Thames Hospice Quality Account **2013/2014**

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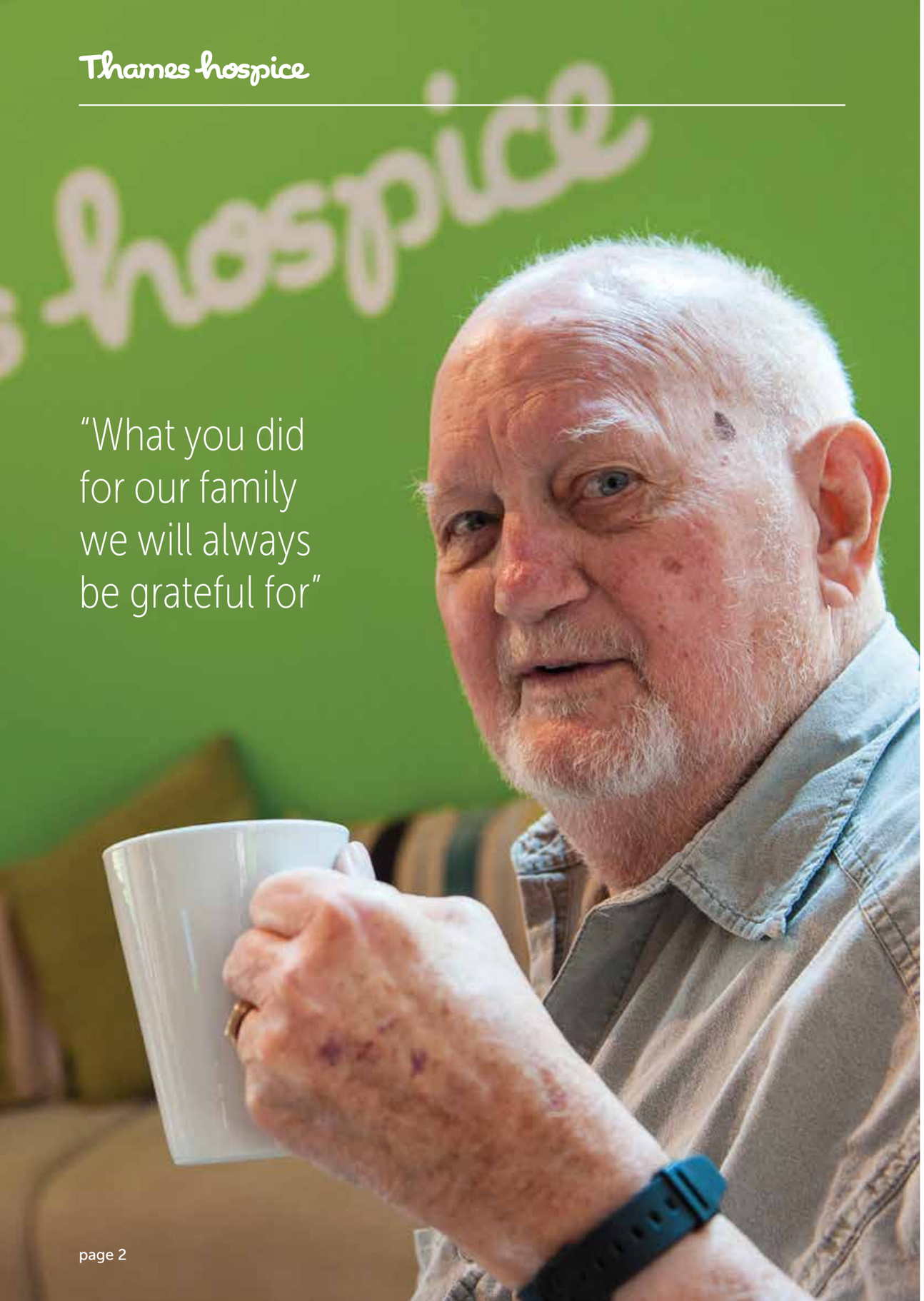

"What you did for our family we will always be grateful for"

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Part 1

1a. Statement by the Chief Executive

On behalf of the Senior Management Team and the Board of Trustees, I am delighted to introduce our Quality Account for the Year April 2013 – March 2014.

