

NORTH·LON
HOSPICE



Quality Account 2012/2013

"The care my mother received was extremely professional"



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Registered charity No: 285300

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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 (NLH) 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, an Out-of-Hours Telephone Advice Service, Day Services, Inpatient Unit (IPU), Palliative Care Support Service (PCSS, NLH's Hospice at Home service) and a Loss and Transition Service (including Bereavement Service).

The following three priorities for improvement for 2013-14 are proposed:

1. Improvement of users' experience through the ongoing development and review of new volunteer roles.
2. Introduction of an ultrasound service on the IPU.
3. The introduction of version 12 Liverpool Care Pathway tool into the community

The 2012-13 priorities for improvement projects are reported and have contributed already to increased user feedback through the rich narratives of patient stories, improved IPU nurse knowledge and documentation of wound care, new planned review of community patient risk assessments where PCSS staff find these uncompleted at point of care and improved training, communication with users and documentation of advanced care planning decisions.

NLH received two unannounced inspections by the Care Quality Commission, one on our site in Enfield and the other on our site in Finchley. We were found to be compliant against the required standards.

Key service developments are described concerning new Enfield Day Service provision, volunteer development, use of Situation Background Assessment Recommendation (SBAR) tool in community multidisciplinary meetings, the introduction of an associate role in the

community and end of life training including the awarding of NLH as national regional centre for end of life training for care homes.

Service data is highlighted and discussed. IPU cared for 306 new patients and their average length of stay was 12.6 days. 26% patients were discharged from IPU. The community teams cared for a total of 1271 patients in their own homes (of which 898 were new patients)and supported 55% of these patients to die at home where this was their preferred place of care. PCSS cared for 242 patients and provided a total of 9,497 hours of one-to-one nursing care to people in their own homes.

NLH's user surveys revealed that 100% patients were satisfied with our service and 98% would recommend service to families and friends. Our case study reported on page 47 provides one current users feedback.

The Board of Trustees give 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 second Quality Account which covers the period 2012-13.

The Quality Account is produced to inform our scrutineers and the public of our commitment to providing high quality 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, thanks to the generous support of our local community.

The charity makes no charge to its patients or their families or carers. It cost £5.8 million to provide these care services during 2012/13. NHS grants contributed 36% towards this.

Our 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.

Our mission states

"We care about people with a potentially life-limiting illness and aim to add quality and meaning to their life journey.

We do this by:

- 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

We provide this care and support to people in their own homes, care homes or in the hospice itself."

As a charity, we are challenged to deliver our vision and mission during the current economic climate. Following two previous years of declining charitable income we have stabilised our voluntary income

through the implementation of a robust fundraising strategy. However the running costs of the Hospice continue to increase. Due to careful management in the past, North London Hospice has reserves that we have continued to use to prevent any reduction in our care services but obviously this is not sustainable indefinitely and we are currently exploring options that would return us to financial balance by April 2015. Our Hospice charity shops have done well and our expansion to 18 shops has helped. Central to our corporate objectives for 2012-13, therefore, was balancing the sometimes conflicting priorities of developing quality services whilst making cost savings.

We have worked together with our staff to review our workforce skill mix and numbers and to identify cost savings.

This year has shown significant developments in our volunteering workforce and we have increased the training and supervision of our volunteers so that they can work more closely with our users. We were successful in receiving Department of Health capital funding which we successfully matched with a Fundraising Capital Appeal to build a second NLH site at Enfield. This site was opened in late summer of 2012 and re-housed our Enfield Community Team as well as providing a purpose-built site for our new style day service providing services closer to our Enfield and Haringey users.

NLH Board of Trustees reviewed and approved this Quality Account at a meeting

On....

I am confident that the information set out in this Quality Account is a true reflection of the quality of our current health care provision.

Quality is important to us. We hope you find our Quality Account useful. We welcome your suggestions for our future accounts.

Douglas Bennett
Chief Executive of North London Hospice
April 2013

Introduction

NLH started to produce and share with the public its Quality Accounts from 2011-12. This 2012-2013 Quality Account is however the first mandatory Quality Account.

Quality Accounts provide information about the quality of the Hospice's clinical care and initiatives to the public and NHS commissioners. Some sections and statements are mandatory for inclusion. These are italicised to help identify these.

The 2011-12 Quality Account has been made available to the public on the internet (NHS Choices and NLH website) and a copy is readily available to read in the reception areas at the Finchley and Enfield sites. Paper copies are made 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, chaplains and volunteers. NLH offers the following clinical services:

1. Community Specialist Palliative Care Teams (CSPCT)
2. An Out-of-Hours Telephone Advice Service
3. Day Services (DS)
4. Inpatient unit (IPU)
5. Palliative Care Support Service (PCSS, NLH's Hospice at Home service)
6. Loss and Transition Service (including Bereavement Service)

For a full description of our services please see Appendix One

Part 2

Priorities for Improvement 2013-2014

The following priorities for improvement for 2013-2014 were identified by the clinical teams and are endorsed by the Clinical Governance Sub Committee and Board of Trustees.

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

1. Priority One: Patient experience

Improvement of service users' experience through the ongoing development and review of new volunteer roles.

It is the Hospice's goal to develop a more skilled and patient-centred volunteer workforce. New roles currently exist supporting patients living at home and their families (through the first year following their bereavement). They work alongside the Hospice's clinical services providing emotional and practical support to patients and their families. New volunteer roles are planned for Finchley Site Hospitality and the Inpatient Unit.

This project will encompass the surveying of service users, as well as volunteers and affected staff, concerning the impact of the newly developed and future volunteer roles on the patient experience.

- April 2013 Project Group formed
 - May 2013 six-month Volunteer Transition Lead post appointed. Recruit survey volunteers
 - By June 2013 agree user survey questions
 - June-September 13 user survey period
 - By July 2013 complete staff/volunteer survey re reception volunteering and identify actions for developing new hospitality volunteer role. Identify questions for staff/volunteer surveys re existing volunteer roles.
 - September 2013 start staff/volunteer survey re existing volunteer roles
 - January 2014 Project Group to consider findings from all surveys
 - February 2014 publicise survey findings internally with volunteers and staff
 - March 2014 review arrangements based on feedback and produce action plan
- This will lead to a more evidenced, user-informed action plan for these developments.

2. Priority Two: Patient safety

Introduction of an ultrasound service on the Inpatient Unit

The inpatient unit (IPU) team plan to develop an ultrasound service for assessing if patients have an accumulation of fluid within their abdomen (ascites). Currently the team rely on clinical assessment alone to assess for the presence of ascites and perform paracentesis (drainage of the fluid) or have to transfer the patient to the local hospital for an ultrasound.

The use of ultrasound assessment prior to paracentesis is now considered best practice where ultrasound is available. This will improve the diagnostic certainty regarding the presence of ascites and exclude differential diagnoses. It will enable the team to identify if proceeding to paracentesis is safe and appropriate. On completion of training for all the IPU consultants it should be standard practice for all IPU patients to be assessed by ultrasound prior to paracentesis.

This ultrasound service will be available for IPU patients but can also be accessed by community patients who are able to attend the Hospice for assessment. The primary aim of introducing the ultrasound service is to improve patient safety and improve the efficacy of our resources. However, it will also limit the need for patients to attend hospital for an ultrasound, which will improve the patient experience.

