### **Project Delivery:**

Both community and IPU projects have worked with the evidence based documents developed by the UCLPartners Five Priorities of Care project.

In the community, the project has delivered the creation of a New Five Priorities of Care documentation which is used by the community CNSs to have a central NLH record. This has helped with communication within and across teams in and out of hours. Training has been delivered by UCLPartners to the community CNSs as part of a Train the Trainer programme on End of Life (EOL) Care. With the leadership of the Haringey EOL Partnership Group, the CNSs in Haringey have been enabled to deliver the training to the district nurses. UCLH are piloting Pan London Five Priorities documentation. It is planned that this will be rolled out into Haringey and Enfield. Barnet District Nurses are using Central London Community Healthcare NHS Trust (CLCH) EOL document.

On the IPU, a new Five Priorities of Care documentation was created from UCLPartners in patient care plan document. This records key conversations, religious/spiritual and psychological needs, key contacts of those important to the dying person, key elements of the medical plan. In the autumn this was introduced alongside UCLPartners Five Priorities evidence based nursing care plan (Last days of life care plan) via MDT training sessions. The document is completed during the daily MDT meeting when a patient is identified by the team as entering the dying phase (using the Phase of Illness outcome tool). It also triggers the change to the last days of life care plan. Audits were commenced to monitor the new documents use. The document has created a central record of key communication of EOL discussions and plans and staff have commented that it has enhanced more seamless, effective and coordinated end of life care.

**Outcome:**

- The first audit of IPU deaths demonstrated 100% compliance of completed documentation. A second in depth audit is planned for May 2017.
- Following the appointment of a new IPU senior nurse, it was agreed they would lead on the implementation of a new training plan which included face to face teaching and use of reflection using a poor practice patient story video with all nursing staff. Following learning identified in May's audit, nursing competencies will be introduced in the autumn to ensure ongoing training and demonstrate effective utilisation of the documentation for current and new staff. The senior ward doctor trained the doctors and this will be repeated at induction for new ward doctors.

**Challenges to date**

Staff continuing to value and understand the purpose of increased documentation.

**Conclusions/Ongoing Plan:**

- The IPU documentation will continue to be used.
- Regular audits to monitor its use will be conducted and actions taken as required.

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# PRIORITIES FOR IMPROVEMENT 2017-18

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The following Priority for Improvement Projects for 2017-18 have been identified by the clinical teams and endorsed by the Quality, Safety and Risk Committee, Board of Trustees and local commissioners and Health and Overview Scrutiny Committees. The hospice's Feedback Group, which consists of OP&T patients and their families, heard about the projects selected for the coming year and provided comment particularly on Project 2 (see below).

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

## Patient Experience - Project 1: Scoping Hard To Reach Groups to address potential inequalities in service provision

### **Current situation:**

Over the years NLH has worked in a variety of ways to understand and promote its service to encourage equal access for potential users of its local community and referring services.

This has included:

- outreach promotional work by its clinical, volunteering and fundraising services;
- collaborative working and projects with local schools, faith groups and services e.g. learning disability service
- user feedback focus groups with hard to reach groups of society.

Our local boroughs, health commissioners and providers are responding to the Equality Act 2010 and the Public Sector Equality Duties and will have plans in place to reduce inequalities in access to health services. NLH wants to review the reach of its current services in order to better understand any new focus required to reach groups in its local boroughs that are not accessing equally the services provided. A Steering Group for this work has developed a plan for the coming year to deliver the results it aspires to meet.

### **Result to be Achieved:**

- Scoping the priorities of CCG's, boroughs and Hospice UK gaps in specialist palliative care provision in relation to improving access to services by Hard to Reach Groups (HTR)
- Identify the current reach of referrals received and taken up by the these HTR groups
- Highlight the gaps in referrals received and service taken up by these HTR groups
- Prioritise a specific HTR group and begin to identify recommendations for NLH to consider for widening access

**Timescale of project:** This will be at least a two year project. Year One is broadly to scope and identify focus for Year Two.

## Patient Experience - Project 2: Coproduction of services in Outpatient & Therapies (OP&T)

### **Current situation:**

In 2015-16, Priority for Improvement Project scoped the need of people living with long term conditions. It identified a model of care for OP&T for people with long term conditions which included outpatient clinics, therapies provision, social support, carer services and the development of wellbeing/social support for patients and their carers in our communities. It recommended the development of these services using a co-production model of engaging with patients, carers, staff and volunteers. New investment in extending the OP&T team including the appointment of an Associate Director, Physiotherapist, Occupational Therapist, Social Worker and Centre Administrator has led to the development of our outpatient and therapy services over the last few months using a co-production model:

- We have completed a Managing Breathlessness programme in March 2017 which has been developed by working with relevant stakeholders; experts in the field, patients and carers, the community respiratory team and our staff. Feedback is currently being evaluated with plans to run another course in a few months time.
- We are now looking at a service development that is required by those affected by neurological conditions. A survey for those with the condition and their carers is about to be sent out as part of the co-production model to start understanding what may be of benefit to this group of patients. Further involvement from experts and specific neurological services will be sought.

### **Results to be achieved:**

- Evaluation of all new service developments will describe whether the users received the right intervention by the right people at the right time by the new co-produced intervention (including use of Outcome Assessment and Complexity Collaborative (OACC) measures)
- The pilot of:
  - three co-produced new interventions for those with long term conditions
  - two co-produced new interventions for those with cancer
  - two co-produced new interventions for carers
  -

### **Timescale of project:**

- One year with the new co-production model to be embedded in all OP&T service development

## Patient Safety - Project 3: Falls Management and Prevention Project on the In Patient Unit

### **Current situation:**

The reduction of falls on the inpatient unit has been an ongoing focus for the organisation. The aim has always been to reduce the risk of falls so as to minimize distress and injury to patients. NLH monitors the number of falls per occupied bed days in order to benchmark itself against other hospices which it has done for the past three years.

Hospice UK have revised their falls prevention care plan guidance and the Physiotherapy team believe there is a need to increase the multidisciplinary team's understanding and confidence of falls management and prevention to ensure a consistent approach to the

management of patients.

The project will deliver a new training programme to small clusters of staff in short sessions by the physiotherapy team. Performance tools (modified Karnofsky Performance Scale and Phase of Illness) used on IPU will act as a trigger at the daily Multi-Disciplinary Team (MDT) review for a seamless review of falls and manual handling practice using revised documentation.

**Result to be Achieved:**

- Revised falls risk and manual handling risk assessment documentation. Policies modified accordingly.
- Daily review of Karnofsky and Phase of Illness tools will be used as a prompt to review patient risk of fall through a new assessment. This will be monitored through spot checks.
- Improvement on the completion of falls risk assessment and manual handling risk assessment documentation. To be monitored by pre and post documentation audit.
- Falls prevention training programme for the IPU MDT in place and 75% IPU staff having completed
- Improved knowledge and confidence of falls prevention strategies. This will be measured by before and after staff questionnaire

**User Feedback**

OP&T users recommended that the needs of patients in the community and the ability of the hospice to influence external organisations with this work are considered. The project lead will update user feedback group with regards to looking at our falls pathway throughout the organisation.

**Timescale of project:**

One year

## Clinical Effectiveness - Project 4: Establishing a Multi Professional Journal Club for hospice clinicians

**Current situation:**

The Hospice currently has an established journal club for the doctors, it is felt that it would be beneficial to expand this to a multi professional journal club to:

- Support continuing professional development for clinical staff
- Promote multi-professional working
- Stimulate debate and improved understanding of current topics
- Staff are kept abreast of new literature, clinical evidence and research
- Staff are able to learn / improve their ability to critically analyse and appraise research
- Promote awareness of research skills and encourage research projects
- Improve clinical care & patient outcomes by promoting professional practice that is evidence based
- Fostering of organization-wide practice changes

**Result to be Achieved:**

- Attendance list of all sessions held
- Journal club schedule will demonstrate different professions as presenters
- Session evaluation to capture any immediate learning and changes required for future sessions

- Summaries of each session will be available to all clinical staff for those unable to attend
- End of year review from attendees of value of Multi Professional Journal Club.

**Timescale of project:**

Spring 2018

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## STATEMENTS OF ASSURANCE FROM THE BOARD

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The following are a series of statements (italicized) 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 2016-17, NLH provided and/or sub-contracted 2 services 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 2016-17 represents 32 per cent of the total operational income generated by NLH for the reporting period.*

### Participation in clinical audits

*During 2016-17, 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 2016-17 are as follows (nil). The national clinical audits and national confidential enquiries that NLH participated in, and for which data collection was completed for 2016-17, 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 2016-17 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 8 local clinical audits in 2016-17 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:*

## **1&2. CONTROLLED DRUGS AND CONTROLLED DRUGS ACCOUNTABLE OFFICER AUDIT**

The audit has been devised by Hospice UK to meet the requirements of the Misuse of Drugs Regulations (2001) as amended 2007, The Health Act (2006) and The Controlled Drugs (Supervision of Management and Use) Regulations 2013 and is undertaken annually. As a result of 2015-16 audit the Medicines Management Policy has been reviewed, updated and re-issued with a resultant increase in compliance in the 2016-17 audit. Recruitment to additional Pharmacy hours have been agreed with Barnet Pharmacy who provide Pharmacy services to NLH.