This account is designed to present our work and achievements for the year, and to highlight our commitment and objectives for the forthcoming year.

You will see that in 2013/14 the services we provided to our patients continued to be of an exceptional standard and that we have made solid progress against the pledges we made to you in last year's Quality Account. Our teams of both staff and volunteers have worked exceptionally hard in ensuring our services continue to be of the highest possible standard whilst embracing the increasing demand and complexity of those in need of our care. For this I would like to formally thank all of those involved in delivering services, and in raising the funds needed to run our Hospice.

We have continued to see strong growth and development in 2013/14 and we move into this year with a sense of purpose and a clear direction of travel. This will be the final year of our strategy which has been enormously successful in establishing the basis of our service offering. To recap, our strategic aims which underpin everything we do are outlined below:

- To be the local preferred provider of specialist palliative care in East Berkshire and South Buckinghamshire.
- To add value to the communities we serve, providing care and support to adults toward the end of their lives which statutory services cannot provide.
- To value, support and utilise the talents of our staff and volunteers, empowering them to help us deliver our vision.
- To continue to be a successful charity for the next 25 years and beyond.

This year, we will be reviewing our strategy and setting our vision for the next 5 years, although I believe the sentiments and values now deeply embedded within our organisation hold true now and into the future.

Thank you for the interest you have shown in reading this report, I am extremely proud of the work we do at Thames Hospice and I hope you will continue to support us in the future.

Best wishes,

Jacqueline Clark
Chief Executive

1b. Statement by the Chair of the Patient Care & Quality Committee

On behalf of the Board of Trustees and as Chair of the Patient Care and Quality Committee, it is my pleasure to present this Quality Account.

Good Governance is essential and should underpin everything that is done in any organisation, but never more so than in palliative care. This has been an area of particular focus for us in 2013/14 not least because we have seen significant increases in both numbers of patients and the complexity of their conditions. At Thames Hospice we have extremely robust governance structures and processes, and we regularly seek feedback from those who use our services. We are accountable to the Care Quality Commission and continually measure, review and develop our service offerings. We are also accountable to our commissioners whose complimentary comments are included at the end of this report.

This year we have focussed on embedding the revised referral criteria whilst maintaining quality, with great success. For example, we have experienced a 17% increase in the use of our Inpatient Unit whilst maintaining – and in some cases increasing – the quality of care we provide. We continue to prioritise sound governance and underpin all of our service offerings with this principle.

My role as Chair of the Patient Care and Quality Committee is to provide oversight, and thus assure the Board of our compliance on clinical quality matters. This report is a summary of those assurances, and I believe confirms that we provide very high standards of quality care across all our clinical services against a backdrop of increase in demand. This report also highlights the priorities we have agreed to enable us to maintain the current quality of care, as well as facilitating continuous improvement.

Thank you for taking the time to read this report. I hope you find it both reassuring and informative.

Kind regards,

Mr Jonathan Jones, Trustee
Chair of Patient Care and Quality Committee

Part 2

Review of Quality Performance 2013/4

2a In-Patient Service

In-Patient Unit	Number 2012/13	Number 2013/14
New Patients	249	306
Total Admissions	351	410
% Occupancy	64%	83%
Discharges (episodes not people)	171 (49%)	218 (54%)
Patients Died	181 (51%)	189 (46%)
Patient Satisfaction (scored excellent)	90%	91%
Average length of stay (days)	13	12

2b Community Services

1. Hospice at Home

Hospice at Home	Number 2012/13	Number 2013/14
No of patients	134	142
Patient Satisfaction (scored excellent)	Not Available	95%
Average number of hours of care	26 hrs per pt	9 hrs per pt
Total day hours provided	2,245	1,294
Total night hours provided	1,197	17
No of deaths achieved at home	55 (out of 78)	90 (out of 99)

