Serving the communities of
Hartlepool & East Durham

Alice House Hospice

Quality Accounts

2018/2019

Dignity, Respect, Support and Care

CONTENTS

PART 1: STATEMENTS OF QUALITY FROM THE CHIEF EXECUTIVE AND CHAIRMAN

CHIEF EXECUTIVE'S STATEMENT

Alice House Hospice provides a range of essential services to the communities of Hartlepool and East Durham. As a provider of Specialist Palliative Care, we provide a Consultant led service which ensures that even the patients with the most complex problems have a safe and supportive place to go to for symptom control, respite and end of life care.

Alice House Hospice is unique in terms of the range of services available, in particular our long stay unit whereby people who normally would be placed in a care home are able to stay in this supportive specialist environment. We have a 100% success rate for not admitting patients into an acute hospital as they are treated by our highly skilled and compassionate Palliative Care Team.

We are proud of our philosophy of collaboration and joined up working. This is reflected in the work we do with the Hospices North East collaboration and our willingness to support other providers in delivering high quality care.

Our Volunteers are incredibly important to us and we could not achieve what we do without them. Our aim is always to add social value to our community by providing meaningful training and work experiences that ultimately lead to employment.

We are proud of our reputation and the place we hold in the hearts of families that use our services.

Tracy Woodall
Chief Executive
May 2019

CHAIRMAN'S STATEMENT

I am proud to be able to endorse these quality accounts for another year and to thank the staff and volunteers who work here, for upholding the Outstanding Care we are rated for and also to thank the many individuals and companies that support us financially and make this Hospice possible.

The demands on our services are ever increasing, as is the cost of delivering these services. However, through using a lean approach and value for money philosophy and our robust governance controls, ensures we manage to balance our resources in a responsible manner.

We have a vibrant Trustee Board who are open and welcoming to new ideas and ways of supporting people and we have faith in the Senior Management Team to identify and deliver new projects that increase our reach and impact, which inevitably improve our services to patients.

Ray Priestman
Chair of Trustees
May 2019

PART 2: PRIORITIES FOR IMPROVEMENT 2019/20 AND MANDATORY STATEMENT OF ASSURANCE FROM THE BOARD

2.1 INTRODUCTION

The Hospice was established in 1980 as a local charity (Hartlepool Hospice Ltd) delivering specialist palliative care to individuals affected by life limiting illnesses within the local communities of Hartlepool (including Stockton-on-Tees) and East Durham.

The Hospice's clinical services are Consultant led and supported by a Multi-Disciplinary Team of professionals who provide patients with individualised care, whilst promoting and maintaining the best quality of life possible. Some of the professionals within the Multi-Disciplinary Team include: Consultant, Staff Grade Doctor, F2 Doctors, Specialist Registrar Trainees, GP Trainees, Clinical Lead, Band Six Sister for Inpatients and Community, Specialist Nurses, Registered Nurses, Senior Healthcare Assistants, Healthcare Assistants, Clinical Workforce and Activity Manager, Complementary Therapist, Occupational Therapist, Physiotherapist, Bereavement & Support Counsellors and Volunteers.

From March 2018 our registered beds with the Care Quality Commission increased to 18 to respond to increasing demand from the local health economy. Alice House Hospice now provides 18 inpatient beds, which consist of 8 specialist complex management, 9 long term nursing and 1 respite. A wider variety of inpatient services allows the Hospice to have an extended referral criteria, thereby supporting more patients in the local communities and providing greater choice around Preferred Place of Care (PPC).

The Hospice also offers community services including domiciliary care for patients in their own homes, regardless of diagnosis, which is funded through Continuing Healthcare budgets, personal budgets or privately funded. This allows us to support a wider range of patients and their families in our local communities, enabling them to live in their own homes and maintain their independence. This also supports the opportunity for palliative patients to be introduced to Hospice services at the earliest opportunity, allowing them to remain in control of choices around accessing services to support them. During 2018/19 the Hospice provided 9,936.25 hours of homecare support to 15 clients. This represents an increase of 29% on the previous year's hours of support.

Other community services include Day Hospice services, which are delivered from the Hospice's purpose built Holistic Wellbeing Centre. Day Hospice continues to provide specialist clinical support in an outpatient environment to help control symptoms and provide effective treatment, alongside the provision of psychological and emotional support to improve wellbeing. This service forms part of the commissioning arrangements with both Hartlepool & Stockton CCG and Durham Dales, Easington & Sedgefield CCG.

The Hospice continues to provide Day Care services on Tuesday and Thursdays which support the social care needs of the local community,

reducing isolation and offering a peer support approach. A further day was opened on Fridays specifically to support male patients and this is very popular. These services are delivered in a relaxed, friendly environment in our purpose built Holistic Wellbeing Centre and can be funded through Continuing Healthcare, Local Authority, Personal Budgets/Direct Payments or Self-Funded.

The Holistic & Wellbeing Centre also facilitates the provision of Counselling & Support Services, which provide bereavement and anticipatory grief counselling for both adults and children. The Hospice continues to run the Jo & Mya Project which was established in 2015, however funding for this project ceased in 2017 and is currently funded through sponsored school activities for those participating in the project. This gives local schools, teaching staff, child minders and those agencies dealing with refugees, support for dealing with bereaved children and encourages fundraising on behalf of the Hospice.

Other therapy support is also available, including Complementary Therapies, which are designed to offer relaxation and help to relieve symptoms. The therapies are used to complement the specialist medical and nursing care our patients may be receiving. This service is provided wherever the patient requires it, even in their own home environment and is also available to the wider public.

The Hospice continues to provide a 24 Hour Helpline which is supported by trained staff who can give clinical advice and support or signpost to other professionals if appropriate. The Helpline is available for the public and professionals and is not funded.

The 24 Hour Helpline has been promoted during the recent Education Alliance Project which commenced in January 2017 and was extended into 2018/19 and 2019/20. The project is a collaborative alliance approach to palliative and end of life education across all care homes within Hartlepool & Stockton, involving the Mental Health Teams, the Falls Teams, North Tees & Hartlepool NHS Trust and Alice House Hospice. The aim of the project is to reduce hospital admissions from care homes and help patients achieve their Preferred Place of Care (PPC). During the period February 2018 to January 2019 the Hospice's Education Lead successfully delivered 39 training and education sessions to care homes across both Stockton on Tees and Hartlepool. A Service Level Agreement covering a two year period was awarded in April 2018 from the Education Alliance Project to deliver training on End of Life Care and Advanced Care Planning to local care homes.

NICE Guidelines (2004, Improving Supportive & Palliative Care for Adults with Cancer) state that providers should offer a range of services that meet the individual's physical, environmental, spiritual and social support and improve quality of life. The Hospice ensures that patients and their families receive excellent care from diagnosis to post bereavement, which is based around their holistic needs. This is achieved through a whole range of services for both cancer and non-cancer patients, promoting the philosophy of living life to the full.

It is the Hospice's Vision to ensure that, 'every person, to the last moment of their life has the right to dignity, respect, support and care' and our Mission is, 'to provide services that add value to life and make a difference to patients and their families'.

As the future of Hospice care evolves in the constantly changing health environment, we have developed positive and effective working relationships that ensure cross organisational integration and representation through different working groups, to identify pressures and inadequacies in the healthcare system and to generate innovative solutions to patient service problems.

Alice House Hospice is an integral partner in the Hospices North East; Transforming Care Together Collaborative, who take a partnership approach to addressing the ever increasing demands of service provision, education, training and workforce development. This collaboration demonstrates a region wide commitment to working in partnership to improve palliative and end of life care for all patients, regardless of demography or diagnosis. The Hospice is a member of the following collaborative groups:

- Chief Executives
- Executive Clinical Leads in Hospice & Palliative Care (ECLiPH)
- Education
- Marketing & Communications
- Human Resources
- Finance

The Quality Accounts will demonstrate the standard of service delivery and innovative practice implemented in partnership with the local Clinical Commissioning Groups (NHS Hartlepool & Stockton-on-Tees CCG and Durham, Dales, Easington & Sedgefield CCG) during 2018/19. The Hospice's Strategy for 2015 to 2020 continues to underpin our future priorities.

The forthcoming year will be the Hospices 40th anniversary and a new Five Year Strategy will be developed which reflects the changing needs of communities in relation to health and wellbeing. Supporting more people with mental health conditions through our Therapeutic Team and new projects is one of our aims which responds to the increasing need and lack of services in the local health economy.

Please note that the Quality Accounts do not include non-clinical quality initiatives, such as fundraising, administration and finance.