## **3. SAFE PRACTICE IN THE MANAGEMENT OF MEDICINES**

The audit has been devised by Hospice UK to meet the requirements of the Misuse of Drugs Regulations (2001) as amended 2007 and The Health Act (2006) and is undertaken annually. As a result of 2015-16 audit the Medicines Management Policy has been reviewed, updated and re-issued with a resultant increase in compliance in the 2016-17 audit.

## **4. ANNUAL EXTERNAL INFECTION CONTROL AUDIT ACROSS THREE SITES**

At Winchmore Hill site, the overall level of compliance has risen from 90% to 94%. At the Haringey site a small drop in compliance from 100% to 98% was noted. This reflected a requirement for regular reviews of the Infection Prevention & Control policy manual rather than any deterioration in operational working practices. In Finchley the compliance fell since last year's audit from 95% to 89%. This reflects a range of minor non-compliances in areas including linen management, management of re-usable and single use equipment, sharps and waste management and training updates.

Action plans were developed to cover all the issues raised and have been fully implemented.

## **5. HAND WASHING AUDITS**

On the IPU levels of compliance were 86% in May 2016 and 88% in November 2016 which represents a reduction from November 2015 when it was 97%. In Winchmore Hill levels of compliance were 91% in June 2016 and 86% in November 2016 which both represent a significant improvement from January 2016 when it was 61%. A rolling programme of training, reinforcement and challenge will be led by the Infection Prevention and Control Nurse Lead.

## **6. SPIRITUAL CARE DOCUMENTATION RE-AUDIT**

This audit reviewed the nature of the records made in terms of spiritual needs and care for a random selection of patients known to either a Community Team or the IPU. This was a re-audit, following an initial audit in 2012, thus closing the audit cycle. The results of this re-audit indicate that documentation of spiritual issues still

does not fully meet the level to which we aspire and that the introduction of a records template has not been effective in improving documentation in this area. The Spiritual Care Reference Group continues to evolve and develop, including work to develop new Patient & Family Support service Guidelines.

## **7. CROSS-ORGANISATIONAL DOCUMENTATION AUDIT**

Based on the standards defined in the NLH Record Keeping Policy an audit was undertaken to review the standard of clinical record keeping. Overall the results were encouraging, but a key finding was the widespread use of abbreviations not on the approved list included in the NLH Record Keeping Policy. In paper notes on the IPU, the format of the notes was generally good. In electronic patient notes 92% of the records reviewed included ethnicity. In terms of the format requirements levels of compliance were close to 100% in all categories except the use of abbreviations. There were, however, 9 occasions when an entry in an electronic record was deemed to be non-contemporaneous. An action plan is being developed, including a review of the agreed list of approved abbreviations.

## **8. COMMUNITY NURSE SPECIALIST TIME TO FIRST VISIT AUDIT**

Referrals to NLH three Community Team (based in Barnet, Enfield & Haringey) are handled by the Triage Team. At the point that a patient is passed from Triage to the relevant Community Team they are assessed as being either a 'standard' or a 'rapid response' referral. The Community Operational Policy sets a standard for how quickly patients in each category should be first contacted and then assessed by a CNS. This audit was against these standards. The overall level of compliance was 95% in terms of the timing of first contact and 85% in terms of first assessment. It has been agreed that further work is required to ensure there is clarity about which patients are standard and which are rapid referrals. This clarification will be one of the outcomes of the full review of the Triage Service, due to be completed by Summer 2017.

We have also been involved in one external audit:

### **1. NLH COLLABORATIVE BLOOD TRANSFUSION AUDIT**

NLH has taken part in an external audit organised by the National Blood Transfusion Service, in collaboration with the Royal College of Nursing, the Association of Palliative Medicine and Hospice UK, to compare blood transfusion practice across hospices. Data collection has taken place during Oct to Dec 2016 and the results will be analysed by NHS Blood & Transplant. We expect to receive the audit report by June 2017 and will then consider any action required at a local level.

## **Research**

*The number of patients receiving NHS services, provided or sub-contracted by NLH in 2016-17, that were recruited during that period to participate in research approved by a research ethics committee was nil.*

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

NLH has contributed to a national research study, which was supported by Hospice UK and undertaken by researchers from the University of Leeds. The aim of the study was to explore which factors influence the duration of time patients receive hospice care prior to their death. The study used routinely collected data to determine the length of time that UK patients receive palliative care before their death and had received NHS ethics approval. NLH has submitted anonymised data concerning patients known to the Hospice who died during 2015. Once the results of the study are published we will be able to benchmark our activity against a range of other hospices.

## Quality improvement and innovation goals agreed with our commissioners

*NLH income in 2016-17 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework.*

## What others say about us

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

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

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

*NLH is required to register with the Care Quality Commission and its current registration status is unconditional. NLH has the following conditions on its registration (none). The Care Quality Commission has not taken any enforcement action against North London Hospice during 2016-17 as of the 31<sup>st</sup> March 2017.*

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

NLH's three sites were separately inspected in 2016. They observed how people were being cared for, reviewed documentation of care and staff records, examined organisational processes and talked to staff and the people who used our services. NLH was found to be compliant in all of the areas assessed;

- Woodside Park, North Finchley site (IPU, PCSS and Barnet Community Palliative Care Team) received an unannounced inspection in October 2016 and was rated "Good" in all domains.



- Barrowell Green, Winchmore Hill site (OP&T and Enfield Community Palliative Care Team) received an unannounced inspection in August 2016 and was rated "Good" in all domains.



- George Marsh Centre, St Anne's Hospital, Haringey (Haringey Community Palliative Care Team) received an unannounced inspection in November 2016 and was rated "Good" in all domains.



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## DATA QUALITY

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*NLH did not submit records during 2016-17 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 2016-17 and received a score of 98%. In 2016-17, NLH received confirmation that our assessment has been reviewed by the Health and Social Care Information Centre (HSCIC) and has been confirmed as . NLH was not subject to the payments by results clinical coding audit during 2016-17 by the Audit Commission. This is not applicable to independent hospices.*

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## PART 3: QUALITY OVERVIEW

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### QUALITY SYSTEMS

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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.



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### KEY SERVICE DEVELOPMENTS OF 2016-17:

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#### **Broadening the Offer by Outpatients and Therapies (OP&T)**

The main focus throughout 2016 – 17 for the OP&T service has been the development of the service with a view to broadening what we can offer, concentrating particularly on the needs of those with long term conditions that are under represented in accessing the hospice. New roles have been established: Associate Director, Physiotherapy, Occupational Therapy and Social Work posts to work with the already established medical and nursing outpatient team.

The team has introduced a Co-design service development model to ensure all stakeholders (professionals and service users) are involved in the planning and development of new interventions. It is aimed that this model will become the norm for future service developments.

Alongside individual appointments the number of group sessions are increasing.

- four days of Come and Connect (our social programme), two on each site,
- piloting Managing Fatigue and Breathlessness courses
- exercise group and open gym session established.
- complementary therapy service has continued to grow and a weekly symptom control acupuncture group has been established
- piloting craniosacral therapy sessions for carers.

We are reviewing our volunteer roles and developing some new roles with specific skills to support the developments in the service.

### **Community Nurse Specialists' (CNS) Development**

An Enfield CNS has commenced the Non Medical Prescribing course to enable prompt access to appropriate medications and treatment for patients in their own homes.

Enfield and Barnet team CNSs have started the Advanced Physical Assessment course to enable prompt and effective assessment to support effective treatment for people in their own homes.

### **Haringey GP teaching session**

Delivered by Medical Consultant and the CNS team.

### **Training to Haringey District Nurses**

A teaching programme was delivered to District nurses at the request of the District Nursing leads and CCG. 15 sessions were delivered between October – December 2016 by the CNS's in three different sites. The programme provided sessions on communication skills, the Five Priorities of Care and symptom management. We are currently evaluating the programme, however it was generally well received and attendance ranged from 3-11 nurses per session.

### **End Stage Renal failure project in Haringey**

Community Medical Consultant has commenced a project working with patients attending the renal dialysis unit in Tottenham Hale. Support is being provided to the renal team to develop Advanced Care Planning (ACP) for their patients with end stage renal failure.