2. Community Therapy Unit *(Formerly Day Support Unit)*

	Number 2012/13	Number 2013/14
Total Patients	128	139
Patient Satisfaction (scored excellent)	Not Available	95%
Total New Patients	95	139
Discharged (episodes not people)	103 (82%)	98 (70%)
Deaths	23 (18%)	33 (30%)

Our 2 Sisters; Andrea Finch and Anne Jones

2c Other Clinical Services

i. Lymphoedema

	Number 2012/13	Number 2013/14
Total Patients	53	79
Patient Satisfaction (scored excellent)	Not Available	100%
No of Treatments Provided	619	781

ii. Complementary Therapy

	Number 2012/13	Number 2013/14
Total Patients	324	318
Patient Satisfaction (scored excellent)	Not Available	95%
No of Treatments Provided	1,490	1,178

iii. Patient and Family Support Services

	Number 2012/13	Number 2013/14
Total Patients/Clients	209	257
No of Sessions Provided	1,802	2,142

Part 2: Review of Quality Performance 2013/14

2d Alternative Quality Indicators

i. Complaints

In the year Thames Hospice received 2 formal letters of concern/complaint.

Complaint summary:

Topic	Outcomes	Actions Required
Patient expressed a number of issues regarding medical treatments not being addressed during respite admission	Patient written to by Consultant/ Director of Patient and Family Services and offered appointment in outpatient clinic to follow up. Some ambiguity regarding expectations during admission. Patient offered a further respite admission for further review.	Clarity regarding reason for admission with patient. Need for clear, agreed plans for routine respite admissions.
Friends of a deceased patient complained that their friend had been sent to a nursing home from the Hospice before she died and they would have preferred for her to stay at the Hospice	Meeting held with friends and explained that system had now changed as a result of negotiations with Continuing Care and that in future, specialist cases could potentially stay at the Hospice for longer.	Maintain agreement with Continuing Care. Continue to build links with nursing homes to ensure quality of service provision post discharge.

Community Therapy Unit Team Leader – Mairead Whelan

TH aims to use the outcomes and learning gained from complaints received to improve its service provision overall. Complaints are routinely reported and discussed at the Governance Committee and the Patient Care & Quality Committee and significant issues will be reported to the Board, the Care Quality Commission (by exception if very high risk) and NHS Commissioners as part of our quality reporting processes.

ii. Accolades

As well as learning in the areas we have identified we can improve, it is important that we recognise when we have done well. We record all accolades to our services below:

Department	2012/13	2013/14
In-Patient Unit	92	99
Community Therapy Unit	32	30
Hospice at Home	24	73
Complementary Therapy	24	21
Lymphoedema	NA	13
Psychological Support Services	NA	44

iii. Patient Safety Summary

a. Accidents

Type	Number in Year	Seriousness/Impact	Actions
Patient falls	39	Patient's condition and progression of the disease further attributed to their fall.	Mandatory training highlights risks to patients and stresses requirement for risk assessment.
Wheelchair incidents	1	Low	None

Part 2: Review of Quality Performance 2013/14

b. Clinical Incidents – No incidents were reportable

Type	Number in year	Seriousness/Impact	Actions
Controlled Drug Incidents	2	Low	Staff required to undertake reflective practice. Incidents reflected in mandatory medicines training.
Drug Administration Error	9	Low	
Communication Incidents	2	Low	Drs made aware of issues and changes have been implemented.
Information Governance	9	Low	Staff involved receive information governance training on a regular basis and any incidents are thoroughly investigated.
Prescribing Issue (CD)	1	Low	Drs made aware of errors and reflective sessions conducted. Checking of medication procedures emphasised.
Drug Omissions	2	Low	Staff undertaking reflective practice. Incidents reflected in mandatory medicines training.