Project Action Plan:

- Baseline review of current paracentesis activity on the unit.
- Protocol development for the use of ultrasound and paracentesis activity procedures at the Hospice.
- Establishing the service
- Audit to assess the level of access to the service and see if the Hospice is adhering to the protocol.
- Case review (results of assessment, whether proceeded to paracentesis, outcome of the paracentesis procedure, reflection on any learning)
- Learning applied to practice

3. Priority Three: Clinical Effectiveness

The introduction of version 12 of the Liverpool Care Pathway tool into the community

The Liverpool Care Pathway (LCP) is an integrated care pathway published by the Marie Curie Palliative Care Institute Liverpool that is used by healthcare professionals in order to optimise and standardise care during the last hours and days of life. Use of the LCP is widely considered to be best practice when caring for dying patients. Following a national review of the previous document (version 11) an updated (version 12) was published in 2009. The LCP is published in a generic form, which can be used in any care setting, however it is possible for healthcare institutions to amend the generic document to best suit their working environment.

An adapted version of LCP version 12 is currently in use on the inpatient unit at NLH, however the community teams are still using version 11.

The aim of this project is to work with Community Palliative Care Clinical Nurse Specialists from NLH, District Nurses and General Practitioners in order to update the version of the LCP in use in the local community to version 12 in line with nationally accepted standards.

Project Action Plan:

- Approval of version 12 LCP tool Enfield End of Life Steering Boards- **To complete by May 2289368022013**
- Submit to Liverpool (Marie Curie Palliative Care Institute) for matching if required- **To complete by June 2013**
- Plan implementation programme with Clinical Nurse Specialist (CNS)/District Nurse's (DN's) teams- **To Complete by August 2013**
- Implement version 12 LCP to community- to include adapting current LCP training delivered by NLH CNSs to DNs- **To complete by July 2013**
- Audit after 6/12 of use (of complete document using audit tool provided by Liverpool)- **To complete by April 2014**

Project plans will be monitored through management structures and quarterly progress reports to the Clinical Quality Group. The Clinical Governance subcommittee will receive reports on progress every six months.

Statements of Assurance from the Board

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

Review of services

During 2012-2013, North London Hospice 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.

The North London Hospice 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 2012-2013 represents 27 per cent of the total operational income generated by the North London Hospice for the reporting period 2012-2013.

Participation in clinical audits

During 2012-2013, there were 0 national clinical audits and 0 national confidential enquiries covering NHS services that North London Hospice provides. During that period North London Hospice 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 North London Hospice was eligible to participate in during 2012-2013 are as follows (nil). The national clinical audits and national confidential enquiries that North London Hospice participated in, and for which data collection was completed for 2012-2013, 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 2012-2013 and North London Hospice 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 reports of 15 local clinical audits were reviewed by the provider in 2012-13 and NLH has taken or intends to take the following actions to improve the quality of healthcare provided.

Summary of Audits 2012-13:

Audit Topics	Key Findings	Actions
Mouth care audit	Requirement for more detailed documentation and need to involve relatives more	Mouth care guidelines introduced. Assessment tool being developed to include relative's involvement. Standard for 1 st documentation being created.
Room cleaning and maintenance handover between these teams and clinical team on IPU	Standards of cleanliness good. Gaps in room handover sheet documentation.	Housekeeping lead being recruited (May 13) to oversee this and work closer with newly appointed Head of IPU (plan completion August 2013).
Hand-washing Audit 1	High level of hand decontamination compliance though lower between tasks with same patient.	Highlight results to staff (several formats). Looked at reviewing tool for next audit but could not because it is an international used tool (WHO). Agreed to review if reoccurring theme at next audit in 6/12. Planned to extend audit sample to bank and non clinical staff.
Hand-washing Audit 2	As above	Plan observational audit next time.
Infection Control Audit	High level of compliance.	Action plan has shown significant improvements.
Audit of new Incident Policy	Variation in incident form completion & risk score	Incident form reviewed and currently being piloted (June 13)with consideration of developing electronic form. Staff training adapted to share learning.
NICE End of Life Audit	11 green, 7 amber, 2 red standards. Red- verification of death and need for after death policy and 24 hour 7/7	Draft after death policy being reviewed by IPU (expected implementation date August 13), environment outside viewing room improved, 24 7/7 restricted by resources of hospice as charity funded organisation.

	admissions.	
Opioid Documentation in the Community Teams Notes on iCare	Inconsistencies in documentation persist despite increased staff training (may have been affected by IT issues at time).	New process in place for recording medication changes and medication charts now reviewed as part of weekly MDT.
Care Quality Commission (CQC) Standards Compliance Audit for All Clinical Services		Action plans incorporated in to services corporate plans and monitored by Clinical Quality Group (CQG)
Wound Care Audit	High level of pressure sore status documented on admission. Appropriate mattresses in place for all.	Pressure sore/wound care status added to First Assessment Checklist. Electronic patient record code for wound care introduced to identify all such entries. Wound care plan in use. Wound care teaching topic for April 13.
Blood Transfusion Checklist Audit	Poor documentation of procedure	Risk identified. Results fed back to staff. Observational audit actioned confirmed practice good so risk was isolated to documentation. Questionnaire given to staff to assess knowledge of practice & procedures.
Completion of risk assessments for the Palliative Care Support Services (PCSS) Audit	Good (75%) completion rate. Not all held in correct location or updated.	Risk identified. Results fed back to staff including District Nursing Services who considered completion rate high. Moved to carbon copy so can be held at required sites. Review of NLH lone worker policy.
Recording of allergies at first visit	community teams re audit- 100% compliance.	IPU implemented community improvement of checking status at weekly MDT. This will be added to MDT review performa

	IPU- new audit lower compliance.	being developed.
Drug Errors Reporting Audit	Increase in drug error reporting. Identified incident form did not monitor all aspects of procedure so documentation required improvement.	Reporting increase suspected to be part of increased incident reporting organisational culture change. Risk identified to poor documentation of procedure. Staff informed and debated changes required at Clinical Forum. Prospective review of drug error incident identified good practice. Pilot of new drug error incident form. Re audit planned.
Complaints Audit	High completion of new form and procedure compliance.	Fed back to staff. Improvements required highlighted in staff annual training programme.

Research

The number of patients receiving NHS services, provided or sub-contracted by North London Hospice in 2012/2013, 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 in.

Quality improvement and innovation goals agreed with our commissioners

North London Hospice income in 2012/2013 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. North London Hospice 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 against North London Hospice during 2012-2013.

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

In June 2012 the Care Quality Commission (CQC) approved the registration of the Hospice's new building in Enfield and day services commenced there in August 2012.

In September 2012 (Finchley site) and February 2013 (Enfield site) the CQC carried out unannounced inspections as part of a routine schedule of planned reviews. 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.

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

Data quality

North London Hospice did not submit records during 2012-2013 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.

NLH has reviewed the processes and where necessary put in place procedure to capture and maintain the accuracy of the patient data.

A more detailed review has been done of the clinical data to enable NLH to provide the information split between the different Boroughs to which it provides a service.

NLH is committed to developing electronic documentation system to reduce clinical time spent in form filling and support the need to provide greater evidence of care actioned. NLH is in the process of introducing SMART forms (user defined patient and professional information tools) onto the iCare clinical record computer system.

NLH is also working on ways to improve the capture and timely reporting of Human Resource statistics and where possible relate it to performance.

All of this work compliments the work this year on Information Governance.

Statistics relating to activity for the various services

North London Hospice Information Governance assessment report score overall score for 2012-2013 was 60 % and was graded not satisfactory.