2.2 FUTURE IMPROVEMENT ASPIRATIONS 2019/20

Alice House Hospice has developed the following improvement aspirations in line with the organisational Clinical Strategy 2019 to 2022 with the involvement of patients, their families, staff and external stakeholders. This is demonstrated within the three priority quality domains of; Patient Safety, Clinical Effectiveness and Patient Experience.

2.2.1 **Priority 1 – Patient Safety**

Strengthen Key Link Roles

2.2.1.1 **How the priority was identified**

As part of the Service Level Agreement with Hartlepool & Stockton-on-Tees CCG and Durham, Dales, Easington and Sedgefield CCG for 2019/20, Key Link roles were added as a CQUIN measure along with being identified in the Hospice's Clinical Strategy 2019-2022 short term goals. The Link Nurse role improves the quality of care delivered to patients through the development and education of staff, directly responsible for patient care.

The aim of a Link Nurse is:

- To establish networks of appropriately trained links within healthcare and allied disciplines.
- To use the network to monitor standards and improve the care of the patients within your area.
- To share and implement information distributed by the specialist team.
- To escalate any concerns to the Clinical Lead or specialist team.
- To share and monitor safe evidenced based current practice in your area.
- Develop the Link role in-house through appropriate training and skill development.

As part of the role the Key Link Worker will:

- Act as a competent role model and be an advocate within that speciality.
- Provide a visible presence and be accessible/contactable in the workplace to the clinical team, patients and their carer's.
- Enable individuals to learn and develop their specialist practice by working alongside staff and students to generate creative opportunities for learning.
- Patient safety will be promoted and monitored.
- Communication will be improved as the key link workers will feedback to staff ensuring positive and constructive feedback enabling staff to celebrate success. This will also develop the Hospice's open and honest culture in reporting and learning from clinical incidents.
- The Key Link Worker will work closely with line managers to produce effective action plans where needed.
- The Key Link Worker will update and maintain a resource file which is readily available for staff to access and monitor their key areas through regular audits.

The following Link roles have been identified with RGN lead and support provided by named Senior Health Care Assistants and Health Care Assistants:

- Nutrition/Oral Care
- Stoma Care
- Life Limiting Conditions (MS, MND, Parkinson's MSA)

- COPD/Breathlessness
- Infection Control
- Catheter Care
- Heart Failure
- Pain
- Tracheostomy Care
- Diabetes
- Tissue Viability including Wound Care/Pressure Area Care
- Dementia Care
- Lymphoedema
- Hickman Lines
- Falls

2.2.1.2 **How the priority will be achieved**

- Network with other Link Advisors.
- Access to specialist support via Service level Agreements with Infection Control and Tissue Viability through North Tees and Hartlepool NHS Trust.
- Resource File on Key Link subjects.
- Monitoring Audits and Improvement Action Plans.
- Task and Finish Groups.
- Quarterly Link Work Meeting.

2.2.1.3 **How the priority will be measured**

Alice House Hospice will develop a check sheet which includes name, date and piece of research/evidence added to file.

- Audit of file.
- Line manager to discuss individual roles and progress during contact meetings.
- Introduction of article of the month, focusing on one of the above areas.
- Update documentation/care plan in line with current evidence based practice.
- Evidence in staff survey of training needs met and confidence in providing holistic care.
- Attendance of rolling programme.

2.2.2 **Priority 2 – Clinical Effectiveness**

Increasing Services within the Community

2.2.2.1 **How the priority was identified**

Increasing services within the community has been identified in Alice House Hospice's Clinical Strategy 2019-2022 short term goals. Due to the loss of funding for Marie Curie within Hartlepool, Marie Curie have removed their overnight support within the community leaving a gap in services. Following a meeting with the Matron of the District Nursing Team it was identified that there is a shortage of local care providers providing peg feeding for patients within the community. The government has pledged an extra £3.5bn a year

in annual funding for primary and community care by 2023/24, as part of the £20.5bn funding increase for the NHS announced earlier this year. Prime Minister Theresa May said the funding will be used to ensure that more patients are cared for at home and in the community, which will reduce 'needless' hospital admissions.

She said: "Too often people end up in hospital not because it's the best place to meet their needs but because the support that would allow them to be treated or recover in their own home just isn't available.

"Many of us might assume that hospital is the safest place to be – but in reality many patients would be much better off being cared for in the community. And the longer a patient stays in hospital the more it costs the NHS and the more pressure is put on its hardworking staff. This needs to change."

2.2.2.2 How the priority will be achieved

Alice House Hospice will continue to build partnership working with the District Nursing Team within Hartlepool to ensure patients who have expressed a preference to remain within the community have the opportunity where possible to do so.

All Healthcare Assistants will receive training and competencies in PEG feeding.

Alice House Hospice will be proactive in recruiting the necessary staff to deliver the additional support within additional homecare packages.

2.2.2.3 How the priority will be measured

Outcome measures will be captured on the following and included in the bi-monthly report to Trustees and quarterly performance report to Commissioners:

- Number of District Nurse Team meetings Alice House Hospice attend.
- Number of Community Multi-Disciplinary meetings District Nurses attend at Alice House Hospice.
- Number of referrals received for Community Homecare.
- Number of patients accepted for Community Homecare.
- Number of staff recruited for additional Homecare packages.
- Number of staff receiving training including additional training to cover the holistic needs of patients within the community.

2.2.3 Priority 3 – Patient Experience

Opening up Hospice Care

2.2.3.1 How the priority was identified

Hartlepool Joint Health and Wellbeing Strategy 2018–2025 have set the following priorities: Starting, Working, Ageing and Living Well. Following consultation with the general public Hartlepool have added an additional

priority: Dying Well. The main priorities that impact Alice House Hospice are:

- **Ageing Well**
  The aim is for Older People in Hartlepool to live active and independent lives and are supported to manage their own health and wellbeing. Similar to most areas in England, the proportion of older people in Hartlepool is increasing. For instance, the number of people who were aged 85 years or more in 2005 was 1,400; this increased to 2,100 by 2015 and will continue to increase to 3,330 by 2025 and to 4,700 by 2035. Although most people are living longer, the majority of their later years (approximately 20 years for males; and 26 years for females) are lived with poor health and wellbeing. The strategy is to support people to develop and maintain health and independence as long as possible. When people start to develop a long-term health problem, the focus is on preventing them from developing further health and social problems. The objective is services are focused on those who have the greatest need, to reduce health inequality and to enable a greater focus on prevention of ill health.
- **Living Well**
  The aim is for Hartlepool to be a safe and healthy place to live with strong communities. Enabling those who live in Hartlepool to be healthy and well for a lifetime involves much more than good health and social care services. Many different things impact on health and wellbeing – housing, jobs, leisure, sport & access to open spaces, education, health services and transport. The strategy want Hartlepool to be a healthy place with supportive neighbourhoods and communities which are strong and resourceful, making best use of their community assets. The objective is to support people in Hartlepool to take steps to avoid premature deaths.
- **Dying Well**
  The aim is for People in Hartlepool to be supported for a good death. Some will experience death suddenly or prematurely; others will die after a period of illness or frailty, which can sometimes be protracted over time. The objective is to engage communities so that people from Hartlepool are supported to die with dignity, compassion and that relevant support is available to carers to deal with dying and death.

In the Draft Consultation (NICE, April 2019) End of Life Care for Adults in the Last Year of Life: Service Delivery Evidence Review: Barriers to Accessing End of Life Care Services, NICE Guideline Evidence Review stated there was a lack of awareness of end of life services available and how to gain support. Understanding of the concepts of end of life care such as palliative and hospice care was variable which could lead to wrong expectations of services.

Research by Hospice UK has shown 1 in 4 families miss out on expert support at the end of life. Studies have shown that people from economically deprived areas, BAME (black and minority ethnic) and LGBT (lesbian, gay, bisexual and transgender) people are not seen in palliative and expert end of life care services as often as expected. People with terminal conditions other than cancer access hospice care in fewer numbers and later in their illness than others. People who live alone at end of life also tend to have barriers to

accessing expert end of life care. For the BAME community, research suggests that there are numerous potential barriers to accessing palliative care services. These include “lack of cultural and religious sensitivity in how services are delivered, discrimination (and/or fear of it), absence of translation resources, different cultural views regarding the acceptability of openly discussing death, shortages of female doctors for Muslim women and assumptions that family members from BAME backgrounds will be able and willing to care for relatives at home. People of BAME backgrounds are also more likely to die in hospital than non-BAME people, which may indicate difficulties with both referrals to appropriate end of life services and of uptake of referrals.

