Thames Hospice Quality Account **2012/2013**

Thames hospice

Expert care, everyday kindness

thameshospice.org.uk

"Thank you to the most amazing caring team of people..."

Index

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 2012 – March 2013, our 25th anniversary year.

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 2012/13 the services we provided to our patients were of an exceptional standard and that our aim is to continually improve and develop upon the solid foundations we already have in place. We are able to do this through the commitment and tireless dedication of our staff and volunteers, all of whom I would like to formally thank in this introduction.

I would also like to thank our generous supporters and fundraisers for their tireless support, without them we wouldn't be able to keep our services running.

Last year was a fantastic year for us and we were able to set the scene via our organisational strategy for the next 3 years. We have rebranded our organisation to adopt a fresher, more inclusive look and feel. Our name is now Thames Hospice. Whilst this account focuses mainly on 2012/13, I do think it is worth touching on our strategic objectives which stretch beyond this time, whilst reflecting upon our successes in the previous year. Our strategic aims are owned by everyone within the organisation and 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.

We don't anticipate that this will be easy and recognise that we must continue to strive for excellence in offering the very best palliative care services but, we are confident and committed to achieving our aims.

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. 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 you will see within the body of this report the results of the unannounced inspection of Thames Hospice earlier in the year.

This year has been a difficult one for many NHS trusts in regard to the provision of quality care and we have taken the learning from investigations such as the Francis Report and applied it as appropriate to our own organisation. We are acutely aware that we must never take the quality of our clinical services for granted, and consequently, we are regularly measuring, reviewing and continually developing our service offerings.

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. 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

2a In-Patient Service

	Number 2012-13	Number 2011-12
New Patients	249	227
Total Admissions	352	326
% Occupancy	64%	69%
Patients Discharged	171	172
Patients Died	181	156
Average length of stay	11	13
Patient Satisfaction % patients satisfied or very satisfied with care	90%	

2b Community Services

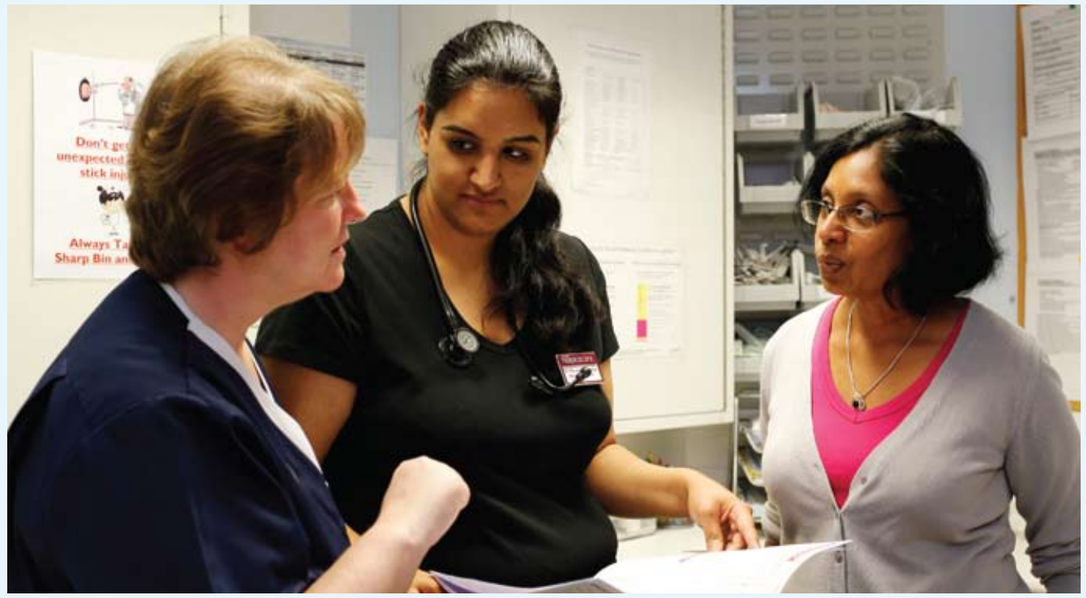
1. Hospice at Home

	Number 2012-13	Number 2011-12
No of patients	134	112
Average number of hours of care	26 hrs per pt	44 hrs per pt
Total Day hours provided	2245	3108
Total Night hours provided	1197	1866
No of deaths achieved at home (enabled by using service)	55 (out 78)	37 (out of 60)