c. Infection Control

Incidents	Outcomes	Actions Required
None reported in year		

iv. Significant Audits

Topic Audited	Outcomes	Actions Required
Meeting Nutritional Needs	Overall good outcomes, a welcome pack is available which informs our patients and families of the catering provision at Thames Hospice allowing for more informed choices. A proposal has been accepted which will include protected meal times for patients to ensure meal times are not disturbed. Clinical assessment and care were present within patient files but required more detail in relation to the admissions process.	The care plan must identify and include all risks so that staff are aware of any controls that must be in place relating to patient care.
Infection Control	Hand washing audits undertaken monthly. Environmental audits quarterly. Consistently high compliance.	Small remedies required – with housekeeping and nursing staff. Minor issues only resolved on the day.
Care and Welfare of people who use services	All risk assessments must be performed for mobility, pressures, falls and/or mouthcare. Care plans must be in place for patients at high risk.	All care plans are completed accurately and high risk areas are documented appropriately.
Safeguarding people who use services from abuse	A staff questionnaire was produced to identify any potential areas where knowledge or training maybe required. Outcomes were very good, 95% and above at both our Ascot and Windsor sites.	None
Cooperating with other providers	Overall good outcomes, the new Hospice at Home assessment forms requires a little more focus.	All information to be recorded in a new assessment form.

v: Regulatory Inspection

Thames Hospice, Windsor received an unannounced inspection visit by the Care Quality Commission in July 2013.

The Hospice was inspected against the following Essential Standards of Quality & Safety and was found to be fully compliant in:

- Consent to care and treatment
- Care and welfare of people who use services
- Requirements relating to workers
- Supporting workers
- Complaints

To access a full copy of this and other past reports, please go to **www.cqc.oeg.uk/directory/1-120819354** or visit our website.

What families say about our services

We receive some incredibly positive feedback from our patients and their families. We measure this satisfaction through our Satisfaction Surveys (results recorded in statistics above) and through the Palliative Care Forum held annually with the local community and acute trust palliative care teams.

Most of our feedback is verbal or via the many commendations and compliments we receive in writing.

Typical statements are:

"It is comforting to know that this level of care and compassion still exists in the world today"

"The staff are amazing and always have a smile for you"

"We found empathy and understanding at every level, from everybody we spoke to"

"No patient could have been better treated, cared for or provided for with more dignity than our brother"

"I thought I had already arrived in heaven the way I was looked after"

Each month we record letters received and these commendations are reported at the Patient Care & Quality Committee.

In order to focus our Board Meetings, we show a presentation of a patient or family member's story at the start of the meeting to enable them to express their experience of the hospice in their own words. We find this very thought provoking and supportive of core service decision making.

Part 3

Update on last year's pledges (2012/13)

1. Patient Safety

Priority Action	How identified as a priority?	How will priority be achieved?	How will progress be monitored and reported?	2013/14 Update
Undertake a staffing review of In-Patient Unit Team to ensure the quality of care is maintained	Increased occupancy and more complex patients care needs and feedback from nursing team.	The newly appointed Head of Clinical Services has this as a priority objective for Q1 2012/13.	The review and it recommendations will be reported to the Patient Care & Quality Committee (July 2013) and should additional staffing & skill mix resource be required a business proposal will be made to the Board to increase staffing budget and enable recruitment of additional staff by September 2013.	Review completed and additional £164,000 of funding secured. All staff recruited and team fully established.
Implement the recommendations identified as relevant to the Hospice as a result of the publication of the Francis Report	The Francis Report applies to those services which provide care on behalf of the NHS.	An action plan has been recorded and key members of the Senior Management Team and the Board have specific task to achieve within set time limits.	The Action Plan has been approved by the Board and will be reviewed within the Patient care & Quality Committee to monitor action against timescale. Progress and outcomes will be reported quarterly to the Board.	All recommendations implemented.
More staff will be required to achieve advanced clinical skills competencies e.g. IV Drugs etc	As a result of the increasing numbers of patients with more complex symptom management needs and the introduction of a Consultant led medical team it highlighted the need for more nurses to have advanced skills.	A training programme will be implemented to increase the number of nurses with advanced skills.	Progress will be monitored through reports by the Head of Clinical Services to the Patient Care and Quality Committee.	Courses sourced and funded for all nurses. Training in progress.
Implement a stronger and more resourced governance framework within the organisation	The necessity to keep up to date with key governance priorities identified the need for more people resource to maintain compliance.	Introduction of focussed Head of Governance role and an additional post of Audit & Compliance Manager. Clearer governance agenda/model.	Progress will be monitored through the monthly Governance Meetings and the Patient Care & Quality Committee. External inspection by the CQC will provide external assessment of achievement.	Clinical governance well embedded across organisation. Positive CQC inspection. Head of Governance recruited and in post.