Recent research by Marie Curie noted that LGBT people may experience barriers to palliative care because of several related social determinants known to correlate with poor access to appropriate care, such as being single, not having children or estrangement from one’s birth family. This is in addition to real and perceived pressure to hide one’s true self. These challenges, in accessing care for themselves and their loved ones, are also experienced by partners and spouses before and after bereavement.

Research has shown that a cancer diagnosis significantly influences the likelihood of being referred to expert palliative and end of life care services. Even though cancer accounts for 29 per cent of deaths, in 2012-13 in England, Wales and Northern Ireland, 88 per cent of palliative care inpatients and 75 per cent of new referrals to hospital support and outpatient services were for people diagnosed with cancer. This same pattern is seen in hospice services. People with a cancer diagnosis are currently over-represented in hospice care referrals. Charitable hospices estimated that the vast majority of the referrals they received in 2015-16 were for people with cancer. Hospices report that referrals for people with a non-cancer diagnosis are slowly increasing, but cancer remains the primary diagnosis in most people they see. This tells us a lot about what doctors, from GPs to specialists, know about hospice care and how they understand end of life.

2.2.3.2 **How the priority will be achieved**

Alice House Hospice will have a rigorous information campaign to educate a variety of harder to reach groups such as BAME and LGBT communities. This will be achieved through joint working with the local community sector within Hartlepool.

Alice House Hospice’s website will be developed to include a translation facility to ensure information is available in a variety of languages.

Alice House will hold a quarterly information drop in and promote this through Hartlepool Now so that anyone who has long term conditions can receive information and support.

2.2.3.3 **How the priority will be measured**

- Number of organisations receiving Alice House Hospice information.
- Number of request on the website for translation.
- Number of organisations attending quarterly drop in.
- Number of people with long term conditions attending drop in.

2.3 PROGRESS ON IMPROVEMENT PRIORITIES FOR 2018/19

The quality improvement priorities for the previous year are reported on below.

2.3.1 Priority 1 – Patient Safety

Reduce Clinical Staff Sickness Levels

2.3.1.1 What we have achieved

Clinical sickness levels have been collated and compared with the previous period as displayed:

MONTH	SICKNESS COSTINGS
APRIL 2017	£1,245.87
MAY 2017	£3,034.20
JUNE 2017	£457.65
JULY 2017	£2,491.50
AUGUST 2017	£4,378.70
SEPTEMBER 2017	£2,320.02
OCTOBER 2017	£2,521.47
NOVEMBER 2017	£3,257.63
DECEMBER 2017	£2,511.95
JANUARY 2018	£4,249.61
FEBRUARY 2018	£3,784.67
MARCH 2018	£4,359.24
TOTAL	**£34,614.51**

MONTH	SICKNESS COSTINGS
APRIL 2018	£3,137.03
MAY 2018	£4,093.41
JUNE 2018	£8,098.76
JULY 2018	£1,546.16
AUGUST 2018	£1,362.59
SEPTEMBER 2018	£9,447.41
OCTOBER 2018	£8,508.26
NOVEMBER 2018	£6,990.00
DECEMBER 2018	£1,649.71
JANUARY 2019	£6,979.35
FEBRUARY 2019	£2,663.83
MARCH 2019	£3,137.03
TOTAL	**£54,476.51**

As represented the actual sickness levels have increased by £19,862.00. However during the financial year 2018/2019 clinical sickness was compounded by long term sickness within the clinical department and these are some of the examples.

- 1 Band 6 Specialist Nurse absent for 7 months due to skeletal illness, now resigned on medical retirement
- 1 Band 6 Specialist Nurse absent for 4 months due to heart problems.
- 1 clinical member of staff absent for 2 months with ligament damage.
- 1 Registered Nurse absent for 5 months due to personal stress.
- 1 Senior Health Care Assistant absent for 6 months due to personal problems at home.
- 1 Ambulance Driver absent for 2 months due to fractured ribs and punctured lung.

All staff on sick are given monthly welfare meetings with the HR Department to identify ways of returning staff back to work as quickly as possible with options of lighter duties or graduated return. Staff are also given leaflets introducing them to the Employee Assistance Programme which offers them confidential face to face or over the telephone counselling.

The impact of staff sickness has been mitigated on the negative effects on staff by adding additional pressures to cover staff absences as a Nursing

Agency has been utilised to ensure Patient Safety is maintained. The agency has been able to supply all grades of clinical staff and the agency ensures that their staff are pre-vetted, insured and DBS checked. Wherever possible the agency has used a small number of staff who have become familiar with Alice House Hospice patients, staff and processes which in turn effectively manages the disruption to patient safety.

2.3.1.2 How we will continue to improve

Alice House Hospice will continue to communicate with staff using an open and honest approach to make sure staff are aware of the effects on the organisation due to staff sickness. However, Alice House Hospice are a compassionate employer and will continue to engage with staff on ways to reduce clinical staff sickness. One of the ways Alice House Hospice are looking to address this issue is by consulting with staff on the current clinical rota system and trying to identify if alternative shift patterns will have an effect on staff sickness.

Due to the cost of staff sickness Alice House Hospice have also looked at the Terms and Conditions offered at other hospices in the region and are in the early stages of consultations to amend staff Terms and Conditions, which will have little impact on staff who have been with the organisation for many years but will effectively save the organisation money to ensure the sustainability of the organisation.

2.3.2 Priority 2 – Clinical Effectiveness

Raise Clinical Standards

2.3.2.1 What we have achieved

5 clinical staff have completed the Care Standards Certificate. 5 clinical staff are in the process of completing the Care Standards Certificate. Alice House Hospice aim for 5 staff to complete the Care Standards Certificate each year.

Alice House Hospice have an open and transparent approach to clinical incidents and staff report everything. However, from February 2018 we added a further category of pressure sores/moisture lesions which includes patients who come into the service who already have any pressure damage or moisture lesions. Alice House Hospice regard any from grade 3 as a safeguarding situation and report accordingly. The rationale behind recording all pressure damage or moisture lesions was to enable Alice House to closely monitor patients and record if the issue had started since admission to the Hospice.

From April 2018 to March 2019 a total of 153 clinical incidents were recorded:

- 45 drug incidents which include spillage, patient own, missed medication, counting errors etc.
- 52 falls which include when patients have been guided to the floor or are independently mobile.
- 29 other incidents including incidents against staff, shortage of staff.

Pressure damage/moisture lesions which was previously recorded under other incidents and now include details of patients coming into the Hospice with these:

Although Alice House Hospice noted a slight rise in recorded incidents during 2018/19 there was an increase in bed occupancy of 12.5% within the Inpatient Unit from 66.8% to 79.3% and an increase in bed occupancy in the long term beds from 66.1% to 71.6% (a further 5.5% increase).

Examples of audit scores are detailed below:

Tissue Viability Audits (Sample size 10)	**12/01/18 - 21/05/18**	**23/05/18 - 21/08/18**	**17/10/18 - 20/12/18**	**01/01/2019 - 31/03/2019**
Braden Score	100% completed, 80% correct	100% completed, 100% correct	100% completed, 100% correct	100% completed, 100% correct
SSKIN	100%	80%	100%	100%
Intentional Rounding Charts	100%	100%	90%	90%
Moving and Handling Care Plan	80%, 20% of patients were independent therefore not applicable for this care plan at this time.	80%, 20% of patients were independent therefore not applicable for this care plan at this time.	100%	80%, 20% of patients were independent therefore not applicable for this care plan at this time.

Documentation	**23/05/18-21/08/18**	**17/10/18 – 20/12/18**	**01/01/2019-31/03/2019**
Care Plan Signed	100%	100%	100%
Time and Date	100%	80%	100%
NMC Number	40%	40%	60%
Stickers	70%	100%	100%
Holistic Assessment	70%	100%	100%

Environmental	**23/05/18-21/08/18**	**17/10/18 – 20/12/18**	**01/01/2019-31/03/2019**
Room appearance (tidy, bedding, nurse call in reach, table, drink and equipment available)	100%	100%	100%
Staff (tasks, sitting with patients, handovers, answering nurse call)	100%	100%	100%
Staff appearance (hair, jewellery, mobile phone, uniform)	100%	100%	100%

Clinical observations regarding Hand Hygiene Assessments have taken place with 9 members of the clinical team on a one to one basis.