NB. No Patient Satisfaction surveys undertaken in 2012

2. Community Therapy Unit

Formerly Day Support Unit	Number 2012-13	Number 2011-12
Places offered	2112	1876
Total Patients	128	145
Total New Patients	95	108
Discharges	103	97
Deaths	23	26
Patient Satisfaction % patients satisfied or very satisfied with care	93%	



2c Other Clinical Services

i. Lymphoedema

	Number 2012-13	Number 2011-12
Total Patients	53	60
No of Treatments Provided	619	623
Patient Satisfaction % patients satisfied or very satisfied with care	96.5%	

ii. Complementary Therapy

	Number 2012-13	Number 2011-12
Total Patients	324	291
No of Treatments Provided	1490	1621
Patient Satisfaction % patients satisfied or very satisfied with care	93%	

iii. Patient and Family Support Services

	Number 2012-13	Number 2011-12
Total Patients/Clients	209	188
No of Sessions Provided	1802	1703
Patient Satisfaction % patients satisfied or very satisfied with care	100%	

Part 2

2d Alternative Quality Indicators

i. Complaints

In the year Thames Hospice received 11 formal letters of concern/complaint, two of which after initial discussion and investigation were more queries about care and process rather than complaints. Complaint summary:

Topic	Outcomes	Actions Required
Family complained that patient had not had a bath during short admission for EOLC	Investigation identified the patient had an intestinal infection and that they were generally too poorly to have shower/bath. Explained to family.	Ensure staff communicate clearly why they can/cannot provide certain types of care.
Inpatients (x2) during year complained about the communication style of members of staff (medical and nursing)	Investigations upheld the complaints, although circumstances contributed to situations.	Members of staff made aware that behaviour was unacceptable. Apologies offered either in writing or in person.
Complaints about service flexibility related to Out Patient/Day Support	Investigation did not find the offer of care to be poor or outside of our normal service provision but acknowledged the distress of the relative involved who personally found them unacceptable.	Multidisciplinary team agreed ongoing management plan for patient/family to ensure effective communication and continuity of care.
Family distressed by information provided by different service providers that was contradictory (TH/CN/Mac)	Discussion with the TH Consultant resolved the issue of best choices for patient related to symptom management.	Consultant discussed how to improve working practices between the two teams to minimise the likelihood of contradicting information.
Concerns raised over processes to re-admit to TH from Nursing Home for EOLC	Discussion with individuals enabled current processes to be discussed and new developments explained that may have supported this individual.	TH implemented support for younger people who need end of life care outside of Nursing Home environments (and who cannot be cared for at home).
Patient raised concerns over doctor's assessment and summary of care at hospice as recorded in discharge letter to GP	Review of notes suggested letter was an accurate summary of assessment and care offered.	None required.
Executor of Will seeking information about family	Letter seemed to be complaint about staff sharing information inappropriately but on discussion was really seeking clarification, which was enabled with support of GP.	Identified that not all discussions held with patients and families (of importance) were always recorded. Clinical staff reminded of importance of record keeping.
Counselling client unhappy with counsellor/ team lead	Unable to offer alternative service as client needs greater than expertise of resource available.	Team discussed how to manage clients with needs outside of expertise.

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 of January 2013 the clinical teams maintained formal records of accolades received. These are also reported at the Patient Care & Quality Committee's quarterly meetings.

In the last quarter of 2012/13 a total of 54 formal accolades were received by the clinical services. We have also included the aggregated full year effect.

	Last Quarter 2012/13	Full Year Effect
In-Patient Unit	24	92
Community Therapy Unit	8	32
Hospice at Home	6	24
Complementary Therapy	6	24

iii. Patient Safety Summary

a. Accidents

Type	Number in Year	Seriousness/Impact	Actions
Patient falls	55	53 Minor rated accidents – and mostly due to patients deteriorating physical state. 2 High rated issues.	Mandatory Training highlights risks to patients. Patients who are at high risk are placed carefully in view and have access to Hi-Lo bed. 2 X Serious injuries reported to RIDDOR/CQC as required.
Wheelchair incidents	1	LOW	None