Our nursing team

2. Clinical Effectiveness

Priority Action	How identified as a priority?	How will priority be achieved?	How will progress be monitored and reported?	2013/14 Update
Recruit a second Palliative Care Consultant	Local needs assessment identified two consultants across the acute, community and hospice settings are appropriate for population.	Agreement with acute trust to recruit second consultant – employed by Trust but based at TH/community.	Impact of second consultant will be monitored through Patient Care and Quality Committee, progress with service review and developments and impact on patient outcomes.	Achieved. Consultant working across hospice & community with positive impact.
Integrate Community CNS team with Hospice Community Team	The need for a seamless joined up approach was identified through a review of service provision.	Agreement on a community model of provision across palliative care. Implementation of integrated model.	Impact on patient numbers, accessibility and outcomes related to symptom control advice, nursing care at home and achievement of preferred place of care/death (at home) – reporting processes via the Patient Care & Quality Committee.	Co-location achieved – further work required to achieve full community model.
Implementation of RiO (NHS Community Patient database)	In order to provide a seamless service it is known that a single patient database supports communication between teams and therefore improves continuity of care.	Work with BHFT to adopt RiO database currently used by community nursing and palliative care teams locally – across all hospice clinical teams. Achieve IGSOC/IG Toolkit approval.	IGSOC/IG Toolkit approval acts as key to access database. Monitor implementation and impact on service provision and information sharing via Patient Care & Quality Committee.	Achieved. Single point of access implemented.

Part 3: Update on last year's pledges (2012/13) cont'd

3. Patient Experience

Priority Action	How identified as a priority?	How will priority be achieved?	How will progress be monitored and reported?	2013/14 Update
Develop and implement regular patient and carer forums to influence the development of services and site	Currently TH has a shared forum for palliative care users but does not have a focus group of its own. With plans to develop services and site it was identified by the Senior Management Team that the opportunity to involve patients and carers in planning was essential.	A Programme Manager is to be employed to facilitate the site development and part of the role will be to consult and work with service users to gain their views and identify their needs in relation to the developments.	Progress will be monitored through the PCQ Committee and through regular reporting to the Board by the Programme Manager.	Full consultation has been implemented regarding future developments and suggestions incorporated into design.
Build a Sanctuary to support the spiritual care of service users, volunteers and staff	It was identified that the Hospice does not have a dedicated space for spiritual care.	An application was made to the Dept of Health Hospice Grants programme to support the implementation of the plan. This funding will be supplemented by hospice funds. The Senior Management team and the Programme Manager will implement the plans and achieve the completion of the building by end March 2014.	Progress will be monitored through the PCQ Committee and through regular reporting to the Board by the Programme Manager.	Sanctuary completed end of June 2014. Operating policy complete. Official opening September 2014.