Training

- 87 staff completed Awareness of Child Abuse Training
- 44 staff competed CJD Training
- 12 staff completed Clinical Strategy Workshop Training
- 7 Clinical Observation Training
- 106 staff completed Conflict Resolution Training
- 53 staff completed CPR Training
- 11 staff completed Delirium Training
- 45 staff completed Dementia Awareness Training
- 3 staff completed Deprivation of Liberty Training
- 44 staff completed Documentation Training
- 1 staff completed End of Life Care Training
- 1 staff completed First Aid Training
- 98 staff completed Fire Safety Training
- 104 staff completed Food Hygiene Training
- 56 staff completed GDPR Training
- 5 staff completed HCA Documentation Training
- 102 staff completed Health and Safety Training
- 110 Staff completed Infection Control Training
- 54 staff completed Lone Worker Training
- 3 staff completed MCA Training
- 43 staff completed Medicine Awareness Training
- 21 staff completed Administration of Medications/ In-house Medication Training
- 12 staff completed Level 3 Medication Training
- 17 staff completed Medicines Management Training
- 52 staff completed Clinical Moving and Handling Training
- 44 staff completed NEAS/ Advanced Care Planning Training
- 25 staff completed Nutrition in Palliative Care Training
- 50 staff completed Peg Training
- 10 staff completed Peg Competencies Training
- 94 staff completed Prevent (Radicalisation Training)
- 11 staff completed Safeguarding Adults Training
- 25 staff completed Tissue Viability Training
- 2 staff completed Verification of Expected Death Training

2.3.2.2 How we will continue to improve

Hand Hygiene Assessments will continue to take place with the Specialist Nurse for Education and Standards in which two staff will be identified at random to complete the assessment.

Moving forward a competency check list has been devised in addition to Verification of Death training.

Mandatory and induction training will continue to provide the necessary training to staff.

Alice House Hospice will continue its involvement with the Hospices North East Collaboration providing training opportunities to staff.

Root Cause Analysis will be used to identify and improve standards within Alice House Hospice.

2.3.3 Priority 3 – Patient Experience

To Develop and Deliver a Carer Focused Informal Support Group for Carers and Ex-Carers

2.3.3.1 What we have achieved

Alice House Hospice have engaged with Hartlepool Carers and invited them to take part in sessions offered to carers to promote their services and all family members are made aware of the service. Guest speakers from local voluntary services and the Specialist Nurse for Dementia and staff from Alice House Hospice were available to speak with carers regarding issues such as moving and handling and medicine management. A tool was devised entitled "This is me", where carers looked at six elements of their caring role including: health, caring role, my time, home and family, work, education and training and finances. Each section of the tool has a scale that carers can rate their starting point to help identify a realistic expectation along with what would improve their circumstances, what difference it would make to the carer, how this would improve their life, what would help them to manage things better, what would make a difference and who can support the carer to achieve this. In each section there is an ecomap designed for carers to identify who can support them and how and encourages carers to think about their needs before the situation hits crisis point and a review section to ensure the support they feel is in place is the right support for them. The sessions were available on a rolling programme over six weeks and as one of the barriers identified was that carers are reluctant to leave the person they are caring for to attend, additional staff were available to care for the patient should the carer be caring for their family member within their own home. The programme was advertised directly with volunteer groups working with long term conditions and statutory services such as District Nurses and the Local Authority, as well as promotion via leaflets within services in-house and on social media. The aim of the six sessions was to build support network for carers who would then continue to provide peer support. However, this pilot was poorly attended with only 3 carers attending. Feedback from all carers was positive and it was stated in particular the moving and handling and medicine management was beneficial.

Carer's individual needs are discussed on a daily basis at morning handover and if carers would like to be referred to counselling services either in-house or through our partnership with North Tees & Hartlepool NHS Trust's Psychology Team. Furthermore, carers' needs are discussed as part of the weekly Multi-Disciplinary Team meeting.

During the period April 2018 until March 2019, 32 individuals accessed support from Alice House Hospice's Counselling & Support Team (over 266 sessions). Within these numbers some family members solely attended 1 or 2 sessions of anticipatory grief before the death of their family member, whist

others returned to access bereavement support. A total of 95 patients families were contacted following the death of their loved one offering bereavement support.

2.3.3.2 How we will continue to improve

Carers support will continue to be provided via speaking directly to carers to ensure their needs are met within the service through the provision of counselling support and ensuring carers are aware of both statutory assessments to meet their needs and voluntary support available locally. Alice House Hospice will continue to listen to the voice of carers and continuously adapt support accordingly to the holistic needs of carers.

2.4 MANDATORY STATEMENT OF ASSURANCE FROM THE BOARD

The following statements must be provided within the Quality Accounts by all providers. Many of these statements are not directly applicable to specialist palliative care providers including Alice House Hospice, therefore explanations of what these mean are given.

2.4.1 Review of Services

During the reporting period 2018/2019 Alice House Hospice provided the following services:

- 8 bedded Inpatient Unit for short term symptom management and end of life care.
- 9 bedded Long Term Care Unit for residential nursing care.
- 1 Respite Bed.
- Community Domiciliary Care.
- Day Hospice designed around symptom management, health and social care.
- Day Care designed around social care and wellbeing.
- Complementary Therapies.
- Counselling & Support Service.
- 24 hr Helpline.
- Physiotherapy.
- Occupational Therapy.
- Chaplaincy.

The income generated by the NHS services received in 2018/19 represents 19.97% of the total income generated from the provision of NHS services by Alice House Hospice for 2018/19.

This means that the remaining 81.03% of the overall costs of service delivery is fundraised by the Hospice from voluntary charitable donations, legacies, Hospice shops, Hospice lottery, events and community fundraising.

2.4.2 Participation in Clinical Audit

During 2018/2019 0 national clinical audits and 0 national confidential enquiries covered NHS services that Alice House Hospice provides.

During 2018/2019 Alice House Hospice participated in 0% national clinical audits and 0% national confidential enquiries of the national clinical audit and national confidential enquiries as it was not eligible to do so.

2.4.3 Research

The number of patients receiving NHS services provided or sub contracted by Alice House Hospice in 2018/2019 that were recruited during that period to participate in research approved by a research ethics committee was 0.

2.4.4 CQUIN Payment Framework

Alice House Hospice's income for 2018/2019 from Durham Dales, Easington & Sedgefield Clinical Commissioning Group was conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation (CQUIN) payment framework.

The Hospice completed the following CQUIN indicator, which represented 2.5% of the overall contract value:

Durham Dales, Easington & Sedgefield CCG

- The Outcome Assessment and Complexity Collaborative (OACC)

2.4.5 Statement from Care Quality Commission

Alice House Hospice is required to register with the Care Quality Commission and it is currently registered to carry out the following regulated activities:

- Treatment of disease, disorder or injury.
- Diagnostic and screening procedures.
- Accommodation for persons who require nursing or personal care.

Alice House Hospice is registered with the following conditions:

- To accommodate up to a maximum of 18 patients overnight.
- To provide a service for people over the age of 18 years old.
- The registered provider's regulated activity is managed by a Registered Manager.
- The provider location where regulated activity can be carried out is: Alice House, Wells Avenue, Hartlepool, TS24 9DA.

The Care Quality Commission has not taken any enforcement actions against Alice House Hospice during 2018/2019. There have been no special reviews or investigations carried out by the Care Quality Commission during this reporting period.

The Hospice's last inspection by the Care Quality Commission was unannounced and carried out on 23 March 2015. The formal report and rating from the inspection was received on 20 August 2015 and the Hospice received an overall rating of Good, as detailed below:

Domain	Rating	CQC Comments
Is the service safe?	GOOD	• People and family members told us the Hospice was a safe place to stay. • Staff demonstrated a good understanding of safeguarding adults and whistle blowing. • There were enough skilled, experienced and knowledgeable staff to meet people's needs in a timely manner. • The Hospice was well maintained and clean.
Is the service effective?	GOOD	• The provider had invested in providing leadership training to all staff within the organisation. • The registered provider delivered a dynamic training programme for staff which evolved to meet changing priorities. • People described how staff went out of their way to meet their meal preferences. People gave us positive feedback about the meals the Hospice provided. • The provider was empowering people to self-manage their health conditions through running a unique innovative pilot 'breathlessness programme.'
Is the service caring?	OUTSTANDING	• People received excellent care from kind, compassionate and caring staff who listened to them. • We viewed numerous compliments praising the registered provider and staff for their kindness and support through difficult times. • Care was planned around what was important to each person. • We observed kindness and respect between the staff and people. People were treated with dignity and respect. • The provider had a strong focus on supporting people with their social and psychological wellbeing. • People could access social and therapeutic support in the bright and modern Holistic Wellbeing Centre.
Is the service responsive?	GOOD	• People who used the service were actively in control of the care and treatment they received. • Care plans identified specific interventions based on people's particular priorities. • Staff also discussed with people their plans for the future including their preferred place of care and preferences for their future care needs. • People were encouraged to remain as independent as possible and continue doing their everyday things as much as possible. • People said they were listened to and staff responded to their wishes.