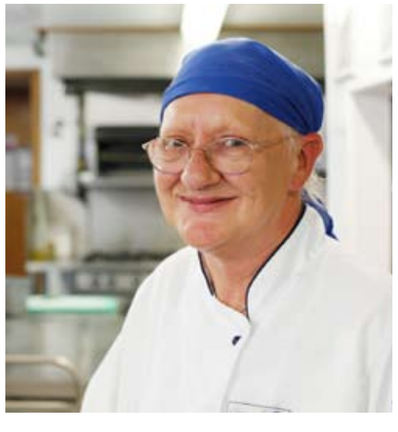
Part 2

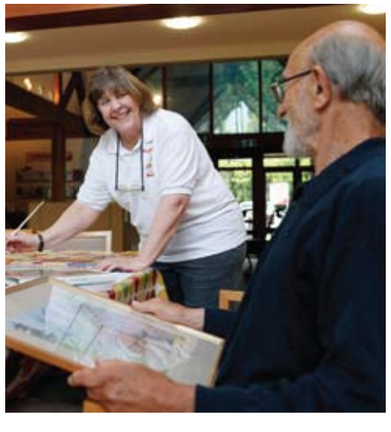
b. Clinical Incidents – No incidents were reportable

Type	Number in year	Seriousness/Impact	Actions
Controlled Drug Incidents	11	LOW	Staff required to undertake reflective practice. Incidents reflected in mandatory medicines training.
Drug Administration Error	7	LOW	
Communication Incidents	5	LOW	IPU Senior Nurse fed back to team/ individuals.
Information Governance	2	LOW	Involved staff being unclear about which printer they were using – IT update provided.
Lost Patient	1	LOW	Patient wanted to go home, noticed quickly and found outside of building in hospice grounds.
Prescribing issue (CD)	2	LOW	Drs made aware of errors through nurses checking procedures. Change of approach re prescribing Syringe Drivers.
CD Stock Management	2	LOW	Nurses asked to reflect on procedures. Spot checks undertaken by Pharmacist.
Drug Omissions	4	LOW	Staff required to undertake 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
Applications for Continuing Health Care Funding	Identified that of those people who needed CHC funding average length of life post discharge to Nursing home was less than 3 weeks.	Negotiated with Commissioners/ CHC for service to be provided to patients at TH where appropriate.
Meeting Nutritional Needs	Overall good outcomes. Need a little more focus on assessment and recording dietary intake.	IPU Sister to feed back to staff and improvements to be made to assessment details.
Time of Death	To ascertain if deaths are more prevalent at weekends – 15% on average therefore NO.	None
Preferred Place of Care	94% of records detailed PPC. Achieved in 94% of cases. PPC changed in 22% of cases.	None
Infection Control	Handwashing audits undertaken monthly, Environmental audits quarterly. Consistently high compliance.	Small remedies required – with housekeeping and nursing staff. Minor issues only resolved on the day.

Undertaking audits during the year proved to be challenging because of staff resource. This has now been addressed and an audit manager has been recruited specifically to undertake the audit programme.

v: Regulatory Inspection

Thames Hospice, Windsor received an unannounced inspection visit by the Care Quality Commission in November 2012.

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

- Respecting and involving people who use the services
- Care and welfare of people who use services
- Safeguarding people who use services from abuse
- Cleanliness and infection control
- Safety and suitability of premises
- Assessing and monitoring the quality of service provision

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

Part 2

What families say about our services

Overall families are very satisfied with our service provision. 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:

"A heartfelt thank you for all the wonderful care you gave to my late father."

"We are comforted that Dad was in the best place..."

"This is such a quiet and peaceful place and everyone is so kind and helpful."

"M. wanted to die at Pine Lodge and you all made that and the peaceful end to his life possible."

"Thank you to the most amazing caring team of people..."

"Mum received wonderful, compassionate and professional support as an Out Patient, when receiving day care, company and massages. Latterly she was wonderfully looked after as she stayed at Pine Lodge."

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 have introduced a patient or family member Video Clip 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

3a Priorities for Improvement

1. Patient Safety

Priority Action	How identified as a priority?	How will priority be achieved?	How will progress be monitored and reported?
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 its 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.
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.
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.
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.

2. Clinical Effectiveness

Priority Action	How identified as a priority?	How will priority be achieved?	How will progress be monitored and reported?
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.
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.
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.

Part 3

3. Patient Experience

Priority Action	How identified as a priority?	How will priority be achieved?	How will progress be monitored and reported?
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.
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.

3b 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

Thames Hospice has in the last year reviewed its referral criteria to ensure that those people most in need of its services are able to access them easily and in a timely manner. The emphasis of the care it provides is to those people whose diagnosis had led to a prognosis of less than two years. Each team will have its own criteria that reflect their specific care offering but within the boundaries of the core criteria which 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

TH is not part of the NSH and currently has not participated in national clinical audits or national confidential enquiries.

iii. Research

Thames Hospice does not currently instigate research projects itself but has participated in one current study – ChemDel: a national study compiling data related to the common prescriptions used in syringe drivers. This study aims to identify the most commonly used drug mixes in syringe drivers which will then support further research to determine any contra-indications in those mixtures.

iv. Completeness of data submitted to the Secondary Uses Service

As TH 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.