In 2012, NLH applied for level two of the toolkit for which the target score was 66%. For the toolkit North London Hospice has to assess itself against requirements for:

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

An action plan has since been approved by NHS Connection for Health which aims to see NLH achieve required score of 66% at the next annual submission in March 14. Progress for this is monitored by the Hospice's Information Governance Steering Group which reports to the Executive Team quarterly

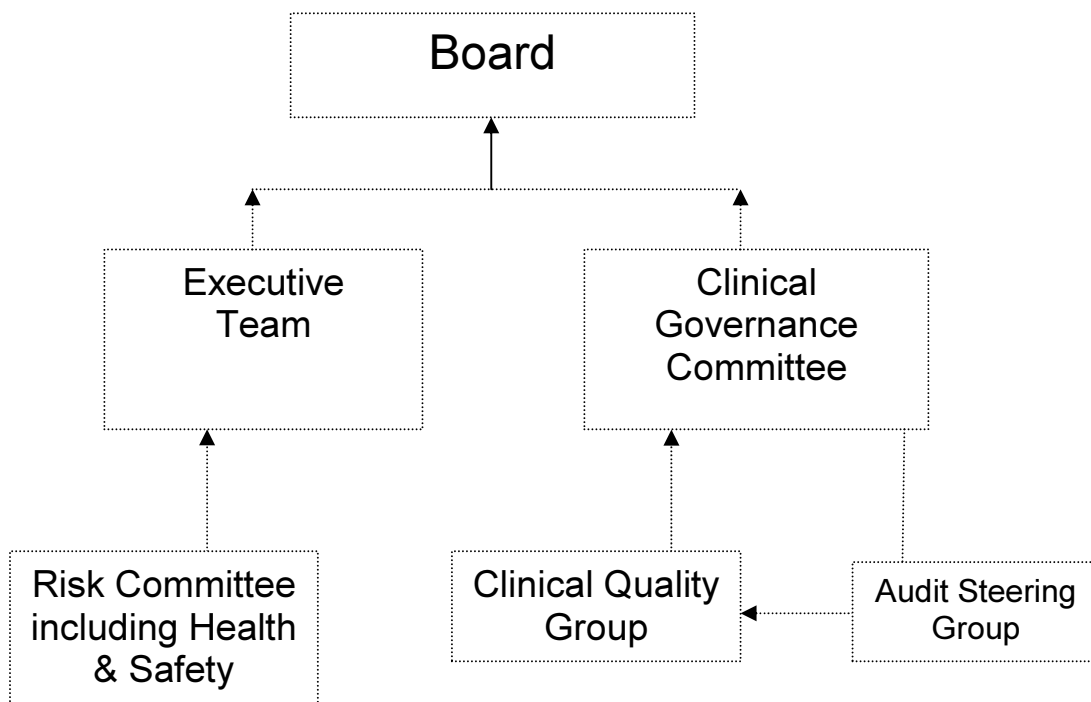
North London Hospice was not subject to the payments by results clinical coding audit during 2012-2013 by the Audit Commission. This is not applicable to independent hospices.

Performance statistics prepared monthly are reviewed by the clinical directors and shared with the various NHS commissioners. Further work to report the performance that best reflects the activity in the Day Services is in progress.

Part 3 Quality Overview

Quality Systems

NLH has quality at the centre of its agenda. The Executive Team identified “A unified organisation which is financially viable and delivering high quality services” as its overall strategic planning aim for the subsequent three years in December 2011. It has six main groups that oversee quality review and development within the organisation.



See Appendix Two for role description of above groups

Key Service Developments of 2012-13:

Enfield new Day Service development

Day Services opened on August 16 2012, initially for one day a week with patients who transferred from the previous Day Centre in Finchley. In September the Hospice expanded the service to include new referrals and to offer more Complementary Therapies. In October it began opening two days a week and in February of this year, three days a week. The Hospice also started a weekly physiotherapy clinic in February. It has now broadened the referral criteria to include referrals from GP's, hospital based Palliative Care Teams and Site Specific CNS.

NLH Day Services is currently offering Reiki, Reflexology, Massage, Hypnotherapy, Group Relaxation, Art Therapy, Beauty Therapy, Hairdressing and a Carers Group. NLH plans to further develop services to include Psychological Therapies and Music Therapy. More informal activities also take place in the 'Open Space' to promote socialisation and a lively cafe at lunchtimes. The Day Services CNS is available to carry out holistic nursing assessments when needed and to offer advice and support for symptom management.

Since September Day Services has been working collaboratively with CAB and Macmillan offering fortnightly appointments for benefits and financial advice to cancer patients and their families. Links have been formed with a local secondary school to offer insight into the work the Hospice does.

Volunteer Development

North London Hospice has more than 930 volunteers working in a variety of roles from fundraising, shops, drivers to counsellors, art therapists and chaplains. NLH Volunteer Strategy 2012 communicated desired changes around the role, delivery and management of volunteer services. 2012-13 has seen much work implemented in increasing the depth of training and supervision to volunteers as well as the development of existing and new volunteer roles across the organisation. This work will continue as well as the move of volunteer management to services. See Appendix Three for further details.

The Use of the SBAR tool within the Community Specialist Palliative Care Multi-disciplinary Team (MDT) Meeting

There is good evidence to suggest that communication improves where the clinical information presented is carried out using a structured reporting format. This led to the recommendation by the World Health Organization for the use of the SBAR tool to standardised handover communications.

The SBAR process is a straightforward framework used to communicate succinct relevant information and focuses the communication on **S**ituation, **B**ackground, **A**ssessment and **R**ecommendation. The Community Service Management Team have introduced the tool for its MDT patient presentations. Over the next few months an electronic SMART FORM in the SBAR framework will be developed for staff to use in iCare. This will continue to build on the efficiency and quality of record keeping.

The Introduction of Associate Community Specialists Palliative Care Nurse role

The introduction of two Band six Posts was a result of a restructuring review of the Community CNS service last year. The posts were recruited in December 2012. Their main role is to work clinically as autonomous practitioners, assisting and supporting the Clinical Nurse Specialist (CNS) in managing a caseload. They work within clear boundaries, always have a CNS overseeing and managing the caseload and therefore do not have the responsibility of all the other components of the CNS role. These posts allow the recruitment of experienced nurses who do not have the essential person specification required for a Band 7 CNS role whilst giving staff career development opportunities.

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.

Education and training

NLH delivers a bi-annual "Foundations in Palliative Care" course for trained nurses and allied health professionals over four days and bi-annual Foundations for Palliative Care" course for Health Care Assistants and Support Workers, which runs over four half days. The Hospice also delivers basic and advanced syringe driver training and Liverpool Care of the Dying Tool training to community nurses on a rolling programme, at both the Finchley and Enfield sites.

NLH provides a variety of training placements for:

- student nurses with the University of Hertfordshire
- social work students' placements with London South Bank University
- half & one day hospice placements for final year medical students

- placements for Specialist Registrars from London Postgraduate Deanery and registrars from Barnet General Practitioner Vocational Training Scheme
- chaplaincy placements
- work experience for those wishing to apply for nurse, medical, allied health professional training
- .

The Hospice is currently providing a commissioned End-of-Life training programme in care homes and this was extended to also include an agreed group of domiciliary agencies in Enfield this year.

In early 2013 NLH became one of seven national regional centres for end-of-life training for care homes through the Gold Standard Framework for Care Homes Programme.

NLH provides a rolling induction programme for new staff and volunteers as well as annual mandatory training. Additional internal training is also provided for staff.

From April 2013, NLH plans to build upon the courses we offer.

Care Environment

At NLH we are committed to providing a warm, friendly and welcoming, non institutional environment for our patients and their visitors. We realise we will not get a second chance to make a good first impression.

The physical design of our new Enfield site provides an open, light and friendly space, including a cafe area looking on to gardens. We purposely chose not to have a reception area; each visitor, patient, family member/significant other is individually welcomed. We are working towards this model on our original Finchley site - this will form part of improvement to the hospitality area.