Domain	Rating	CQC Comments
Is the service well-led?	GOOD	• All of the managers and staff spoke passionately and enthusiastically about the Hospice. • Patients and family members also spoke positively about the service. • The service was forward thinking, creative and modern and continually looked for opportunities to learn and improve practice. • There were excellent examples of innovative practice. • The audits were effective in identifying areas for improvement and ensuring action was taken to improve the service. • The provider was pro-active about sharing good practice to improve care for people at the end of their lives.

2.4.6 Data Quality

Alice House Hospice was not eligible and therefore did not submit records during 2018/2019 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics.

The Hospice has submitted quarterly Contract, Quality & Performance Reports to the Commissioners during 2018/19. These contain service updates, patient activity datasets (quarter position and trends), key performance indicators (KPI), local quality requirements (LQR) reporting, patient safety, patient/carer experience, clinical effectiveness, CQUIN and assurance (Workforce Assurance, Care Quality Commission, Commissioner Visits and Quality Accounts Progress Update).

2.4.7 NHS Data Security and Protection Toolkit Attainment

The NHS Data Security and Protection Toolkit is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards.

All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practising good data security and that personal information is handled correctly.

The Hospice completed and attained achievement of the toolkit by the required deadline of 31 March 2019.

2.4.8 Clinical Coding Error Rate

Alice House Hospice was not subject to the Payment by Results clinical coding audit during 2018/19 by the Audit Commission.

PART 3: REVIEW OF QUALITY PERFORMANCE

Alice House Hospice has considered the three domains of Patient Safety, Clinical Effectiveness and Patient, Carers, Staff and Volunteer Experience within these accounts during the reporting period of 2018/19.

3.1 PATIENT SAFETY

3.1.1 Medicines Safety

Medicine Record Cards have been redeveloped to help in the Long Term Unit. Long Term Unit patients normally have quite stable medications and medicine record cards were being rewritten every week. This promotes a higher risk of error in prescribing and administering. To counteract this we developed the Long Term Medicines Record Card that is extended over 2 pages which means that it lasts for a one month period. Staff were involved in the development and it has been a success at this point.

The Hospice have a Service Level Agreement (SLA) with Lloyds Pharmacy who supply both stock and patients' own medication. The SLA also ensures that a Pharmacist attends the Hospice on a weekly basis to monitor and audit prescriptions and drug kardex's for patients accessing inpatient services. All information obtained during this period is fed back to the Hospice's Medicines Management Group, of which the Pharmacist from Lloyds Pharmacy is a member, which in turn reports directly to the Clinical Governance Group. Alice House have reviewed intravenous medications, taking into account cost effectiveness in the drugs we store and require. We looked over a one year period to see the medications that we use and discontinued what was not required and added to stock what was required for the best patient care and cost effectiveness.

We discuss all safety alerts that come from central alerting system (CAS) to make sure we are keeping our patients safe and prescribing safely.

All drug incidents are discussed at Medicines Management Group and identifies what happened, how it may have happened and how to reduce the possibility of this happening again. This is a multi-disciplinary meeting which allows the incident to be looked at in every possible way.

3.2 CLINICAL EFFECTIVENESS

3.2.1 Patient Incident and Safety Audit

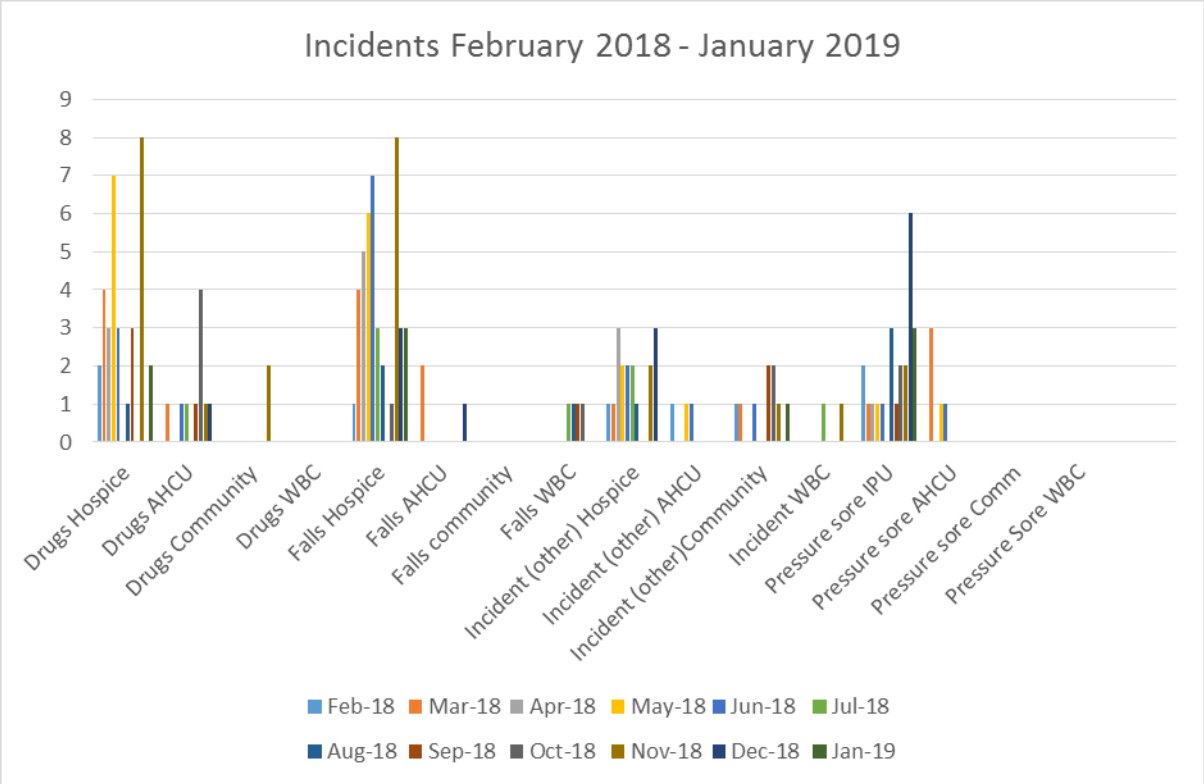
The aims and objectives of the audit were:

- To distinguish if improvements have been made since the previous audit.
- To identify gaps in the provision ensuring improvement.
- To emphasise areas of good practice and reporting procedures.
- To make recommendations on how to continuously improve practice and provision.
- To ensure that patient incidents and safety matters are recorded honestly and accurately to ensure robust procedures are timely implemented.

- To actively research comparable services to identify best practice and service improvements regarding data stratifications.

This audit evaluated all clinical incidents that were reported from February 2018 to January 2019. It examined the frequency, cause and effect of drug errors, patient falls and other incidents that had been reported in the 12-month period. Statistics from this period were compared to those captured during the previous audit period to demonstrate where variation had occurred. It identified if reporting procedures had improved, if incidents had reduced and if the recommendations that were made had been implemented. It identified where practice and procedures had been unsuccessful in meeting compliance and the actions that were required.

The table that follows establishes the annual clinical incidents which were reported between February 2018 and January 2019. It must be highlighted that these incidents took place within all of Alice House Hospice's services including Inpatient Services (end of life, symptom management, respite, and long term care), Day Hospice/Day Care and Community. There was a total of 154 incidents during the period 1 February 2018 to 31 January 2019. This shows an increase of 10.7% since the last audit. The breakdown is as follows:



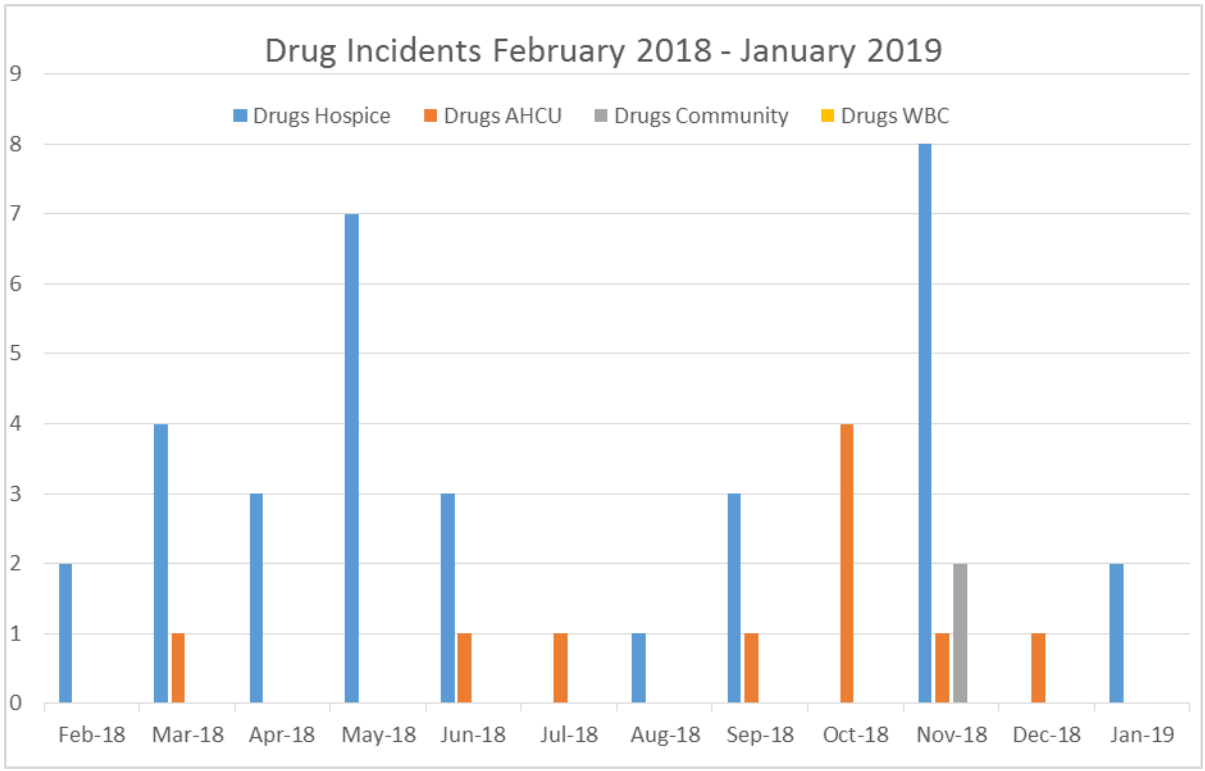
3.2.1.1 **Drug Incidents**

There was a total of 45 drug incidents during the period across all services as opposed to the previous year where there were 54 in total representing a 16% reduction from the previous reporting period. These drug incidents include near misses, unintended drug incidents that resulted in potential or actual harm of a patient, dispensing issues from dispensing organisation, prescribing and administration errors.

A review of the drug incidents highlights that staff are continuing to take collective responsibility in being transparent in practice and addressing issues and potential risk areas. This can be seen in staff reporting issues relating to dispensing issues from pharmacy and prescribing issues. When staff are completing the incident forms they use reflective practice to help identify the problem and how it could have been corrected and the effects to the patient. As an organisation, staff are encouraged to identify areas of improvement within their own working and how the organisation can also improve.

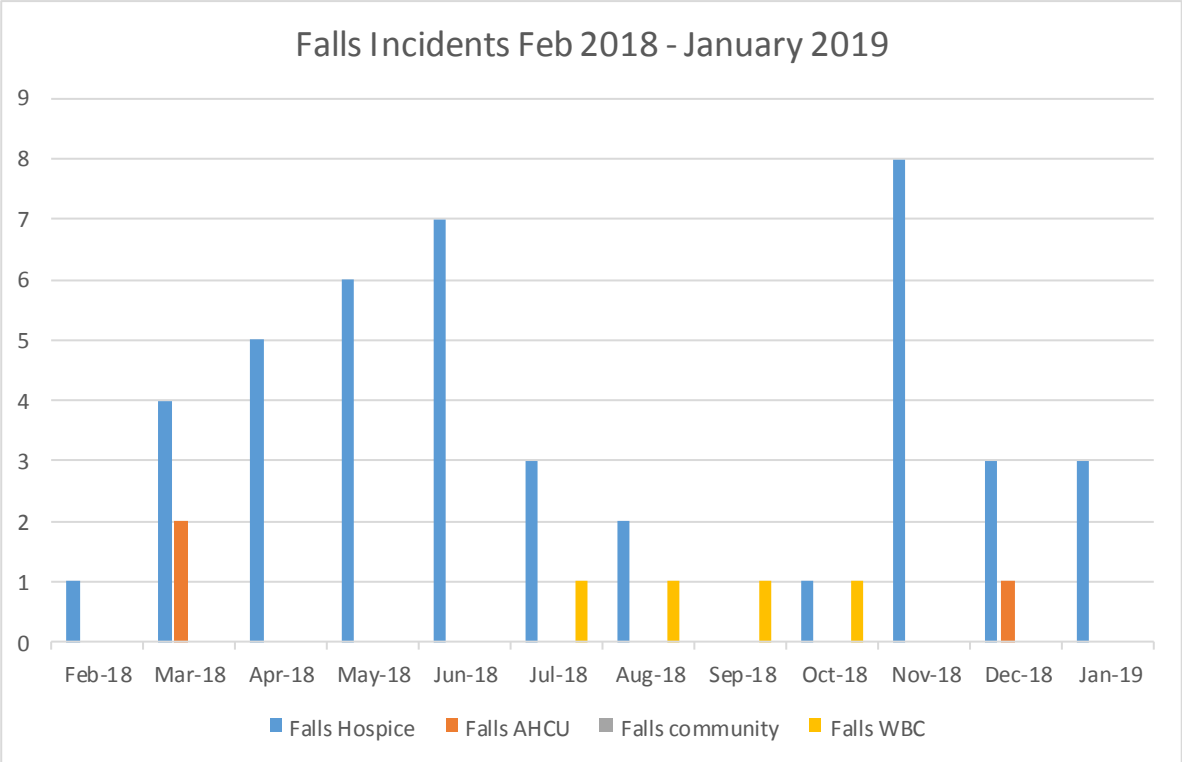
Reporting of incidents is very efficient as staff are aware of the issues that need to be reported and do this as soon as possible. They are aware of who they need to report the issues to and where to place the incident form. This is evidenced by the number of forms completed as staff are very effective and promote prompt reporting.

The Hospice over the last few years has seen an increase in the complexity of patients which are cared for. This means more complex drugs are used and at times complex delivery of the drug is required, which can increase the risk of drug errors. Within this the number of drugs a patient takes has increased especially when it comes to controlled drugs. The breakdown of drug incidents is on the chart below:



3.2.1.2 **Falls Incidents**

There was a total of 50 falls incidents during the period across all services as opposed to the previous year's audit where there were 53 in total representing a reduction of 5.7% These incidents include patients who are extremely independent and wish to maintain their dignity and independence. The breakdown is on the chart below:



The Hospice acknowledge that many patients wish to remain independent for as long as possible and this is promoted within the service because if a patient's independence is reduced their quality of life is also diminished. During this audit period it was noted that we had multiple patients trying to maintain their independence which resulted in recurrent falls, even with all possible safety mechanisms in place

It is imperative for the Hospice to understand if there were any contributing factors to each fall that occurs or if it was a simple accident. Any way of minimising the chance of further falls happening need to be considered both on an individual basis and organisationally. This needs to be done for each patient who accesses the services provided. The changes implemented need to be documented and individual care plans are required and should be updated with current plans of care and any equipment that may be required such as sensor mats etc.