Part 4

Looking forwards

4a Pledges for 2014/15

1. Patient Safety and Experience

Priority Action	How identified as a priority?	How will priority be achieved?	How will progress be monitored and reported?
Embed team nursing within the In Patient Unit, developing leadership further within the teams	Need identified as part of staffing review to provide structure and continuity of care to patients.	Two Sisters on the IPU will lead a team each. Nurses will be allocated to teams.	Patient feedback reports are presented to the Patient Care and Quality Committee quarterly as well as audit results. These cover user experience. Staff will also give feedback via structured team meetings.
Review and improve incident and accident reporting processes, clarifying escalation points to SMT/Board. **Integrate Health and Safety and Governance across the organisation, to ensure a steam lined process which prevents duplication and ensures effective management of both**	Integration points between Health and Safety and Governance are often unclear in clinical organisations. The review will focus on this cross over and develop processes which prevent duplication and protect patients/users.	Health and Safety and Governance to come under the remit of the Head of Governance. Review to be conducted in quarter 2, with recommendations implemented thereafter.	Monthly Governance meetings will review all incidents and a newly formed Health and Safety Committee will be an integral part of governance.
Develop welcome packs across the Inpatient Unit and Community Therapy Unit for patients and relatives to be sent to people before admission and displayed in patient's rooms and clinic rooms	Patient feedback highlighted the need for pre admission information.	Welcome pack to be developed by staff and displayed in all areas as well as being sent to people pre service use.	Welcome pack to be produced and implemented by end Q2. Impact will be monitored through patient feedback and reported to the Governance Committee.
Utilise the Sanctuary, ensuring it meets its original objectives (to enhance the well being of our patients and their families by providing a safe, reflective space)	The Sanctuary is scheduled for completion at the end of June, and will need to be embedded in the organisation to ensure it is utilised appropriately.	Operational policy clearly identifies processes for use.	Usage of Sanctuary to be audited after 6 months of operations to ensure it is being utilised effectively and is fulfilling its purpose. Result to be presented to Governance Committee.
Progress plans for future expansion (P25), incorporating user feedback and ensuring we meet the needs of our patients both now and into the future	Project 25 already underway and will need focus on design in 2014/15.	Maintain project work plan and timescales. Involve staff, volunteers and users in design plans and ideas.	P25 will be on schedule at the end of March 2015 and reported to the Project Board/Board. Views of staff, volunteers and patients/relatives will be incorporated into designs.

2. Clinical Effectiveness

Priority Action	How identified as a priority?	How will priority be achieved?	How will progress be monitored and reported?
Continue to train clinical team in increasing, key complex palliative care competencies such as ultrasound guided paracentesis by Doctors	As the patients conditions are becoming increasingly complicated, so are their treatments. Consequently, the need to transfer people to hospital for treatment is increasing, specifically for paracentesis.	The Hospice will purchase an ultrasound machine, and train members of the medical team in the use of it for paracentesis to avoid hospital transfer.	Ultrasound machine will be purchased in Q2 and medical staff trained. We will not need to transfer any further patients post September.
Having successfully co-located, we must now develop an integrated Community model which ensures effective and timely responses to patient care	The need for an integrated community palliative care team was identified as part of a service review in 2013.	Workshops to implement model commenced in June 2014.	Integrated service will be in place by Jan 2015.
Review the discharge planning model within the IPU to ensure we meet peoples preferred place of care wherever possible	Increasing complexity of patients has led to an increase in issues around discharge planning requiring increased resource.	Recruitment of a full time discharge co-ordinator, supported by Social Care Worker.	Discharge in place and timely discharges occurring. Delays in the discharge process discussed at weekly MDT.

3. Supporting our Staff and Volunteers to Deliver High Quality Care to Patients

Priority Action	How identified as a priority?	How will priority be achieved?	How will progress be monitored and reported?
Embed Schwartz reflective sessions within the Hospice	A review of psychological support for staff and volunteers highlighted a gap in provision.	Schwartz rounds commenced 2014/15.	Formal evaluation at 4 and 12 months to establish effectiveness which will be reported to the Board.
Implement formal supervision forums utilising our pastoral care team and an external provider for the medical team.	The implementation of Schwartz enabled us to consider group supervision and identify the need for formal supervision.	Formal supervision sessions, led by the pastoral care team to commence in September 2014. External supervision for medical team to commence in July 2014.	Evaluation of sessions after 6 months, reported to HR committee and PCQC.
Implement "recognising our volunteers" awards to reward years of service in year	The need to formally recognise volunteers is widely acknowledged and we recognised a lack of formal recognition in the Hospice.	Implement a "Valuing our Volunteers" programme (HR led).	Numbers of awards given and impact monitored at HR committee.
Implement "making a difference awards" to recognise staff contribution to the effective running of the Hospice	Valuing our staff and volunteers is an organisational objective, falling out of our 3 year strategy. 2015 is the final year of this strategy.	Implement a staff recognition scheme (HR led).	Numbers of awards given and impact monitored at HR committee.
Develop communication forums to share future vision and strategy	Staff survey at the beginning of 2014 identified the need for increased communication between the Senior Management Team, Board and staff.	Implement regular communication forums between SMT/Board. Improve visibility of SMT and Board in the organisation.	Evaluation of effectiveness after 12 months – reported via HR committee.