On the IPU, prior to a new patient being admitted, their room undergoes a series of maintenance and housekeeping checks to guarantee the room and bathroom meets the required standard of cleanliness and functionality. An annual infection control audit is carried out by an external auditor. In 2012 NLH scored 87% with Clinical Environment scoring 84%.

The facilities team take pride in their work and gain satisfaction from providing patients with a facility everybody can be proud of.

Service Activity Data

INPATIENT UNIT

Data Highlights

In 2012-2013, the IPU cared for a total of 326 patients, of which 306 were new patients. A total of 346 patient admissions occurred. Comparing this with 2011-12 data the IPU cared for a similar number of total patients (316 in 2011-12 vs 326 in 2012-13), new patients (300 in 11-12 vs 306 in 12-13) and admissions (325 11-12 vs 346 12-13).

Analysis of IPU admissions and outcomes:

1. 49 patients (14%) admitted had been cared for on the unit before (vs 15% 2011-12).
2. A patient's average length of stay was 12.6 days (vs 14 days 2011-12).
3. 7 patients (2%) were admitted as day cases for treatment infusions (vs 1% 2011-12).
4. 264 patients (74%) admitted to the unit died on the unit (vs 71% 2011-12).
5. 80 patients (22%) were discharged home (vs 22% 2011-12).
6. 9 patients (3%) were discharged to a care home (vs 3% 2011-12).
7. 4 patients (1%) were transferred to hospital for acute care management (vs 4% 2011-12).

Bed Usage

The IPU had a 73% bed occupancy rate. This was the same in 2011-12. The definition of bed occupancy is 'a bed that is occupied at midnight' so if for example a patient died at 2345 hours the bed will be counted as not occupied for that day. This definition impacts on this rate.

Over the last year, IPU have had a total of 85 closed bed days. This was mainly due to plumbing repairs and deep cleaning of rooms following patients with MRSA. This accounts for 1% of the total bed availability. This is improved on 2011-12 when there were 156 closed bed days.

There are peaks and troughs of demand for beds on the IPU but to try and increase bed usage and address peaks in demand, a number of strategies are in place:

- Trying to make beds available sooner after patient's death, whilst balancing sensitively the needs of deceased patients' relatives.
- The refurbishment of the room to view patients who have died to improve the experience of relatives and friends as well as increase its use. Working with the hygiene technician team to complete cleaning of rooms as soon as is possible and reviewing the shift patterns of the hygiene technicians.
- The introduction of a standard for room turnover.
- An increase in junior doctor staffing, has enabled us to increase the number of admissions during the day
- A review by the clinical team to look at the feasibility of staggering doctors' working times to accommodate later medical admission clerking.

Also to prevent admission to an acute hospital while a patient is awaiting an IPU bed, the NLH PCSS has supported patients to remain at home.

DAY CARE SERVICES

As discussed previously, this year the model and site of day service provision changed so the day service data is split accordingly.

In anticipation of these changes and to minimise the impact on patients using the day service, the Finchley day service site ceased to accept new referrals from July 2011 but continued to care for existing patients until they died or were discharged with a small number transferring over to the Enfield site. For the period of 13 weeks (April-June 2012) Finchley Day service cared for 13 patients. There were 173 attendances (70% attendance) and 73 (30%) where patients were booked but did not attend.

As described on page seventeen, the new model Day Service has been developing at the Enfield site this year with increasing patient numbers and a range of services provided. From middle of August 2012 to March 2013 there have been a total of 415 attendances with only 15 patients (3%) who were booked that did not attend.

The table below shows the increasing use of new components of the service since August.

Sessions provided by Day Services at Enfield

	Aug/Sept	Oct/Dec	Jan/Mar
Acupuncture (Started November)	n/a	9	13
Art Class	7	20	25
Art Therapy (Started October)	n/a	13	22
Beauty Therapy (Manicure/Pedicure)	5	46	54
Carer Group	12	18	20
CNS Assessment	9	40	31
Hair Dressing (Started October)	n/a	9	15
Hypnotherapy	5	9	7
Massage	1	15	16
Reflexology (Started October)	n/a	3	6
Reiki	11	37	39
Relaxation Group	21	52	84
Total	71	271	332
Patients attending during Quarter	45	155	215
Days provided during Quarter	7	23	27*

* During March six Day Services days were cancelled because of adverse weather

COMMUNITY TEAMS

Highlight information

In 2012-2013, a total of 1271 patients were seen by the two specialist community teams (607 Enfield, 664 Finchley). This was a similar figure to 2011-12 where they cared for 1255 patients.

In 2012-13 898 of these patients (Finchley 483, Enfield 415) were new patients. Of which:

- 76% had a cancer diagnosis.
- 21% had a non-cancer diagnosis.

From the specialist community teams, each patient had an average of:

- 5 visits (vs 5 in 2011-12).
- 12 phone calls to/from patient and family (vs 16 in 2011-12).
- 9 phone calls to/from other professionals (vs 12% in 2011-12)

In addition, outside the normal working hours of the Community Teams, the IPU team supported, through its advice line, each community team patient with an average of

- 3 phone calls to/from patient and family.
- 1 phone calls to/from other professionals

In 2012-13, 61% of the total patients seen by the two specialist community teams died during their care period. Of these:

- 55% (n=427) died in their own home (including 12% who died in a care home i.e. their home)
- 22% died in a hospice.
- 20% died in hospital.
- 3% died in other places.

Figures regarding place of death were similar for 2011-12.

PALLIATIVE CARE SUPPORT SERVICE (PCSS)

PCSS was launched as a new service in Barnet on 1st April 2011. In June 2012, the service incorporated care to Enfield patients too.

It has cared for 242 patients in 2012-13 and provided a total of 9,497 hours of direct care to patients in their own homes. This is an average of 39.25 hours of care per patient.

This reveals a marked increase (29%) in service care provision compared to 2011-12 where the service cared for a total of 188 patients and provided 8339 hours of direct care.

PCSS Work provided for each Borough 2012/13			
	Barnet	Enfield	Total
Total number of patients	149	93	242
Health Care Assistants	4,419.50 hours	3,718.25hours	8,137.75 hours
Registered Nurses	732.50 hours	626.75 hours	1,356.25 hours
Total hours of care	5152.00 hours	4345 hours	9,497.00 hours
Average hours per patient	34.6 hours	46.72 hours	39.25 hours

Service Quality Data

Indicator	Threshold	Outcome
Percentage of audits completed on schedule	80%	42 % actual (65% anticipated*)

There were 29 audits on the original 12-13 audit cycle. During the year 2 additional audits have been added so a total of 31 audits were due for completion through the year. The ability to complete more audits has been impacted by workforce reorganisation and staff vacancies some at senior level. It has become apparent that the audit plan for 12-13 was aspirational in terms of numbers of audits.

NLH anticipates a total of 19/31 (65%) audits will be completed for the audit year 12-13 in 13-14 cycle. Of the remaining audits scheduled for the 12-13 audit 6 have been deferred. 6 audits will not be completed but will be assessed via the internal CQC audit in September.