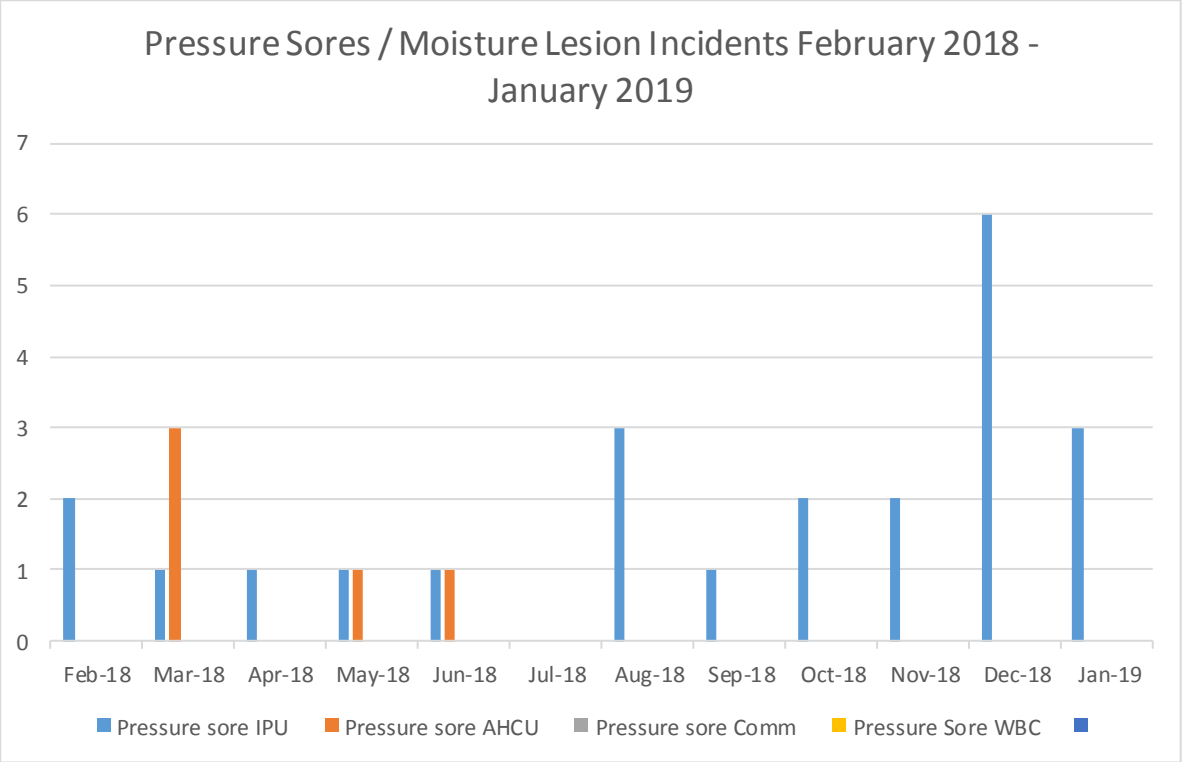
A falls analysis is completed for each patient that falls within the organisation. The falls analysis determines what changes are required to the care plans and highlights any risk assessments that may be required. It also helps to identify when and if other professionals should be involved such as physiotherapists and occupational therapists.

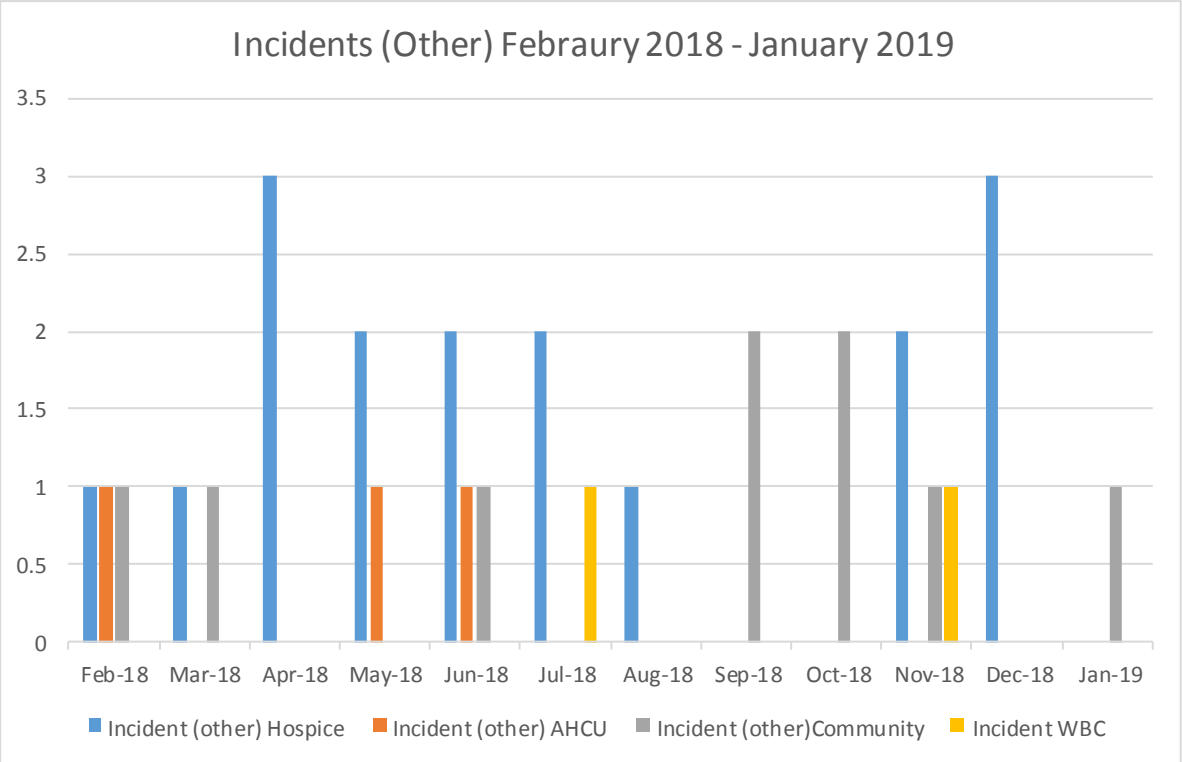
When looking at the contributing factors it was highlighted that confusion in patients caused 25 of all the falls. Due to the patients the Hospice cares for confusion is a regular side effect noted from a patient's disease progression and medications used to elevate other more troublesome symptoms. Bearing this in mind it can be hard to determine when a patient is in the beginning stages of confusion and some patients can experience fluctuating confusion. Therefore, it can be difficult to know what support a patient may need when these symptoms manifest. Also, referrals the Hospice receives

do not always contain the patient's capacity so it can be hard to know what is needed until the patient arrives at the Hospice.

3.2.1.3 Pressure Damage and Other Incidents

The Hospice collates information for all clinical incidents under the 'other' categories. These incidents are those that do not involve drug incidents or falls. During this reporting period there were 28 pressure/moisture related incidents and 31 other incidents.





The following shows a month by month breakdown of all the clinical incidents during the period 1 February 2018 to 31 January 2019. The breakdown is as follows:

February Activity

In February there was a total of 8 incidents comprising of:

- One drug count error.
- One patient had their drugs omitted by accident, resulting in no harm to the patient.
- One fall recorded in IPU.
- One incident on IPU concerning a member of staff making a relative uncomfortable.
- One incident in AHCU, unable to contact doctor on-call.
- One incident in the Community with a relative unhappy about lateness of call.
- Two patients with moisture lesions/ pressure sores recorded in IPU.
- There had been one incident recorded where a patient had been agitated, possibly resulting in a skin tear.

March Activity

In March there was a total of 17 incidents comprising of:

- Four incidents of drug errors in IPU, including a loss of Methadone due to bottle leaking and re-measuring.
- One incident of drug error on AHCU due to weekly patch being removed early.
- Four falls recorded in IPU
- Two falls recorded in AHCU

- One incident recorded on IPU with regards to ensuring patient rooms are cleaned and emptied.
- One incident form completed with regards to raised concerns in the community.
- One patient with moisture lesion/pressure sores recorded in IPU.
- Three patients with moisture lesion/pressure sores recorded in AHCU.

April Activity

In April there was a total of 12 incidents comprising of:

- Three drug errors on IPU, including one spillage, and shortage of liquid Oramorph noted, probably lost when measuring.
- Five falls recorded in IPU including one patient falling twice.
- Three incidents recorded, one that documentation not completed, one that a patient had to wait for assistance for forty minutes as staff very busy and one regarding a patient having a syringe in her pocket.
- One patient with moisture lesion/pressure sores recorded in IPU.

May Activity

In May there was a total of 18 incidents comprising of:

- Seven drug errors on IPU including two patients not receiving medication, four errors found when carrying out weekly drug check and one patient drug not being prescribed when writing drug kardex.
- Six falls recorded in IPU, two patients each falling twice.
- Two incidents recorded in IPU, one patient dropped a glass, and one patient received needle stick injury.
- One incident recording that deceased patient was dropped by undertakers.
- One patient with moisture lesion/pressure sores recorded in IPU.
- One patient with moisture lesion/pressure sores recorded in AHCU.

June Activity

In June there was a total of 17 Incidents comprising of:

- Three drug errors in IPU including drugs not being ordered, dose not being changed, and wrong dose given.
- One drug error in ADCU, wrong dose given.
- Seven falls recorded in IPU, one patient falling twice.
- Two incidents recorded, one for IPU being short staffed and used syringe and needle found inside patient white medication file.
- One incident on AHCU recording a patient skin tear.
- One incident in Community where client made allegation against staff.
- One patient with moisture lesion/pressure sores recorded in IPU.
- One patient with moisture lesion/pressure sores recorded in AHCU.