### **Whittington Respiratory Team**

The Haringey team are working together with the Respiratory Team to identify appropriate referrals to palliative care services and promote ACP discussions.

### **Advanced Care Planning in Care Homes in Haringey**

The North Middlesex University Hospital have employed a Nurse to develop ACP in the two nursing homes in Haringey. The nurse will be based within the community palliative care team in Haringey and managed by NLH Community Team Leader.

### **Rapid response by Community Teams**

All the community teams now have a nurse identified each day who can respond to urgent issues.

### **Finchley Laundry Refurbishment**

IPU Laundry Facility has undergone a full refurbishment with the installation of new washing machines, dryers and an ironing machine. The equipment is more energy efficient as they have quicker wash and drying cycles. This provides assurance that laundry is washed at an appropriate temperature.

We are very pleased to continue to be able to launder patients washing at the Hospice as this removes the need for relatives to do this and helps the patient to remain independent.

### **Finchley Easy to Read Plans**

We have introduced easy to read plans of our In Patient Unit which helps with orientation of both patients and visitors.



NLH initiated the development of an 'End of Life Star' to be used in palliative/EOL care (final name to be decided) and invited in other collaborators to help fund the development. These include: St Josephs Hospice, Macmillan Cancer Support, Jewish Care and the London Association of Directors of Adult [Social] Services. Two one day workshops have taken place. A first draft Star will be designed for piloting in the Spring of 2017 with a view to having a completed version by 2018. This tool will then be available nationally.

### **Clinical Supervision**

A new approach to delivering Clinical Supervision has been put in place. Clinical Supervision is intended to provide patient facing staff with a confidential space in which to reflect on the impact of the work on them as well as their impact in relation to others. This helps to sustain staff who are facing difficult emotional situations on a day to day basis, as well as keeping them open and available emotionally. We have now appointed two Clinical Supervisors to provide four half days a week so that the opportunity to take up Clinical Supervision is available to clinical staff on a regular basis. Some staff are finding support through individual sessions and some in small groups.

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## PARTNERSHIP WORKING

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NLH are working together with:

**Enfield Integrated Team.** The Enfield CNS's continue to offer specialist palliative advice at the meetings for patients predominantly with long term conditions.

**Enfield Social Services Occupational Therapy.** The Occupational Therapist from Enfield social services plans to meet with the CNS's monthly to work with our patients ensuring a timely response for OT assessments.

**Care Home Enhanced Support Service (CHESS) team In Barnet.** The CNSs are working together to avoid unnecessary hospital admissions and improve standards of end of life care for patients in Care Homes.

NLH CNSs are supporting **Two Barnet Nursing Homes** with an embargo preventing further continuing care admissions, to improve their standards of end of life care.

**Locality District Nursing managers and the community teams** hold regular professional meetings.

**Haringey Link District Nurse.** The nurse meets regularly with the community team to develop their skills in end of life (EOL) care.

**Barnet Clinical Commissioning Group pharmaceutical advisor** to improve access to medication required to support people dying in their own homes.

**Barnet Independent Living Team (BILT) Multi-Disciplinary Team.** Community Team regularly attend multidisciplinary meetings discussing older adults with complex care needs to prevent avoidable hospital admissions and identify patients requiring hospice care.

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## EDUCATION AND TRAINING

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The Education Department is situated at the heart of North London Hospice, promoting end of life care of the highest standards. We provide a range of multi-professional courses, supporting both internal and external colleagues to develop their knowledge and skills, thereby improving the care they give to patients and their families. Details of all our courses and a booking form can be found in our Education Prospectus, which is published on the Hospice Website (see <http://www.northlondonhospice.org/for-clinicians/education/>).

North London Hospice is a regional Gold Standards Framework (GSF) Centre offering the 'GSF in Care Homes' training programme. The Gold Standards Framework Care Homes programme (GSFCH) is the UK's largest and most comprehensive training programme for providing end-of-life care.

### Education Department Developments

- The educators ran NLHs first two **Qualifications and Credit Framework (QCF) Level 2 Awards in End of Life Care** for internal and external staff. The QCF is a nationally recognised credit transfer system. All 6 NLH staff who completed the course were successful in achieving the qualification.
- A **4 week course for new PCSS health care assistants new to healthcare** was piloted. It consisted of classroom based training and work experience. The programme will run again in 2017-18.
- NLHs first **Summer School for 16 and 17 year olds** was run as a 3-day workshop to allow them to gain experience of the Hospice and healthcare. It was positively received and 2 further workshops are now planned.
- **Dementia Friends:** (An Alzheimer's Society initiative to create 'dementia friends' and dementia friendly communities) NLH so far this year has created '122 dementia friends'. This is now mandatory for NLH staff and there has also been a great demand for places on sessions advertised externally to the local community.
- **Enfield Care Homes Project:** Recognising Dying and Communication Skills training has been completed in 32 care homes in Enfield.
- **Palliative care study days for both registered nurses and Health Care Assistants**
- **GP end of life care education** afternoon held. Extremely positive feedback on project.
- **The Gold Standards Framework Care homes training programme** is currently being delivered to a cohort of 4 nursing homes. NLH will be working in partnership with GSF and other Regional Centres to update the course material.
- 5 new courses have been developed to feature the 2017-18 **Education Prospectus**. Presentation Skills and Clinical Audit were added to the prospectus in response to needs identified in the NLH Training Analysis.
- A new course, '**Supporting young people facing bereavement**' course, in partnership with Noah's Ark Hospice was delivered in March.
- **Reflection for learning:** A process for reflection on medicine errors was introduced at NLH.

- Kings University Medical students: 45 medical students attended half day attachments of end of life care training.
- **Tours:** 80 people have had a tour of the Finchley site including people from as far afield as Taiwan and the USA.
- NLH supported 8 **student nurses from Hertfordshire University**. Placement feedback was extremely positive. A student e-welcome site was created. Attendance at University meetings, DBS and Fitness to Practice panels maintained.
- **Apprentices:** NLH have been working in partnership with Barnet and Southgate College to introduce health care and administration Apprenticeships into NLH in 2017.

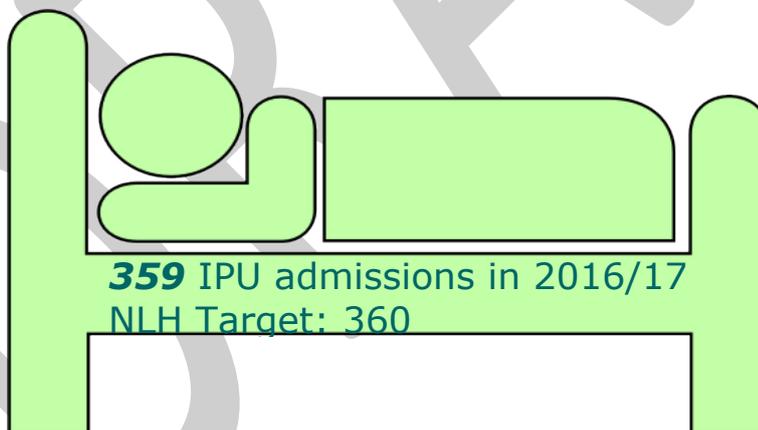
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## SERVICE ACTIVITY DATA

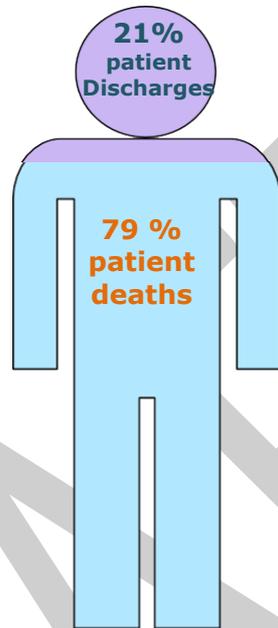
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NLH monitors the performance of different aspects of its services quarterly against some annual targets. Highlights of this year are included here.

### IN Patient Unit (IPU)



The number of IPU admissions has remained fairly consistent over the last 3 years with a similar proportion of patients with a cancer diagnosis (86% in 2016-17) versus non cancer diagnosis (14%) despite NLH referral criteria being inclusive of all life limiting conditions. 21% of IPU patients were discharged home, with the remaining 79% dying whilst with the care of the IPU team. The average length of stay remains consistent year on year and was 13.5 days in 2016-17.