Part 4: Looking forwards

4b Statements of Assurance from the Board

The following are statements that all providers are required to include in their Quality Account. By way of being an independent charity providing palliative care not all of these are directly applicable to Thames Hospice.

i. Review of Services

This year we have focussed on embedding our new referral criteria and increasing the numbers of people who access our services. We are extremely proud of all of our teams across all services areas who have risen to this challenge admirably and delivered care to more people whilst maintaining the high quality which is synonymous with our organisation.

To recap, the service areas which we offer are:

- Adults (age 18 or above)
- End of Life Care: offered to those people with a prognosis of less than 2 weeks
- Symptom Management: offered to patients with complex physical psychological, social or spiritual symptoms with an expected length of stay of less than 2 weeks
- Respite Care: for patients with complex health care needs who have met the Continuing Health Care Criteria with a prognosis of less than 12 months
- Specialist 'amber' patients: with an unstable palliative condition and a prognosis of less than 2 months
- Live, normally within a 15 mile radius of Windsor

In-Patient Unit:
Is a 17 bedded unit offering symptom management for patients with complex needs, care for specialist patients with an unstable palliative condition, respite care (planned and unplanned) and end of life care.

Hospice at Home:
Provides symptom management for patients with complex needs, respite care to support carers and end of life care in their own homes.

Community Therapy Unit (previously Day Support Unit):
Helps people stay at home by supporting them through our 6 week well being group (covering management of breathlessness, fatigue and anxiety), 6 – 12 week individual day support programmes, monthly drop in support group for patients and carers, Consultant Outpatient clinics and Physiotherapy.

Complementary Therapy Team:
Provides therapies for patients and carers in our Out Patient Clinics, in the In-Patient Unit and in Community Therapy Unit. Treatments offered include massage, reflexology, reiki, aromatherapy, visualisation techniques, therapeutic touch and clinical hypnotherapy.

Lymphoedema Service:
A nurse led service for people with Lymphoedema as a result of cancer and its treatments.

Patient & Family Services Team:
Provides emotional support for patients and families up to and following bereavement. The service is delivered by qualified Counsellors and Psychotherapists, trained bereavement support volunteers and social workers and is further supported by the pastoral Care team.

ii. Participation in National Clinical Audits

Thames Hospice is not part of the NHS and currently has not participated in national clinical audits or national confidential enquiries.

iii. Research

Thames Hospice does not currently instigate research projects itself and has not participated in any research.

iv. Completeness of data submitted to the Secondary Uses Service

As Thames Hospice is not part of the NHS it does not submit this data.

v. Use of CQUIN payment framework

Thames Hospice currently reports under: Data Improvement Plan to Understand Community Activity. We are required to record the number of patients seen in the community setting.