Patient Experience

User Involvement 2012-13:

Quality and Performance Indicators	Quality and Performance Indicator(s)	Threshold	Outcome 2011-12	Outcome 2012-13
Service User Experience	% of patient/carers satisfied with the service	80%	99% (n=68) rated care as satisfactory and above	100% (n=87) rated care as satisfactory and above
Service User Experience	% who would recommend service to friends & family	80%	84% (n=68) would recommend service to friends & family	98% (n=85) would recommend service to friends & family
Relatives Experience	% of patient/carers satisfied with the service	80%	95% (n=46) rated care as satisfactory and above	100% (n=138) rated care as satisfactory and above
Relatives Experience	% who would recommend service to friends & family	80%	93% (n=45) would recommend service to friends & family	99% (n=216) would recommend service to friends & family

NLH is committed to listening to the views of patients, relatives, carers and friends across all services and in 2011 the NLH User Involvement Strategy was developed. User feedback has been gathered in a number of ways this year:

- Annual survey
- Comments cards
- Patient stories

Surveys:

3 key areas were measured in the 2011-12 and 2012-13 surveys

- Percentage of overall care marked 'satisfactory' and above
- Percentage who marked 'Yes' or 'Mostly' to being treated with respect and dignity
- Percentage who would recommend the service to family and friends 'to some extent' and above

232 survey responses were received from the total of 890 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)

Overall care rated 'satisfactory' and above

	CT	CT Rel	IPU	IPU Rel	PCSS	Average
2012 %	100	100	100	100	100	100
n=	74	88	13	43	7	
2011 %	92	87	100	100	-	95
n=	61	27	7	19	-	

Were you/the patient treated with respect and dignity?

	CT	CT Rel	IPU	IPU Rel	PCSS	Average
2012 %	97	n/a	100	100	100	99
n=	73	n/a	11	42	7	-
2011 %	99	n/a	100	100	-	99
n=	62	n/a	6	18	-	-

Would you recommend the service to friends or family?

	CT	CT Rel	IPU	IPU Rel	PCSS	Average
2012 %	96	98	100	100	n/a	99
n=	72	89	13	42	-	-
2011 %	96	86	71	100	-	88
n=	63	26	5	19	-	-

The surveys also gave an opportunity to make individual comments throughout.

Total no. of comments included:	371	
Positive comments:	310	86%
Negative comments:	61	14%

Service:	Positive	Negative
Community Team patients	76% (n=39)	24% (n=12)
Community Team relatives	88% (n=148)	12% (n=21)
Inpatient Unit patients	91% (n=10)	9% (n=1)
Inpatient Unit relatives	75% (n=66)	25% (n=22)
Palliative Care Support Service	90% (n=47)	10% (n=5)

Day Services were not included in the 2012-13 surveys as the centre had only just opened and was not fully operational. User views were collected through case studies and during visits by the User Involvement Lead and a volunteer, which were fed back to the Day Services team.

Some comments from new Day Service visitors:

Q: What do you like about coming here?

- a) Meeting other people; chatting; change of environment. Have been twice before on Tuesday – that's quieter but they are building it up. I came today because of an appointment to work out my benefits. They have a lot going on here. (patient)

Q: Do you feel welcome?

- a) Very. People are always being kind and seeing if there is anything I need. (patient)
- b) Really open and welcoming (carer)

Day Services will be included in the 2013-14 User Surveys.

COMPLAINTS

Quality Performance Indicator	Threshold	Outcome 2011-12	Outcome 2012-13
Number of Complaints	25	31	19

Quality Performance Indicator			Outcome 2011-12	Outcome 2012-13
Investigations completed at 31 March 2012			25	14
Investigations incomplete at 31 March 2012			6	5
Investigations Completed, complaint founded			21	13
Investigations Completed, complaint unfounded			4	1
The number of complaints action plans completed	90%	100%	19(90.4%) completed 2(9.6%) Action Plans being completed	14 (100%) completed

The number of complaints in 2012-13 decreased from those in 2011-12. NLH aims to give the best possible care to patients and support to their families, friends and carers. However, sometimes expectations are not met. To help improve services, we encourage feedback about any problems or concerns are encouraged. Any feedback received about clinical or non-clinical services, however minor, follows the complaints process internally to ensure that it is fully investigated and that learning is identified and acted upon. If the complainee states that they do not wish to receive formal feedback, this is acknowledged.

Patient Safety

INCIDENTS

As reported last year NLH introduced a revised incident reporting procedure which, during 2012-13, has continued to show an increase in the number reported.

During the period 2012- 2013, 279 incidents were reported, 168 relating to clinical incidents and 111 to non-clinical incidents, an overall increase of 35% (n=72).

The breakdown of the incidents reported is as follows:

	All Incidents 2011-2012		All Incidents 2012-2013	
Independent Contractor	1	0%	1	0%
Other (Inc. Security, Facilities, IT)	2	1%	56	20%
Patient	147	68%	175	63%
Staff (inc Bank)	47	22%	23	8%
Visitors/Relatives	12	5%	9	3%
Volunteers	8	4%	15	6%
Total	217		279	

The noticeable percentage increase has been under the sub section "Other" which can be attributed to how incidents have been categorized.

This year NLH has embarked on a benchmarking exercise with five other hospices to compare clinical data which initially is including falls, pressure ulcers and medicine incidents. It is hoped this will help understand optimum incident numbers.

ACCIDENTS, INCIDENTS & NEAR MISSES

The impact of every incident reported is risk scored. The incidents reported were classified as detailed below:

Impact of Incidents	2012-13			
Category	Clinical		Non Clinical	
No Effect	51	30%	26	24%
Minor	70	42%	47	42%
Moderate	41	24%	31	28%
Major	6	4%	7	6%
Critical	0	0%	0	0%
	168		111	

There were no significant differences between impact of incident between years.

Category of Incidents	2012-13			
Category	Clinical		Non Clinical	
Admission, discharge, transfer	9	5%	1	1%
Drug Error*	15	9%	0	0%
Medical device/equipment	10	6%	0	0%
Moving and handling	5	3%	6	5%
Patient Information	1	1%	7	6%
Pressure sores	5	3%	0	0%
Slips, trips and falls	60	36%	14	13%
Treatment	26	16%	0	0%
Violence and aggression	4	2%	7	6%
Premises and Security	4	2%	25	23%
Other	29	17%	51	46%
	168		111	

In 2011-12 the category with the largest number of incidents reported was Slips, Trips and Falls. This remains the case in 2012-13 during which time 74 incidents were reported (27%) against 63 (29%) in 2011-12.

No patients suffered a major injury as a result of their falls. However, most falls in patients at the Hospice can be seen as the result of a number of interacting factors such as:

- Walking unsteadily
- Being confused
- Being incontinent or needing to use the toilet frequently
- Taking medication
- Deteriorating condition

- Individual personal struggle to accept limitations of their decreasing mobility

During the year 2012-13 the following measures have continued to be followed by Hospice staff to maintain the safety of the patients:

- Risk Assessment for falls are completed for all patients
- Falls assessment on admission to the Inpatient Unit
- Further assessment when a need is identified e.g. after a fall, as the patient's condition deteriorates
- Environmental audits of the Inpatient rooms
- Use of other falls prevention measures
- Regular maintenance of Hospice equipment
- Guidance and advice given to patients by the physiotherapists'
- All patient related falls incidents are reviewed by the Clinical Quality Group

Pressure sore monitoring and reporting

	2011/12	2012/13
Number of patients admitted to the IPU with pressure sores graded 3 or 4	9	7
Number of patients who developed pressure sores grade 3 or 4 within 72 hours of admission whilst on the IPU	1	0
Number of patients who developed pressure sores grade 3 or 4 after 72 hours of admission on IPU	1	4

During 2012-13 seven patients were admitted to the Hospice's Inpatient Unit with pressure sores graded 3 or 4., i.e. a high score in which a patient is deemed at risk and where the incident has to be reported externally. In all these cases the appropriate declarations were made by the previous carers. In addition, four patients developed grade 3 pressure sores more than 72 hours after admission to the Unit. They had been cared for on the unit for between 31 and 53 days and all patients skin condition deteriorated despite optimum pressure area care because of their generalised deteriorating condition and expected dying period. All cases were reported to adult safeguarding department, the local NHS Trust and the Care Quality Commission in accordance with both local procedures and legislation. In addition Tissue Viability specialist referrals were made regarding the later

group of patients. In all cases hospice staff were advised that they had used the appropriate skin care interventions and that in view of the patient's condition this was unavoidable. The patient and family were kept informed throughout.