## Bed Usage

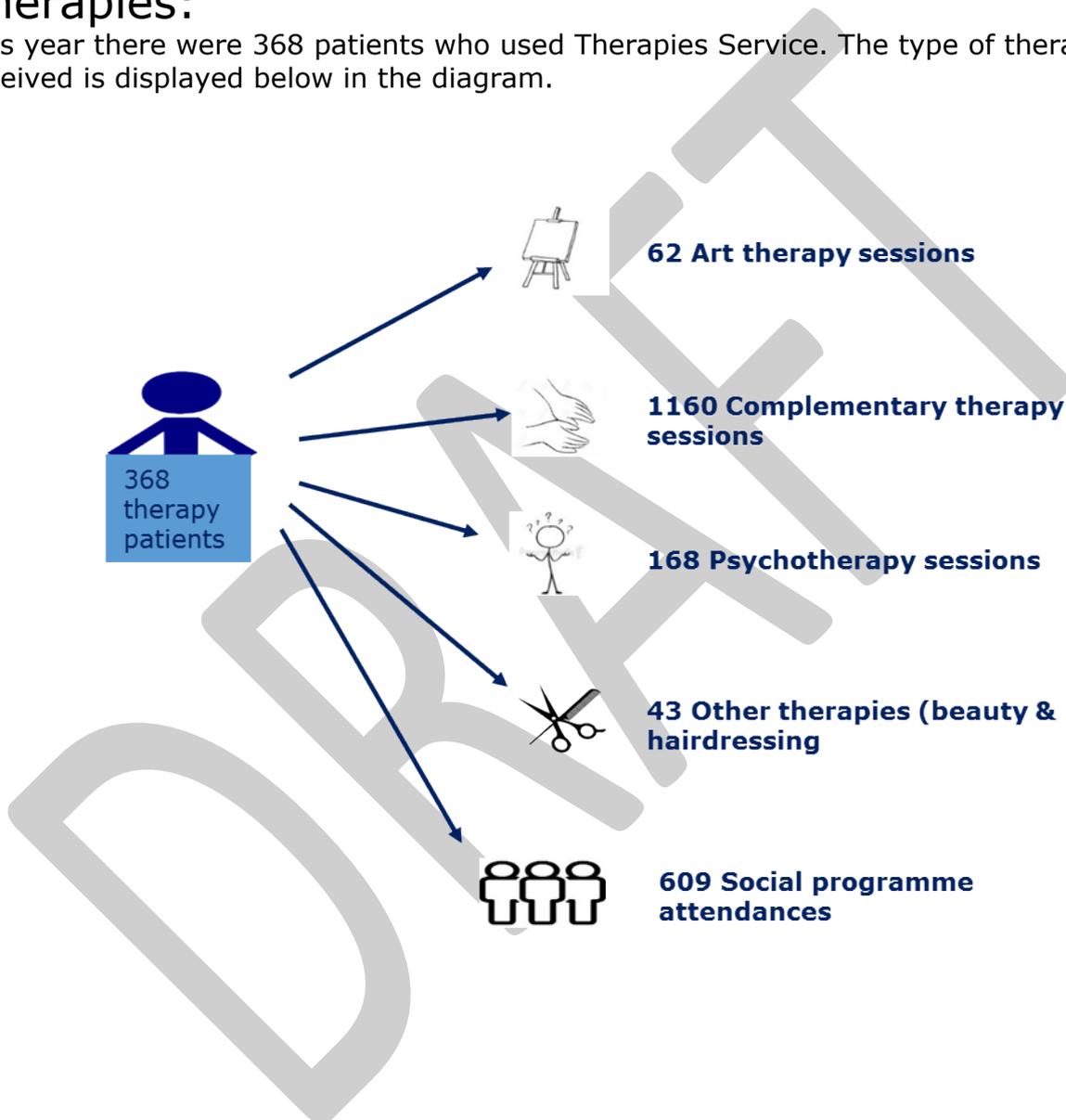
Bed occupancy is the percentage use of all 18 IPU beds calculated for the whole year and is used to monitor maximum use and availability of IPU beds for referrals. This year there has been a slight increase to 74.8% IPU bed occupancy from 70% last year. NLH compares bed occupancy quarterly to other similar sized hospices. In the first two quarters, NLH achieved higher bed occupancy scores (Q1: 79.8%, Q2: 80.7%) when compared with other similar sized hospices (Hospice UK Benchmarking) but lower in third quarter (Q3 69.6% vs 78% national). Full year comparative figures awaited. Factors that impact include ebb in referrals, daily admission capacity, staff sickness and staff vacancies. As part of daily admission meetings, NLH consider actions being taken to address any closed beds.

Closed bed days has increased to 39 days this year compared to 30 days last year. The causes were solely plumbing issues which rendered some rooms unavailable.

## Outpatient and Therapies Service

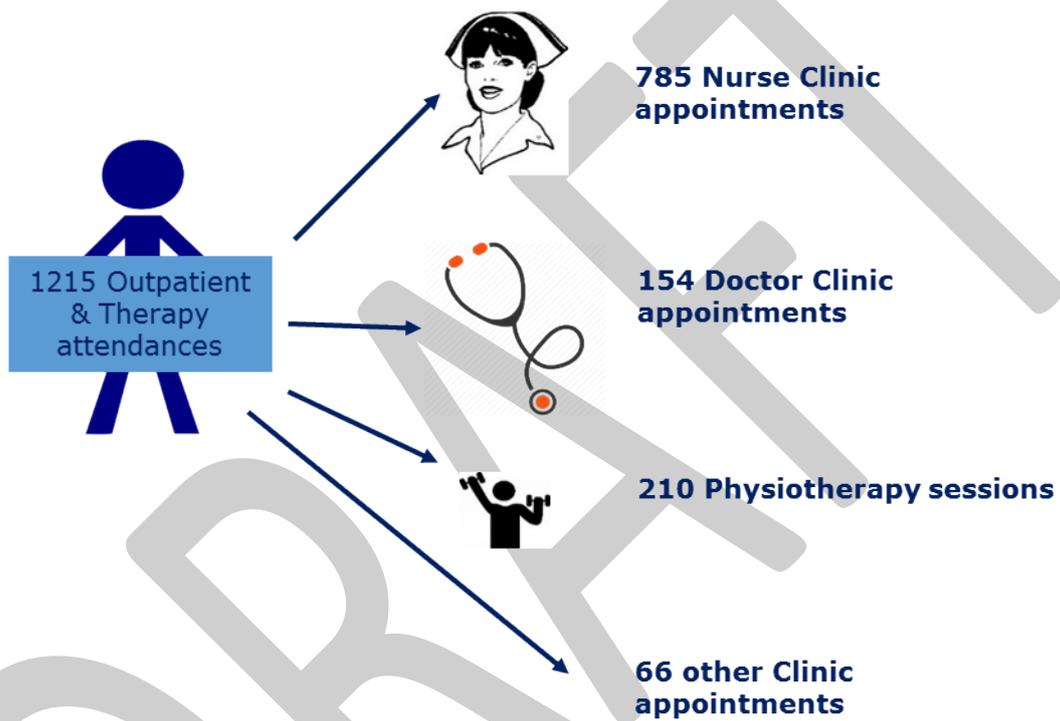
### Therapies:

This year there were 368 patients who used Therapies Service. The type of therapies received is displayed below in the diagram.



## Outpatients:

278 patients were seen in Outpatients with a total of 1215 attendances. "Other appointments" included those with the Occupational Therapist and Social Worker.