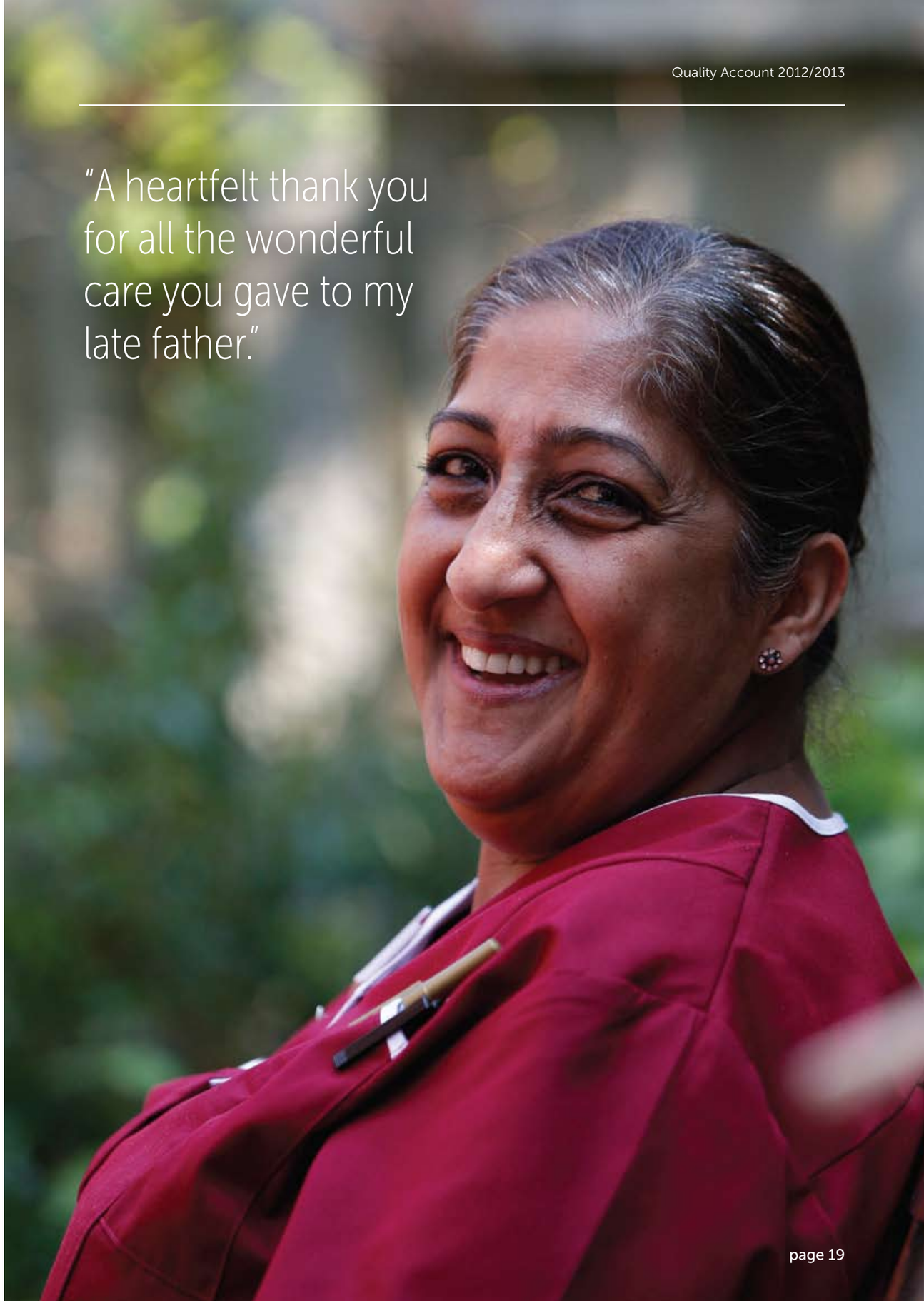
Part 4

Statement from Commissioners

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

"As commissioners we are extremely happy with the quality, responsiveness and value for money offered by Thames Hospice. We have always found them to be open to discussions, willing to try new ideas and responsive to commissioners requests. They work well as a part of our integrated palliative care services, operating in an open and transparent manner. We are grateful for the contribution they make in terms of their charitable funding which enables our patients to receive the high quality care they provide.

We are delighted to be able to commission from them again in 2013/14 and look forward to a continuing productive relationship."



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