Infection control

Quality and Performance Indicator(s)	Number 2011-12	Number 2012-13
The number of patients known to be infected with MRSA on admission to the IPU	2	4
The number of patients known to be infected with Clostridium Difficile, Pseudomonas, Salmonella, ESBL or Klebsiella pneumonia on admission to the IPU	0	0
Patients who contracted these infections whilst on the IPU	0	0

NLH notes patient's infective status on admission and tests where clinically indicated. The clinical team agree, on an individual basis, what is the most appropriate treatment plan, if any, depending on the patient's condition. During 2012-13 there were no cases noted where patients contracted reportable infections whilst on the IPU.

Priorities for Improvement 2012-13

Following consultation with hospice staff and local palliative care commissioners and scrutineers, the following three priorities for improvement were agreed for 2012-13:

Priority 1-Patient Experience- Case Studies

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

Case studies have been obtained from across all services - some involve more than one service.

Service	Total	Positive	Negative
Inpatient Unit	8	8	0
Community Teams	3	2	1
Day Services	2	2	0
PCSS	1	1	0
Mixed	4	4	0

See Appendix Four for sample Case Study

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

Priority 2 -Patient safety

2. a) Care planning and how it ensures patient risk is minimised.

Patients cared for on the IPU have a variety of wounds from pressure sores, fungating tumour lesions to post operative wounds. Due to many patients being near the end of their lives, the focus of wound care is often on maximising comfort and preventing further deterioration rather than treating the wound. The plan of care needs to be individualised to meet patient's specific requirements.

ACTION PLAN:

- August 2012: Questionnaire of nurses learning needs in wound care completed. This identified gaps in nurses' knowledge in grading of wounds and types of dressings to use.
- September 2012: Audit of pressure sore documentation to identify areas for improvement which will translate to all wound care on IPU was completed. This highlighted lack of documentation in wound care plans and the need to be more effective in adding pressure sore grades to ICare. All patients who had a pressure sore were on the appropriate pressure relieving mattress.
- February 2013: Met with practice educator, IPU Consultant about IPU education needs (incorporating wound care) Revamped IPU education programme to be rolled out in April 2013
- April 2013: Draft Wound care competencies for all staff being agreed by Service Management Team and Clinical Quality Group.
- Wound care is the teaching focus on IPU for April 2013. First of two teaching sessions on wound care has taken place. The

second session is planned for 18/4/13 and wound care representative talk planned 23/4/13. Articles are on display on the IPU teaching board. Improvements to wound care assessment to be discussed in Nurses Meeting of 22/4/13. Reflective practice session planned for June 2013 on the prevention, review of care and reporting of grade 3 pressure sores.

- New iCare code in use for all wounds

Sustaining Change Plan 2013-14:

June 2013:

- Wound care competencies to be cascaded to all IPU clinicians

December 2013

- Re-audit of pressure sores and wound care documentation and practice

2.b) PCSS risk assessments in the community

The Community teams planned to review the process of risk assessment for community patients. The project group worked with the local Community Nursing Services.

- The project team gained support for the audit from Barnet Community Services Manager who requested that they adopt NLH risk assessment forms.
- The audit identified that 75% patients had risk assessments available, although 20% of that number were held at NLH rather than in the patient's home. NLH felt an action plan was required to bring this closer to 100% and the recommendations were to consider the use of self duplicating risk assessment forms to enable a copy to be held in the patient's home and the Hospice, and for the completion of risk assessments to be extended to Health Care Assistants (HCAs) if commissioners support.
- Self-duplicating RA's are currently being trialled with the CSPCT in Barnet. Agreement is to be sought from commissioners relating to HCA risk assessment completion. Barnet DNS perceived the results as good which was different to our view. Therefore NLH lone worker policy is to be updated to cover where a risk assessment is not in place.

Priority 3 - Clinical effectiveness: **Advanced Care Planning (ACP)**

Advance Care Planning is recommended by national strategy to enhance end-of-life care, allowing clearer understanding of patient goals, and aiding patient centred decision making.

Some work on ACP had already taken place in 2011, including the development of a policy and relevant documentation.

During 2012-13 the following was achieved:

1. All patients are offered information on ACP

Information leaflet has been approved, is being printed and will then be offered to all patients on first assessment.

2. Training has continued to increase the confidence of staff

The first of regular six-monthly sessions with the community team has been held, and was well evaluated.

Training for IPU staff has been re-assessed. 2 training sessions for IPU staff have been delivered, with more planned, and a process has been agreed to ensure that all staff attend training. ACP will be discussed regularly at the doctors meetings to ensure junior doctors are up to date.

ACP will also form part of the ongoing training offered at the Hospice, incorporated in the training for the Mental Capacity Act.

3. Statement of wishes and preferences and Advanced Directive to Refuse Treatment documents are available on iCare as SMARTt forms.

This has been delayed because of delays to the development of iCare 2. However, this is now being taken forward with the iCare user group.

4. All patients are asked about their preferred place of care where possible and this is documented using the code on iCare

This conversation is a standard part of practice in the community and on IPU, however has not been routinely documented under a separate code. Part of the training session is used to raise awareness of documentation.

Both community teams now routinely highlight ACP as part of the MDT discussion of patients to ensure code is completed. If patient was unwilling to discuss ACP, or it was inappropriate to raise the issue, this is also being documented.

The use of the code is currently being audited. Results of the audit will be available by end of April 2013.

What NLH staff say about the organisation

NLH employs 136 staff, has 930 volunteers, and bank staff 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
Staff joined	17	38
Staff left	21	16

NLH joined 30 other hospices in a Help the Hospices staff survey during summer 2012. The following are NLH's key results:

- 85% were proud to work for NLH and 73% felt job satisfaction
- broad messages were well communicated, but staff felt NLH was less effective in ensuring clear internal communication
- staff thought diversity was valued, and clarity of roles, empowerment and performance feedback scored highly, though some felt procedures could be unhelpful and others said they did not feel appreciated
- 71% would recommend their line manager as a boss, but a number expressed concerns about workload, stress and job security
 - Although only a minority of staff felt comfortable to challenge the status quo and that morale was high, 75% planned to be working for NLH in a year's time

The following significant staff improvement initiatives are underway:

- Workforce Development Programme (WDP): As part of the WDP, a revised Performance Development Review (PDR) process and documentation are being implemented within the nursing workforce prior to roll-out across the whole Hospice. Designed to ensure clear communication between managers and staff, recognise and ensure effective feedback on clearly defined SMART objectives and competencies, and to establish SMART goals and learning and development needs for the future.
- In 2013 we will embark on the third year of NLH's Management Development Programme which will concentrate on specific skills alongside continuing to improve reflecting on management experience across departments and disciplines
- Since survey NLH has appointed Communications Manager and a Communications Strategy has been developed.

- Regular staff presentations are now in place to assist cross-department/cross-discipline understanding and plans for regular information/consultation sessions involving all staff and management.
- A fortnightly staff newsletter is also compiled and distributed to keep all staff aware of what is happening across the Hospice.
- Review of all Human Resources policies and procedures.
- Proposed staff Information and Communication Forum.
- Introduction of HR data base called Staff.Care to assist management and coordination of staff and volunteers
- Re-survey once improvement activities given chance to bed in.