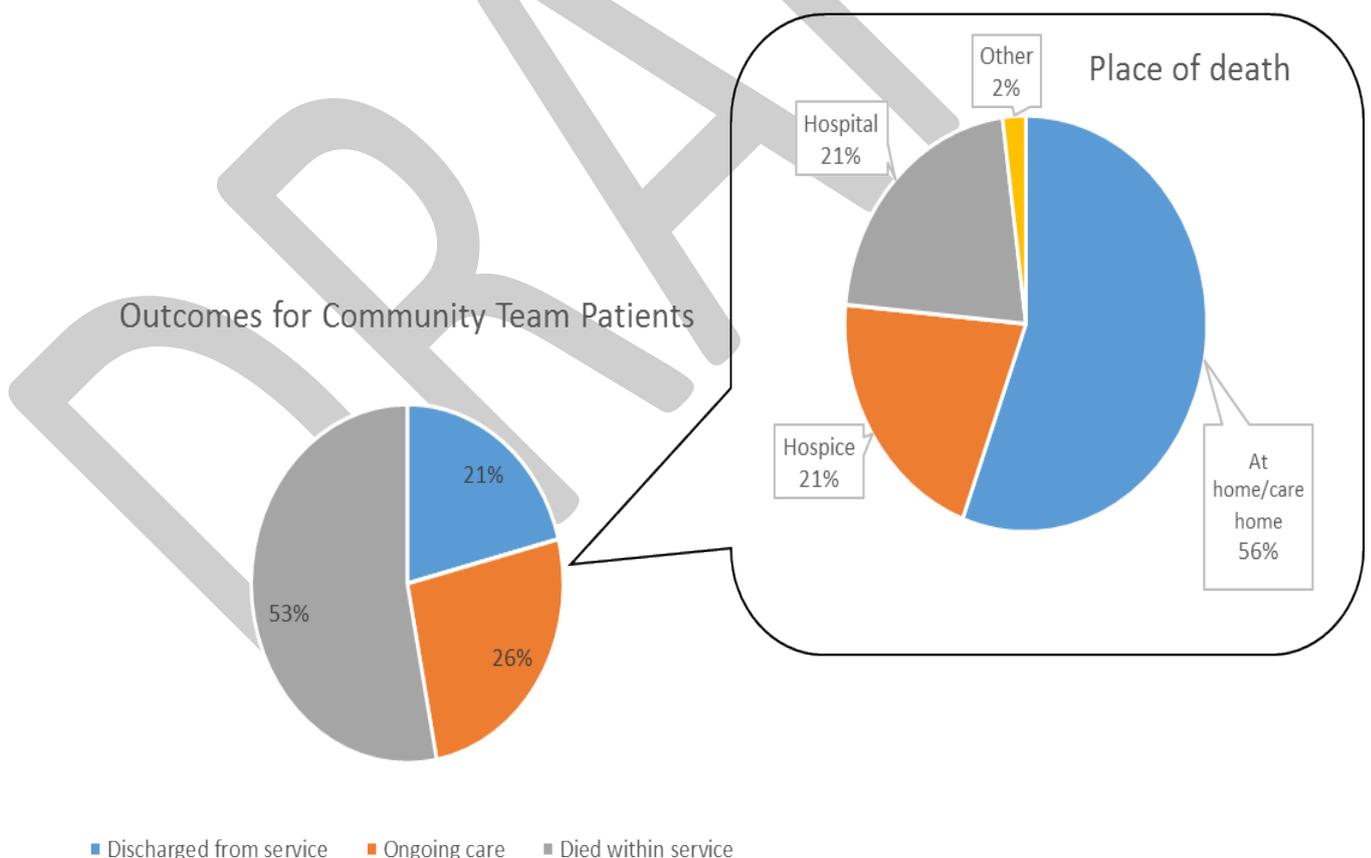


## Community Teams

The community teams have supported 2155 patients in their homes this year which is an increase from last year (1973 patients). NLH are thus supporting more and more very ill people to remain in their own homes.

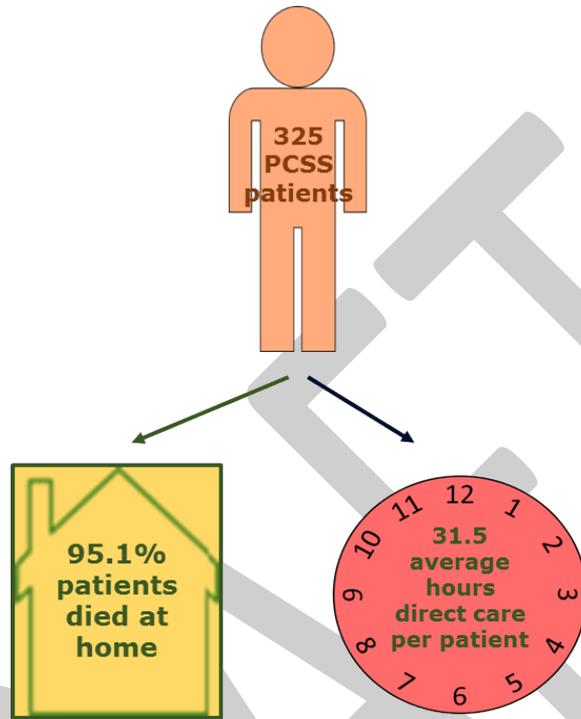
Of these community patients, 21% were discharged when they no longer required specialist support, 53% were supported by the service until their death, with 26% remain on the caseload

Of the 1145 patients who died whilst under the care of the community teams, 641 patients were supported to die in their own homes (56% home deaths) this year.



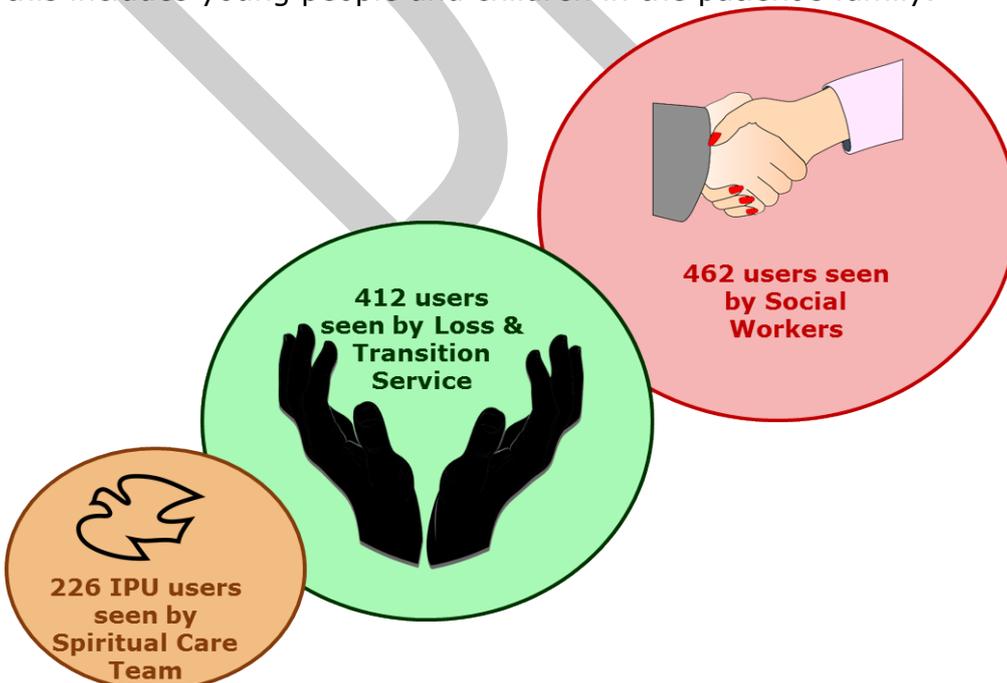
## Palliative Care Support Service (PCSS)

325 patients were supported in their own homes by the PCSS. 95.1% patients died whilst under the care of the service with an average of 31.5 hours of direct care provided per patient.



## Supportive Care Team

The infogram below 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.



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## SERVICE USER EXPERIENCE

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This year, we have been surveying patients attending Therapies service and those on the Inpatient Unit using hand-held tablets, rather than paper surveys. This has enabled us to hear current or real time feedback and gives the opportunity to take immediate action where necessary. Comments cards, the logging of compliments, gathering patient stories to add richer narrative to our user feedback remain the NLH standard for obtaining user feedback. Feedback is reviewed at service level with team members and also through NLH governance groups. All feedback is collated and analysed for themes and to identify improvements or changes required to endeavor to best meet our users needs.

### **User Surveys 2016**

- Paper surveys were sent out from May-October 2016 to the following services:
  - Community patients and relatives
  - Outpatients
  - Inpatient relatives
- Tablet surveys were undertaken throughout the year with
  - Inpatient patients
  - Therapies patients.

There was a 31% overall response rate with 306 patients/relatives providing feedback which is comparable to last year. The full results are collated in a report that has been presented to service leads, the Executive Team, governance meetings and the Board of Trustees. All services each year identify key areas for improvement.

Below NLHs key performance indicators' results are displayed.