Part 5

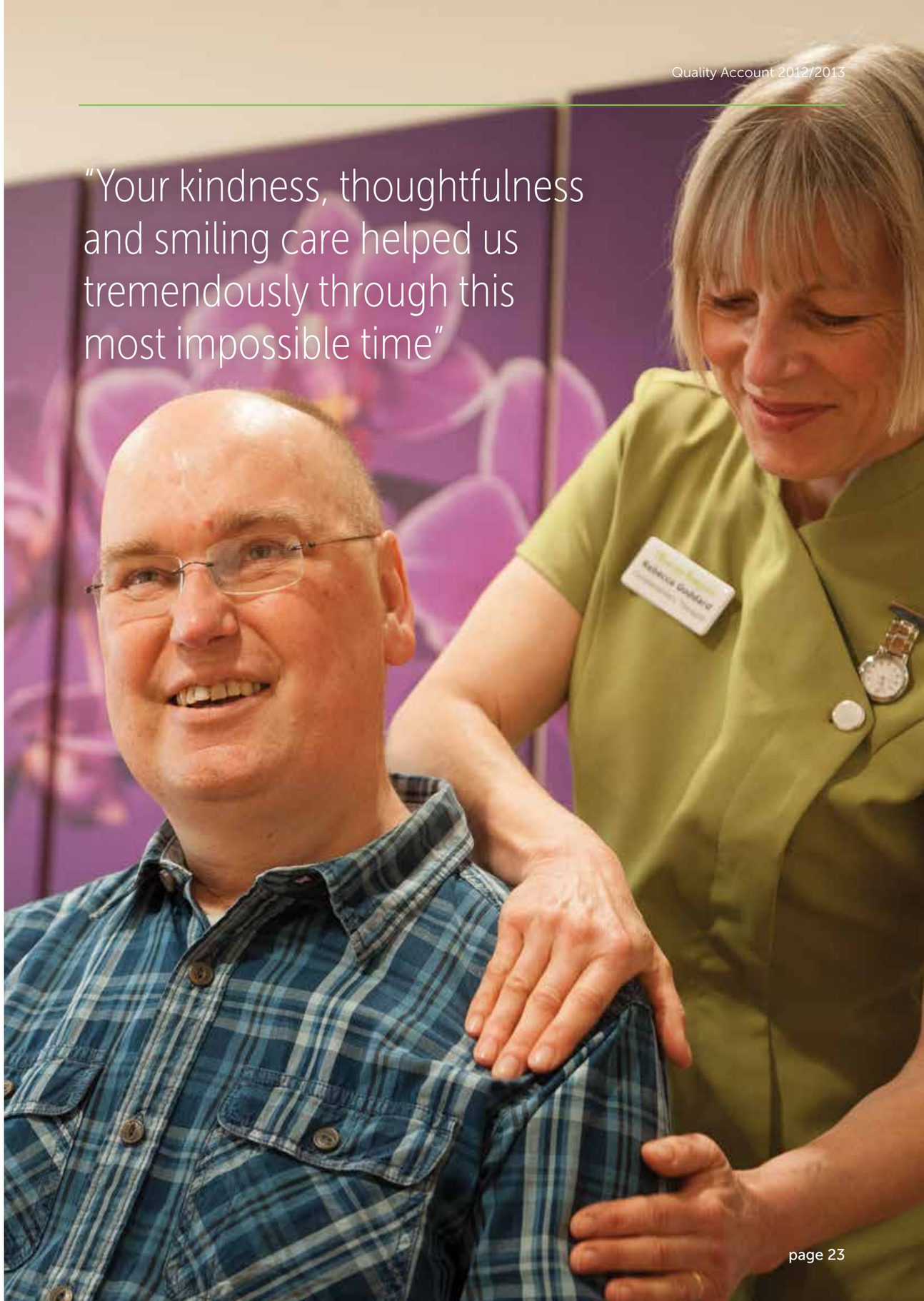
Statement from Commissioners

(Slough, Bracknell and Ascot, Windsor and Maidenhead CCGs)

"The services we commission from Thames Hospice provide exceptionally high quality care for people at the end of their lives and those in need of specialist palliative care.

We welcome their energy and ability to look to the future in planning services which will meet the needs of our locality for years to come, and we are extremely grateful for their charitable contribution of over 80% towards funding this care.

We are delighted to continue our commissioning relationship with Thames Hospice and look forward to a further productive year, knowing that people are well cared for in their hands."



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Thames Hospice
Pine Lodge, Hatch Lane
Windsor, Berkshire SL4 3RW

Call us **01753 842 121**
Visit us **thameshospice.org.uk**
Email us **info@thameshospice.org.uk**

Registered charity number 1108298