NLH Board of Trustees Quality Account Comment

The first Quality Account presented in 2012 set a benchmark. This is the second Quality Account received by the Board of Trustees and the first mandatory Quality Account for NLH. The Board welcomes the assurance provided in the Quality Account of the continuing high standards of care, the commitment of skilled dedicated staff and the ongoing developments that are aimed at increasing the numbers of patients and families who can have access to care through NLH

It is heartening to see the achievements against the priorities for improvement set last year around case studies, care planning and minimising of risk and advanced care planning processes. These are important points along our journey towards providing the best quality of care possible. The User Involvement Strategy with its introduction of User Forums provides the Hospice with continuous feedback streams that inform the way we care for patients and manage our services.

Likewise, there have been some exceptional achievements in the involvement of one of the Hospice's most valuable resource, our volunteers. A comprehensive review of the way in which we use the experience and expertise of our volunteer workforce has generated a way of working that ensures that volunteers are trained and fully supported in the roles that they undertake. Systems have been set up, as with service users, to provide regular opportunities for volunteers to be kept up to date on Hospice developments, and to share their views and perspectives on the quality of all aspects of the work in which they are involved.

In addition, the opening of the Enfield Day Services unit is a major achievement in the journey towards making our services accessible to more people in Barnet, Enfield and Haringey. It also represents a shift in the model of care, with greater emphasis on individual programmes that attend to specialist medical, emotional and social needs generated by living with life limiting illnesses, as well as providing a much wider range of group activities.

As a Board of Trustees, we welcome the increased transparency and scrutiny demonstrated by this report and the recent developments described in the Quality Account. We know that complacency is not an option for us, and that quality has to be at the core of all that we do.

We welcome the priorities identified for the year ahead and will continue to support the Hospice Executive, staff and volunteers in sustaining the achievements to date and achieving the priorities for improvement in the coming year.

We remain committed to the belief that it is the experience of our service users that matters most, and that our principal priority is realising the dignified, respectful and safe care that people want for themselves and for their loved ones.

John Bryce
Chair
North London Hospice Board of Trustees

**Statements from Commissioners, Healthwatch, Health
Overview and Scrutiny Committees**

Appendix 1

Our Clinical Services

1. Community Specialist Palliative Care Teams (CSPCT)

Two teams of nurses, doctors, physiotherapists and social workers working in the community, provide expert support and advice. One team is based in Finchley and provides care to Barnet and Haringey patients; the other is based in Enfield and provides care to Enfield patients. Their work complements that of General Practitioners (GPs), district nurses, social services and hospital teams. This specialist service includes:

- Advice to patients on symptoms, both physical and emotional
- Help with any anxieties or concerns that patients, carers, families and children may have. This includes care at home, housing and financial matters (also supported by CAB Macmillan)

2. An out-of-hours telephone advice service

Community patients are given the out-of-hours advice telephone number for 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 inpatient unit. At weekends and bank holidays, a community Clinical Nurse Specialist deals with calls between 0900-1700 hours.

3. Day Services

Day Services is now based in the new building in Enfield and provides additional specialist palliative care support to patients and carers using a new more bespoke day service model than that previously provided at the Finchley site. The service offers a safe and inviting environment

and the opportunity to discuss physical and emotional symptoms, concerns and anxieties.

The clinical team is supported by a large number of volunteers who provide a range of complementary therapies including, reiki, reflexology, massage and hypnotherapy, Art Therapy, a relaxation group, Citizen's Advice Bureau, beauty therapy and hair dressing as well as hands-on care. Carers/families can attend carer's Groups and can join "Open Space" activities and relaxation groups.

Day Services is currently open four days a week, including a physiotherapy clinic on Mondays. In early 2013, in response to commissioner feedback, the service's referral criteria expanded to also offer specific timed intervention for adults with potentially life-limiting illnesses, whom fit the following criteria:

- Those who are recovering post treatment/surgery and are in need of psychological and/or physical support to optimize strength, confidence and self- management
- Those who may benefit from physiotherapy assessment to improve, maintain, accept or self-manage their level of function
- Those who have a poor prognosis and are likely to deteriorate but have no specific symptoms or need for Community Team involvement

NLH aims to eventually offer a five-day a week service to include out-patients clinics, clinical interventions such as an infusion and transfusion service, music therapy and creative writing and psychological therapies. Bereavement support will also be developed.

4. Inpatient unit (IPU)

NLH has 17 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 aim of this service is to support individual NLH patients or their carers in coping with the emotional effects of loss of health or the loss of a person close to them and eventually to adjust and make the transition to a new way of living.

The support is provided by volunteers who have trained in support skills or by volunteer qualified counsellors. This service is in addition to that provided by the specialist palliative care staff (nurses, social workers and doctors) and is provided following a referral and assessment process to NLH patients and their families/friends while the patient is under the Hospice's care and offered to all families/friends of NLH patients who have died, for up to 14 months after their loss.

Appendix Two: 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 Clinical Governance Sub Committee (CGC) for clinical risks and the Executive Team for non clinical risks.

Executive Team

The Executive Team will monitor non clinical risks on behalf of the Board. They will receive assurance from the Risk Committee and provide assurance to the Board that non clinical risks are being managed within the Hospice. The Clinical Directors are responsible for ensuring high standards of care are maintained.

Clinical Governance Sub Committee (CGC)

The CGC is a sub committee of the Board and provides assurance that an effective system of control for all clinical risks and monitoring of quality is maintained. The committee also reviews the results of audit work completed on the Hospice's Audit Steering Group.

Clinical Quality Group (CQG)

The CQG reports to the CGC with overarching responsibility for ensuring that clinical risk is identified and properly managed. It will advise on controls for high level clinical risks and to develop the concept of residual risk and together with the Risk Committee to ensure that all Directorates take an active role in risk management and that this includes the active development of Risk Registers¹. If the Group has any concerns relating to any issues raised with it, it will specifically report on these to the CGC.

¹ Risk Registers are populated with the identified risks of the Hospice that could have an impact upon their business objectives, compliance with standards.

The CQG is also responsible together with the CGC to ensure that the treatment and care provided by hospice clinical services is subject to systematic, comprehensive and regular quality monitoring.

CQG also authorise and validate the Hospices Audit Programme, receive completed audit reports, endorse recommendations and action plans and prioritises all audits

Risk Committee including Health and Safety Committee

The Risk Committee reports to the Executive Team with responsibility for ensuring that non clinical risks are identified and properly managed. It will also advise on controls for high level non clinical risks and to develop the concept of residual risk and to ensure that all Directorates take an active role in risk management and that this includes the active development of Risk Registers. If the Group has any concerns relating to any clinical issues raised with it, it will specifically report on these to the CGC.