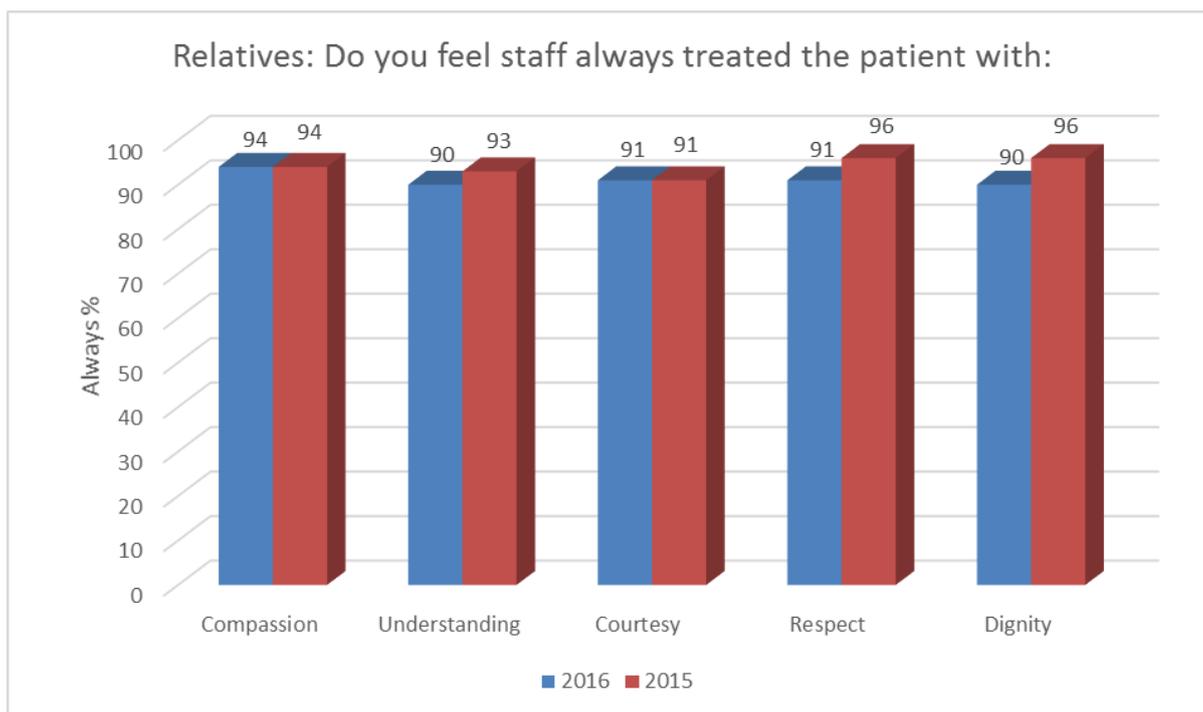
# Key Performance Indicators

## Key Performance Indicator 1



These results are the averages of the patients' experience for Inpatient Unit, Community Teams and Outpatients and Therapies services.

Outpatients and IPU had increases in all areas, Therapies and Community patients each had 3 areas which performed slightly less well in 2016. The Community Team saw a 4% decrease to 87% this year in "understanding". Therapies had a 5% decrease in "courtesy" and "respect" however this was still 95% in 2016.

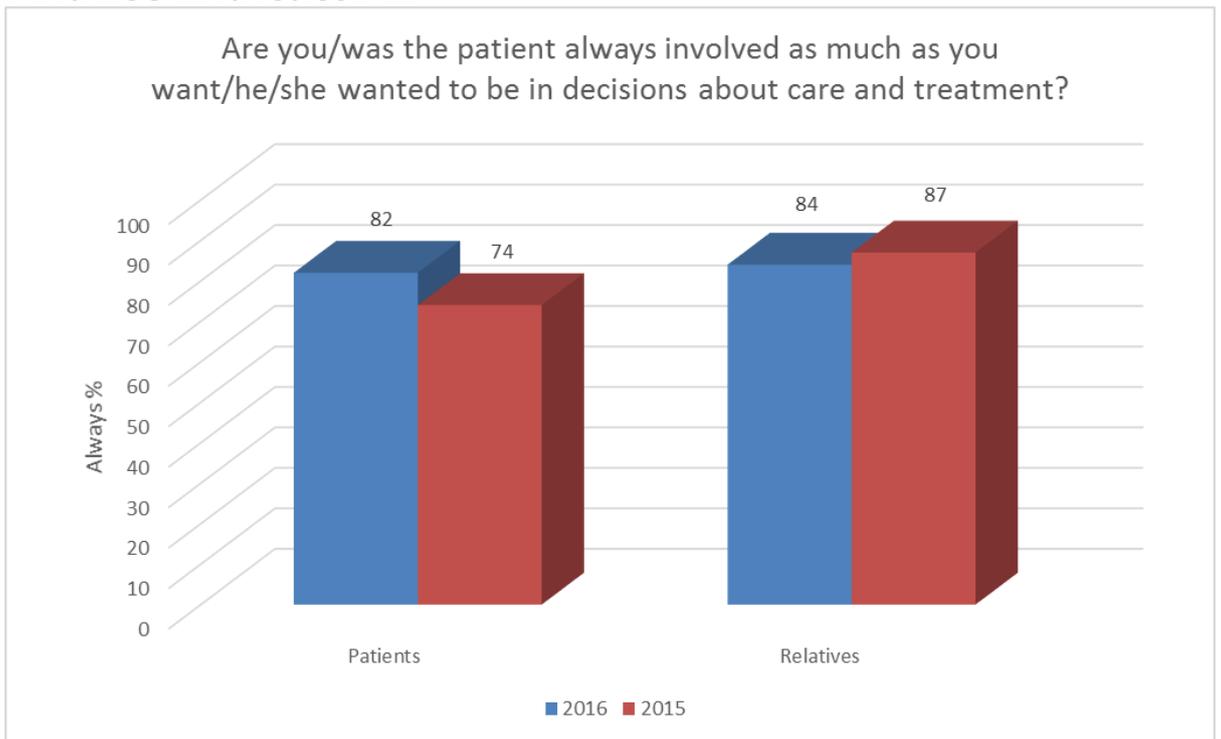


These results are the averages of the “always” results from Inpatient, Community Teams and Palliative Care Support Service relatives.

IPU, Haringey, Barnet and Enfield relatives results have improved from 2015. In all areas Palliative Care Support Service have seen a move from “always” to “sometimes”.

The Palliative Care Support Service has now developed a new training programme on identifying needs of patients and individualising care. This is currently being used with new and existing staff.

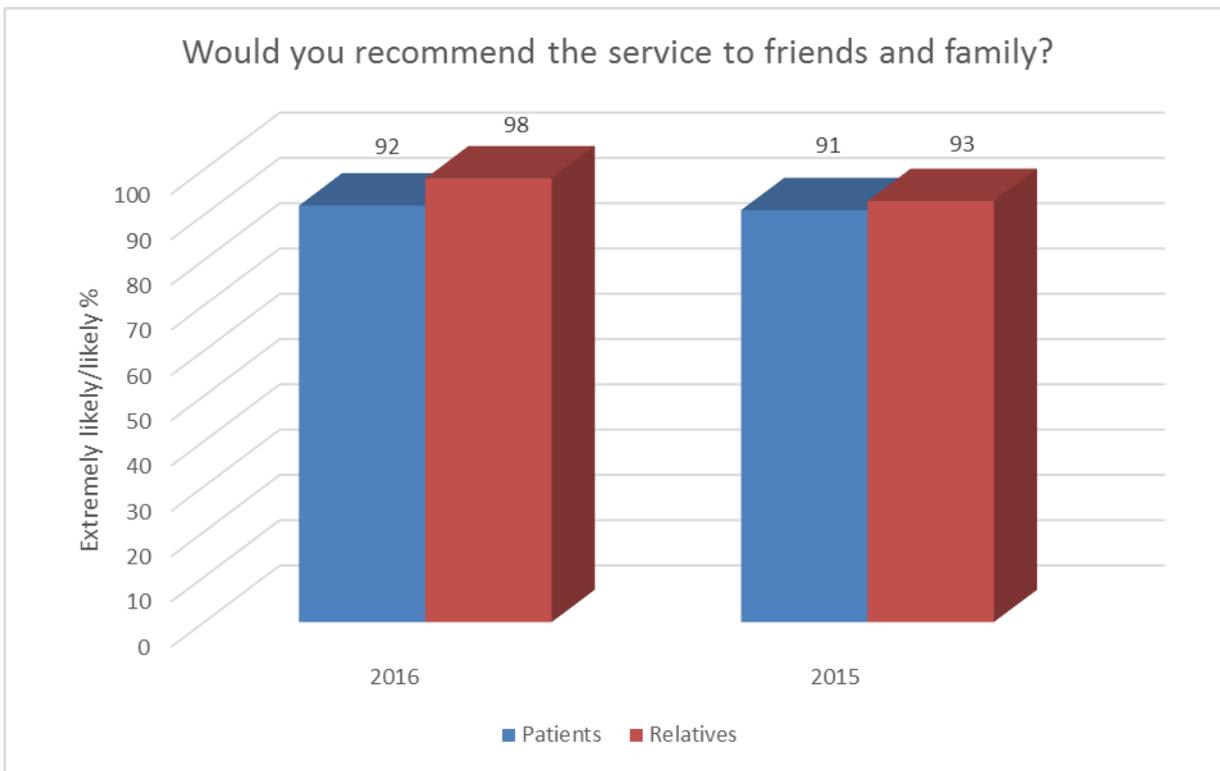
## Key Performance Indicator 2



For patients, this question features on the Community and Inpatient’s surveys only.

For relatives, those who were visited in the community by our Clinical Nurse Specialists had an increase in the number who said they were always involved. The responses of relatives of patients in the Inpatient Unit or who had the Palliative Care Support Service at home are the reason for the decline in the overall results.

### Key Performance Indicator 3



This year, the average of the responses, 'Extremely likely' and 'Likely' across the services is 95%.

There is an increase in the number of Haringey relatives who would be extremely likely to recommend the service. (93% in 2016 - 56% in 2015).

No-one has indicated that they would be unlikely or extremely unlikely to recommend the service.

Across all services 4% answered 'Don't know/not applicable' or left blank.

# COMPLAINTS

Quality Performance Indicator	2013-14	2014-2015	2015-2016	2016-2017
Number of Complaints (NLH target less than 30)	34	19	21	10

Quality Performance Indicator	2013-14	2014-15	2015-16	2016-17
Investigations completed, complaint upheld/partially	25	19	11	8
Investigations completed, complaint not upheld	6	0	5	1
Investigations unable to proceed as complainant not able to give full information	3	0	4	

## Analysis:

NLH receives complaints about its clinical and non clinical (charity shops) aspects of its business. This year of a total of 10 complaints received. 8 were clinical (patient services) complaints. 5 of these clinical complaints involved our community teams and 3 our IPU. This correlates with 0.35% of patients and families supported by NLH this year made a complaint.

Of the completed investigations 8 of the 9 complaints were upheld/part upheld. 1 complaint is in progress. The predominant theme of these complaints was communication issues and two related to inadequate standard of care. The following are some examples of actions taken following completed investigations this year:

- Arranging a meeting with the GP practice to explore ways of improving relationships
- Communication training given to staff member

As well as complaints, we record concerns and compliments. Concerns are an issue raised by a user that requires consideration.

## Concerns:

This year we received 37 concerns from our users. 30 related to clinical care.

Example 1: Difficulty getting through on the telephone to our Barrowell Green site

Conclusion: Increase in staff required so an extra member of staff is available to answer calls.

Example 2: Wife felt upset that her husband was transferred from IPU to a care home and

died shortly afterwards.

Conclusion: Unfortunately, NLH IPU is only able to offer short stay admissions due to the demand for its 18 beds from three Boroughs. When the patient was transferred it was not expected that he would die shortly after transfer.

### **Compliments:**

This year a total of 277 written compliments were received and recorded on NLHs Compliments Log

Community Team Barnet:

"Mums overriding wish was to be able to remain at home and your support and organisation of care and equipment made this possible. We are so incredibly grateful to you for enabling mum to pass peacefully at home."

Community Team Enfield:

"Patient had such confidence in your expert care of him, you always listened to his concerns and respected his wishes."

Community Team Haringey:

"You gave us a shoulder to lean on and for that we are very grateful."

Inpatient Unit:

"The nurse with us at the time of the death went out of his way to help put not just the patient but the whole family. He really put us all at ease with the situation. Because of this nurse the patient died peacefully and with dignity - the whole family felt reassured"

PCSS:

"I was hugely impressed by their knowledge of palliative medicine and their kindness and compassion not just towards him but towards me too. They went well beyond the call of duty."

Outpatients:

".We can't speak highly enough of the kindness, compassion and help we are receiving. A big "Thank you" in gratitude to the Outpatient Department."

Therapies:

"The atmosphere is always friendly and relaxed. The ambiance and the environment is very pleasant & welcoming. The staff are lovely and immediately offer a cup of tea or coffee"

Supportive Care:

"I cannot thank everyone at the North London Hospice enough for getting me through the first five months after my mother died. The combination of the walk and talk and counselling with Ruth, on the same morning really helped me cope."

## User Narratives

Four patients/relatives agreed to record their experience.

"Out of hours number worked well and the instructions are extremely clear. When you're stressed sometimes it's difficult to process information but it was explained to her by the CNS. The card was clear, the message on the phone was also very clear. She always heard back within 15 mins. On one occasion someone phoned her back even when she hadn't been able to leave a message because the nurse spotted a missed call. Other services she dealt with were nowhere near as good. Our telephone service was invaluable."

"The love and care they treated my granddad with was wonderful. He was afraid that he would just be seen as an old man in the corner and not the person he was but the staff asked me to bring some pictures of him when he was younger to show them."

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## PATIENT SAFETY

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### Incidents

	2013-14	2014 -15	2015-16	2016-17
Total number of Incidents	279	250	216	371
Total Number of Clinical Incidents	168	173	152	312

### Analysis:

The total number of reported incidents this year has increased by 58%.

This is attributed to our improved reporting system using Sentinel (electronic reporting system), which is now embedded in the organization. The continued emphasis on the importance of reporting of all incidents and our "no blame" culture has also helped ensure all incidents are reported. We have systems in place to ensure incidents are analysed for trends and themes and any learning needs identified.

Additional training has been carried out for staff on health and safety issues such as being a fire warden or first aider. This has further increased awareness amongst hospice staff on importance of incident reporting.

NLH aims to be open and honest when any incident happens. There is also a legal duty for NLH to follow "Duty of Candour" regulations where incidents have caused or could lead to significant harm to patients. There has been one Duty of Candour incident where a patient was admitted with a grade 2 pressure ulcer and during their admission "acquired" a Grade 3 pressure ulcer. The patient was informed of the change in the grade of her pressure ulcer. The investigation concluded that this was an avoidable pressure ulcer and therefore Duty of Candour applied (as Grade 3 avoidable pressure ulcer equates to significant harm). NLH were unable to proceed in accordance with Duty of Candour Policy and discuss this with the patient or next of kin as the patient had died and their next of kin did not have mental capacity.

### Inpatient incidents:

NLH continues to benchmark itself by submitting quarterly data to Hospice UK and comparing its IPU incident numbers with other hospices of this size.

\*Full year comparative data will be entered when available.

### Falls

	2015 - 2016	2016 - 2017
Number of Patient related slips, trips and falls	36	27
Falls per 1,000 occupied bed days	7.83	5.74
Hospice UK Benchmarking Falls per 1000 occupied bed days	10.6	*

### Medicine Incidents

	2015 - 2016	2016 - 2017
Number of medicine incidents	22	28
Medicine incidents per 1000 occupied bed days	4.8	5.74
Hospice UK Benchmarking Medicine incidents per 1000 occupied bed days	6.4	*

The first three quarters comparative data with other similar sized hospices shows that NLH has well below the national hospice average for falls (40% of national average) and medication errors (5%).

### Pressure Ulcers

Please see Appendix 4 for definition of acquired, inherited, avoidable and non avoidable

	2015 - 2016	2015 - 2016	2016 - 2017	2016 - 2017
	NLH	Hospice UK Benchmarking (average)	NLH	Hospice UK Benchmarking (average)
<b>Pressure ulcers inherited</b>	**	**	139	
<b>Pressure ulcers acquired (avoidable)</b>	36	3.1	6	*
<b>Pressure ulcers acquired (unavoidable)</b>	12	17.8	51	*

\* \*Data for inherited pressure ulcers not collected previously

This data shows us that North London Hospice inherits and acquires patients with a greater number of pressure ulcers than other hospices of its size.

The reason for this is yet to be understood and could be due to differences between units' patient profiles. It is possible NLH admits more patients for end of life care than other similar sized hospices as this would make patients more susceptible to the development of pressure ulcers.

**What we have done / are doing:**

For 2016 – 2017 the increase in numbers of Quality Team staff has enabled more scrutiny of all incidents reported, and for pressure ulcers in particular. All pressure ulcers (inherited and acquired) are logged and reviewed in a timely and detailed manner. This includes assessing to ensure appropriate care is in place as well as accurate reporting and analysis.

Further analysis of inherited pressure ulcers examined where patients admitted with pressure ulcers came from, and did not find any particular trends or patterns

- 40 % from home
- 40 % from local hospitals
- 20% miscellaneous (from individual care homes, private hospitals, other hospitals)

NLH continues to report all patients who are admitted with Grade 3 (or above) Pressure Ulcers to the CQC, relevant CCG and Safeguarding Team as per policy.

NLH will continue to monitor inherited pressure ulcers and are working with Tissue Viability nurses in the Community to ensure best practice is maintained.

NLH aims to have no avoidable pressure ulcers acquired in the IPU. To ensure that all our pressure ulcers are unavoidable, NLH are taking the following actions:

After a 5 month vacancy, in January 2017 a senior registered nurse already working in the inpatient unit was employed, to work 2 days a week as a Tissue Viability nurse.

His current priorities are

- To work with the team to prevent and manage pressure ulcers by ensuring best practice is followed
- To implement recommendations and changes to practice identified from Route Cause Analysis's from Grade 3 pressure ulcers that have developed in the unit.
- To continue to monitor pressure ulcer prevalence and identify trends / patterns that can be learnt from

He will receive training and mentoring to ensure he has the knowledge and skills to undertake this role.