Audit Steering Group (ASG)

The ASG is responsible for providing assurance of all audit activity through reports to the CGC. The ASG presents its Audit Plan and Audit Reports and recommendations to the CQG for approval and will also ensure that any risks identified during an audit process will be added to the appropriate Service Risk Register

Appendix Three: Volunteering Developments

BANDS OF SUPPORT VOLUNTEERS: NORTH LONDON HOSPICE

Banded according to the emotional depth of the support they provide to vulnerable patients & families

LOSS & TRANSITION

SUPPORTER TRAINING

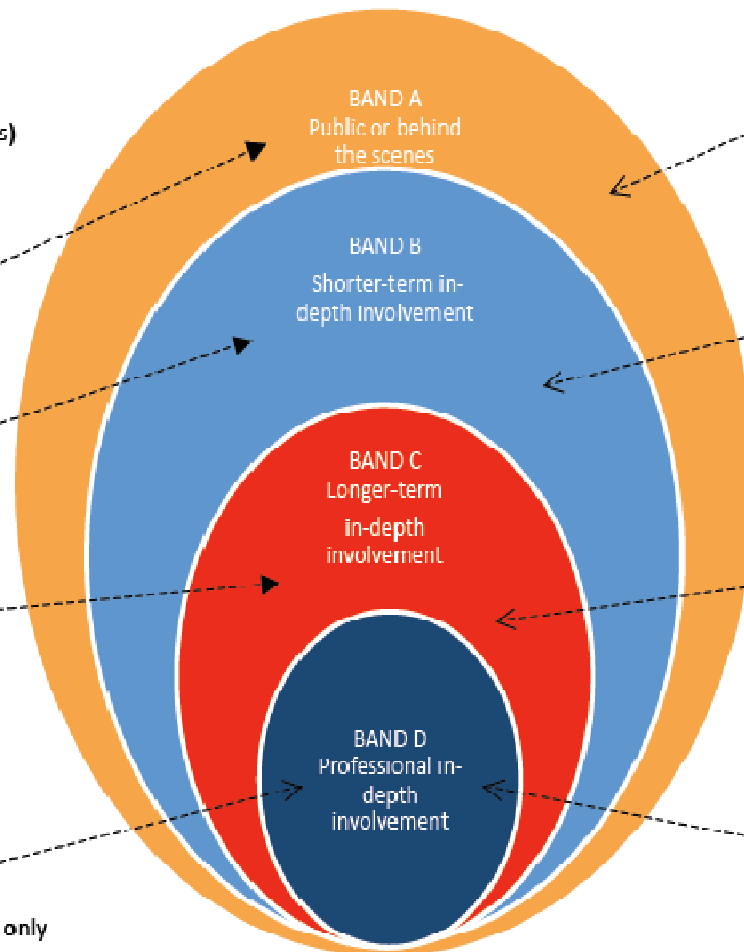
(NR in addition to induction & mandatory training plus updates)

AMBER: half day
'Introduction to Emotional First Aid'

BLUE: 15 hours
'Skills of Emotional First Aid'

CRIMSON: 21 hours
'In-Depth Loss & Transition Support Skills'
(having done Blue training first)
TOTAL: 36 hrs plus updates

DAMSON:
induction & mandatory training only



EXAMPLES OF VOLUNTEER ROLES

Fund-raiser, laundry, admin, gardener, librarian, shop, driving equipment

Driver/companion, ward clerk, phone admin, home companion, welcomer/ reception

Pre-/or post bereavement supporter, assistant to nurses, social workers or spiritual care coordinator

Counsellor, chaplain, art therapist, complementary therapist

TO BE DEVELOPED

LEAD VOLUNTEER ROLES FOR EACH BAND

ORGANISING eg rosters

SUPPORTING & DEVELOPING VOLUNTEERS eg buddying; mentoring; support/ reflection; supervision group training

LEADING NEW PROJECTS eg Fund-raising; practical support teams; ongoing support groups for patients, carers, bereaved; 'Memory Shed'; allotment; hospice Uni of the Third Age etc

Appendix Four: Case Study

Patrick has been visited by Community Nurse Specialist Eileen for the past eight months and has just started attending Day Services on Thursdays.

He lives with his wife, Ursula, who is his main carer. Patrick is dependent on oxygen to help him breathe and cannot be left on his own. His condition is not particularly stable and can deteriorate very quickly.

"I don't know what we'd do without Eileen from the Hospice. Within 10 minutes of being in the house she had correctly assessed my situation. She seemed to instinctively know what I needed and calmly dealt with the situation.

"She is much better than my GP at sorting out my medication. Before Eileen was involved, he didn't seem very interested in me but now Eileen contacts him and tells him what I need and it gets done. Eileen will ring the surgery and if the GP is there my prescription is usually ready within half an hour. That would never happen before. She just sorts everything out for us. Eileen even tried to help my painful shoulder which I've had for years – everyone else always pushed that to one side. She is very concerned that I have a good quality of life and is the only person who treats me like that.

"I also have a respiratory nurse, Helen, who isn't a Hospice nurse. It was Helen who first suggested that the Hospice should be involved in my care. She and Eileen are a fantastic combination and they work together to look after me, each keeping the other informed about my state of health."

Ursula had heard of North London Hospice and although Patrick knew about hospices, he hadn't heard of NLH. Neither were scared of being referred to the Hospice as they knew that it would be a great help to them both. It has taken pressure off Ursula.

"Patrick has complicated health issues and hospital is no longer the right place for him. He needs special care and he can't seem to get that in hospital. We are no longer using carers. It was very awkward as Patrick's condition changes frequently and at certain times of the day he is just not able to do anything, so they would come as arranged but there was nothing they could do. Now his symptoms are

better controlled he can do things when he feels able to and that works very well.

"On Tuesdays and Fridays, we go to our daughter's house and she looks after Patrick while I do a bit of shopping, or anything else that needs to be done. The routine suits us both but we have to keep to it."

Patrick is now attending the Hospice Day Services at Barrowell Green.

"Eileen told me about Day Services and I really enjoy going there every week. I'm having art therapy although I've never painted before - I find it very relaxing. I have also had a manicure, reiki and join in the relaxation session. What I most enjoy though is being able to meet and talk to other people. It's really brought me out of myself. It's no good being stuck at home the whole time - you end up thinking about your illness and problems. Spending time at the Hospice in Enfield takes me away from all that. I don't want to be indoors all the time - I've never done that in my life.

"I chat away to the staff, volunteers and other patients. The canteen is brilliant - I usually have an omelette and mash. The chef puts everything he can think of in the omelette. I can't fault the food at all and the place is immaculately clean. Everyone is so friendly - the chefs all know my name, even if I haven't met them before. How do they do that? It will be lovely there in the summer with the doors opening onto the garden.

"It's so friendly there and you're never left on sitting your own - there's always a volunteer who will come over and chat to you. Ursula was left at the dining table once when I went off to an appointment and within seconds someone else had come over to sit with her.

"Before I had been into the building I thought it would be like being in hospital but it's totally different. In hospital you're being taken off for tests and x-rays all the time and it's hard to relax. The Hospice is very calm and that's what I need."

Ursula takes Patrick to Day Services and picks him up. She stayed with him at first but not now.

"I don't need to - I won't usually leave Patrick anywhere but I know he's well looked after and they understand his condition. When I first walked in, it felt so calm and relaxing. Luisa there knows how to set up his nebuliser and can make sure his medication is correctly given. I

don't even trust the hospitals to do that. They don't know enough about Patrick's condition. I'm sorry to have to say that but I've witnessed it in various places for myself. Luisa will look round at all the patients who are there and knows if they are all ok.

"I am really benefitting from it too. I can do things like go to the dentist, have a physiotherapy appointment and get my medical needs sorted out.

"Patrick has been recommended for some respite care at the Inpatient Unit in Finchley and we're waiting to hear if that will happen. I have complete confidence in all the Hospice staff and would have no qualms about him being there without me, although of course I will visit him."

Patrick would like to stay at the Hospice as it would give Ursula a break from looking after him.

"Everyone I have met at the Hospice is so caring and nothing is too much trouble. I would like to put a halo over all their heads, the care is so fantastic."

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www.northlondonhospice.org

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www.nhs.uk/aboutNHSChoices/professionals/healthandcareprofessionals/quality-accounts/Pages/quality-accounts-20110-2012.aspx

How to provide feedback on the account

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

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