## Infection Control

QUALITY AND PERFORMANCE INDICATOR(S)	NUMBER 2013-14	NUMBER 2014 -15	NUMBER 2015-16	NUMBER 2016-17
Patients who contracted Clostridium Difficile, Pseudomonas, Salmonella, ESBL or Klebsiella pneumonia whilst on the IPU (NLH target 0)	0	0	0	0

NLH are pleased to note that no patients have contracted any of the above infections whilst under the care of IPU.

## NLH STAFFING

NLH employs a total of 196 (154.4 WTE) permanent staff and 58 bank staff. It benefits from the efforts of approximately 980 volunteers who are used as required in clinical and non-clinical roles. The Hospice has many staff working part time or flexible hours.

	2013-14	2014-15	2015-16	2016-17
Staff joined	52	54	50	74
Staff left	30	50	52	59

Recruitment, particularly of Band 5 and Band 7 nurses, has continued to be difficult. NLH has embraced the concept of apprenticeships, enrolling two current employees on appropriate advancement courses. A number of recruitment and retention incentives have been considered, including introduction of a health cash plan launched during the year and agreement in principle to an annual leave sale/purchase scheme for possible future implementation. Research is underway into possible negotiation of staff price discounts with local and national retailers and service providers. Long service will now be recognised by presentation of appropriate certificates during suitable staff functions. As one of a range of measures to improve internal communication, weekly Staff News Exchange events, to which all are invited, are held. The staff Information & Communication Forum continues to mature and plays an important role as a platform for issues and concerns to be raised, discussed and addressed as necessary.

NHS England (2017) asked for comment on NHS Staff Survey KF26 (percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months) and KF21 (percentage believing that the trust provides equal opportunities for career progression or promotion relating to the Workforce Race Equality Standard).

NLH use the Hospice UK-sponsored staff survey where some questions relate to the indicators above. Below are the questions asked and responses:

	In the last year I have not been bullied at work			Diversity is welcomed at the Hospice		
	%			%		
	Staff N=112	Volunteers N=200	All hospices	Staff N=112	Volunteers N=200	All hospices
Strongly disagree	4	0	3	5	1	2
Disagree	10	2	5	5	2	4
Neither agree nor disagree	10	8	8	26	23	23
Agree	32	32	30	41	45	46
Strongly agree	44	58	54	24	29	25

The survey was completed by 43% of our staff and 20% of volunteers. Although participation was marginally lower than the average for all hospices using the survey, responses from NLH staff who took part this year in these two areas, were better than those submitted during the previous year. As the survey was anonymous a further survey was circulated asking for narrative comments on areas where scores were lower. The Executive Team continue to seek clarification where possible and to address any issues felt to be relevant, and satisfaction levels will continue to be monitored through staff surveys, open forums, Personal Development Review comments and exit interviews. Any allegations of bullying are rigorously investigated and dealt with.

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# NLH BOARD OF TRUSTEES QUALITY ACCOUNT COMMENT

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## **NLH Board of Trustees Quality Account Comment**

Reflecting on the many achievements of this last year as we celebrate 25 years of inpatient Hospice care, the Board of Trustees particularly welcomes the independent corroboration by the CQC (Care Quality Commission) of the quality and standards of care provided by the Hospice across all service areas. A rating of GOOD was achieved in all the three service settings visited, Finchley, Winchmore Hill and Haringey. This rating as well as the achievements reflected in this year's Quality Account serve once again to give sound assurance of the ongoing high standards of care as well as the continuous efforts to respond to the views and needs of carers and users of Hospice services across all settings.

The Board has been kept informed of progress made throughout the year against the areas identified as Priorities for Improvement. As in previous years, these build on existing good practice both internally and externally. Establishing the User Forum builds directly on the priorities identified in 2015/16 and is the next step in taking the user feedback pilot to the next level. Likewise, although the work relating to the Five Priorities of Care was well embedded in practice, there was concern that documentation and record keeping did not always reflect the full implementation of good practice. A simple yet very effective communication and engagement tool recognised nationally has been the introduction of the 'Hello my name is...' model. All staff and volunteers have been issued with new names badges and there is positive feedback from relatives and patients about the helpfulness of this initiative. This last year's priorities also recognised the challenging, sometimes distressing and often stressful nature of caring in any health related setting. Although the Hospice has a supportive culture, excellent training and supervision systems, the introduction over the last year of the Schwartz Round model widely implemented in the NHS, has created the opportunity across all disciplines and levels of responsibility to share some of the pressures and anxieties in a safe and containing manner. The Board especially welcomes this development, recognising that the pressures on teams across all services continue to be significant.

The Board welcomes the improvements and achievements illustrated in this year's Quality Account. As in previous years, the Board fully supports the Priorities for Improvement identified for 2017/18, recognising that they build on much of the excellent work already being undertaken. Of particular interest to the Board is the work being proposed around co-production with users of the services, carers, volunteers and staff in shaping the Outpatient and Therapies services and the focus on Hard to Reach groups in the community that the Hospice serves. In terms of patient safety, again, building on good practice and responding to the data around slips, trips and falls, this initiative is particularly welcome as is the ongoing support for the development of staff and maintaining good practice through the work of a multi professional Journal Club.

Once again, this year's Quality Account illustrates that the Hospice is committed to serving the local community and making services more accessible to a greater number of people through the commitment, dedication and loyalty of its skilled staff and volunteers.

**John Bryce**  
**Chair - North London Hospice Board of Trustees**

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STATEMENTS FROM COMMISSIONERS,  
HEALTHWATCH, HEALTH OVERVIEW AND  
SCRUTINY COMMITTEES

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# APPENDIX ONE: OUR CLINICAL SERVICES

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## 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 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

## 2. Out-of-hours telephone advice service

Community patients are given the out of hours 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.

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

The Outpatient and Therapy Service is based at the Winchmore Hill site and aims to improve the quality of life for patients and carers from the time of diagnosis. The services are run at Winchmore Hill and the Finchley site.

The Outpatients and Therapies Service provides a range of interventions on an individual and group basis to help with the management of symptoms, emotional support, wellbeing and planning for the future. The service also offers opportunities for social interaction and peer support.

The multi professional team includes a Palliative Care Consultant, Specialist nurses, physiotherapy, occupational therapy, complementary therapy, psychological therapies and social work.

The services are available from the time of diagnosis and we work closely with the community teams to provide a seamless service.

## 4. 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.

## 5. 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.

## 6. Loss and Transition Service (including Bereavement Service)

The Loss and Transition Support Service supports:

- Individual NLH 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.

## 7. 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. In Haringey, are a signposting service for patients in the last year of life.

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## APPENDIX TWO: INFORMATION GOVERNANCE

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The NLH Information Governance Framework sets the process and procedures by which the Hospice handles information about patients and employees, in particular personal identifiable information. To support this framework the Hospice annually completes the NHS Information Governance Toolkit. The annual submission process provides assurances to external agencies and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

Delivery of the information work programme is overseen by the Information Governance Steering Group which is chaired by the Commercial and Financial Director.

Information Governance (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 .... In April we received confirmation that our assessment has been reviewed by the HSCIC and has been confirmed as satisfactory.

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

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## 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 NLH's Balance Scorecard bi-annually.

## Executive Team (ET)

ET reviews and monitors the minutes of all quality meetings, NLH's Balance Scorecard, and clinical and non-clinical risk.

## Quality, Safety and Risk Committee (QS&R)

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 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 for approval and monitoring. The audit plan is ratified by QSR on an annual basis. ASG 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)

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

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## APPENDIX FOUR: DEFINITION OF *AVOIDABLE AND UNAVOIDABLE PRESSURE ULCERS*

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An **Avoidable pressure** ulcer means the person receiving care developed a pressure ulcer and the provider of care did not do the following:

- Evaluate the person's clinical condition and pressure ulcer risk factors.
- Plan and implement interventions that were consistent with the person's needs and goals and recognised standards of practice.
- Monitor and evaluate the effect of the interventions.
- Revise the interventions as appropriate.

An **Unavoidable pressure** ulcer means 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 were consistent with the person's needs and goals and recognised standards of practice.
- Monitored and evaluated the effect of the interventions.
- Revised the approaches as appropriate.

Alternatively, the individual refused to adhere to prevention strategies in spite of education about the consequences of non-adherence.

(Department of Health 2010)

Acquired pressure ulcer refers to a pressure ulcer that developed after 72 hours of care by a service and the service is accountable for its development.

Inherited pressure ulcer refers to a pressure ulcer that developed before 72 hours of care by a service and the previous service is accountable for its development.

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## ACCESSING FURTHER COPIES

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Copies of this Quality Account may be downloaded from either [www.northlondonhospice.org](http://www.northlondonhospice.org)

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## HOW TO PROVIDE FEEDBACK ON THE ACCOUNT

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

If you have comments contact:

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