July Activity

In July there was a total of 8 Incidents comprising of:

- One incidents of drug error in AHCU.

- Three incidents of falls in IPU.
- One incident of fall in HWC.
- Two incidents in IPU, one patient very aggressive and distressed and one patient found to have a graze on left side of head.
- One incident recorded staff shortage in HWC.

August Activity

In August there was a total of 8 incidents comprising of:

- One incident of drug error in IPU, dosage of Tinzaparin given twice in one day.
- Two incident of falls in IPU.
- One incident of fall in HWC.
- One incident of no DNAR for new admission.
- Three incidents of moisture lesion/pressure sores recorded in IPU.

September Activity

In September there was a total of 8 incidents comprising of:

- Three incidents of drug errors, one incident of drug being missed, one incident of patient being given two doses and one incident of wrong dose given.
- One incident of drug error in AHCU, drug not measured.
- One incident of fall in HWC.
- Two incidents in Community recording, one patient's valve left open on overnight bag, one next of kin not happy with the way husband was being looked after.
- One patient with moisture lesion/pressure sores recorded in IPU.

October Activity

In October there was a total of 10 incidents comprising of:

- Four drug errors on AHCU two for the same patient.
- One incident of fall in IPU.
- One incident of fall in HWC.
- Two incidents recorded in Community, one stating not happy with husband care, one stating member of staff had been physically hurt by client.
- Two incidents of moisture lesion/pressure sores recorded in IPU.

November Activity

In November there was a total of 25 incidents comprising of:

- Eight incidents of drug errors in IPU, including one patient had medication missed three nights in a row, two patients had two incidents each.
- One drug on AHCU.
- One drug error in the Community.
- One incident of CD book being rewrote as wrong amount of tablets noted.
- Eight incidents of fall in IPU, five being for one patient and two for another patient.
- Two incidents in IPU recorded, including one needle stick injury.

- One incident recorded in HWC, patient spilt hot tea on his arm.
- One incident recorded in Community, staff attended client to give personal care, client died whilst they were present.
- Two incidents of moisture lesion/pressure sores being identified in IPU.

December Activity

In December there was a total 14 incidents comprising of:

- One incident of drug error in AHCU.
- Three incidents of falls in IPU.
- One incident of fall in AHCU.
- Two incidents recorded in IPU, one shortage of staff and one patient hurt shin on bed controls.
- Six incidents recorded of patients having moisture lesion/pressure sores in IPU, three patients being admitted with these.
- One incident of patient in AHCU having moisture lesion/pressure sore.

January Activity

In January there was a total of 9 incidents comprising of:

- Two incidents of drug errors, recorded in IPU, including box of CD medication opened and found to be smashed with no liquid in.
- Three incidents of falls recorded in IPU two for the same patient.
- One incident recorded in community where call was missed.
- Three incidents of patients in IPU having moisture lesion/pressure sore.

3.2.2 Hospice Performance against National Council for Palliative Care Minimum Dataset

The table below shows the Hospice's Inpatient Unit (8 commissioned beds) performance measured against the NCPC Minimum Dataset.

INPATIENT UNIT	Total 01/04/13 to 31/03/14	Total 01/04/14 to 31/03/15	Total 01/04/15 to 31/03/16	Total 01/04/16 to 31/03/17	Total 01/04/17 To 31/03/18	Total 01/04/18 To 31/03/19	* National Median
Admissions	242	231	227	217	167	187	-
First Admission	179	180	185	180	137	157	-
% Bed Occupancy	76.7%	80.2%	78.1%	68.9%	66.5%	76.3%	78.6%
Average Length of Stay (Days)	9.2	10.1	10.0	9.3	11.6	12.3	14.1
% Died	42.1%	42.2%	33.9%	43.1%	50.3%	37.46%	59.2%
% Discharges	57.9%	57.8%	66.1%	56.9%	49.7%	29.5%	40.8%
Cancer %	88.0%	87.0%	84.1%	89.9%	88.0%	77.01%	79.6%
Non Cancer %	12.0%	13.0%	15.9%	10.1%	12.0%	22.99%	14.7%
Not Known %	0%	0%	0%	0%	0%	0%	5.7%

**** (National Median data extracted from The National Council for Palliative Care, MDS Report 2014/15)***

The data reflects that the Hospice remains below the national average length of stay. The Hospice continues to support patients to achieve their Preferred Place of Care (PPC), which is demonstrated through a higher than national average discharge rate and a lower than national average Hospice death rate.

The Hospice has seen a significant increase in the complexity and demand of patients referred to the Inpatient services, which has required increased medical and nursing intervention.

3.2.3 Key Performance Indicators

The Hospice submits quarterly reports on Key Performance Indicators to meet contractual requirements with NHS Hartlepool & Stockton-on-Tees CCG and Durham Dales, Easington & Sedgefield CCG. A summary of the performance data for the accounting period can be seen below.

3.2.3.1 NHS Hartlepool & Stockton-on-Tees CCG

Measure	Threshold	Performance Q1	Performance Q2	Performance Q3	Performance Q4	Comments
Number of Inpatients who have been OFFERED an ACP/Deciding Rights.	90%	100%	100%	78.9%	70.0%	Variance due to patients admitted at end of life.
Number of Inpatients RECEIVING an ACP/Deciding Rights.	90%	100%	100%	78.9%	70.0%	Variance due to patients admitted at end of life.
Inpatient bed availability.	95%	99.3%	98.4%	100%	100%	Variance due to deceased patients in bed at midnight.
Inpatient bed occupancy.	85%	65.7%	69.4%	68.8%	90.0%	Variance due to patient complexity/ dependency levels.
Proportion of people who state their preferred place of death and achieve it.	85%	100%	100%	100%	100%	
% of Day Hospice/ Outpatients receiving a care plan.	100%	100%	100%	100%	100%	
Time from Day Hospice/ Outpatient referral to assessment.	>=90% within 7 days	100%	100%	100%	100%	

3.2.3.2 **Durham Dales, Easington & Sedgefield CCG**

Measure	Threshold	Performance Q1	Performance Q2	Performance Q3	Performance Q4	Comments
Number of Inpatients who have been OFFERED an ACP/Deciding Rights.	90%	75.0%	28.6%	100%	100%	Variance due to patients admitted at end of life
Number of Inpatients RECEIVING an ACP/Deciding Rights.	90%	75.0%	28.6%	100%	100%	Variance due to patients admitted at end of life
Inpatient bed availability.	95%	99.5%	98.4%	100%	100%	Variance due to deceased patients in bed at midnight.
Inpatient bed occupancy.	85%	63.0%	65.2%	55.4%	76.1%	Variance due to patient complexity/ dependency levels.
Proportion of people who state their preferred place of death and achieve it.	85%	100%	100%	100%	100%	
% of Day Hospice/ Outpatients receiving a care plan.	100%	100%	100%	100%	100%	
Time from Day Hospice/ Outpatient referral to assessment.	>=90% within 7 days	100%	100%	100%	100%	

3.2.4 **Local Audits**

The Hospice has a Clinical Audit Sub Group who ensure that current clinical issues and practices are explored and audited. Nationally agreed organisational audit tools, such as Hospice UK, are used to support the Hospice in capturing the appropriate detail to benchmark its expectations of the services it delivers. The audits support and monitor the quality of these services and also identify where there are areas for improvement and change to best practice. Alice House Hospice ensures that the results of audits and the recommendations to improve practice are approved by the Clinical Governance Group and shared with all clinical staff.

All clinical audits are reviewed and monitored by the Clinical Audit Sub Group via an action plan to demonstrate a 360 degree approach to improving practice. The following clinical audits are conducted at the Hospice:

- Inpatient Respite
- Tissue Viability
- Infection Control
- Controlled Drug Audit of Prescribing

- Prescribing of Medications Documentation
- Incident reporting (including fall, Drug Errors, etc.)
- Oral Hygiene
- Controlled Drugs and Controlled Drugs Register
- Patient Experience
- Resuscitation Status (A Deciding Right Initiative)
- Care for the Dying Patient Document
- Consent to Treatment
- Hospice Helpline
- Bedrails
- FP10 Prescription Pads
- Thromboprophylaxis
- Homecare Patient/Domiciliary Experience Audit
- Documentation Audit
- Completion of Referral Forms
- Clinical Environments
- Medicines Reconciliation

The Hospice continues to review its auditing processes and ensures that audits are conducted for an appropriate purpose and that evidence is provided to quantify the quality of the services delivered.

3.2.5 Clinical Governance

The Clinical Governance Group steer the quality of clinical services within the Hospice and the framework allows us to demonstrate safe, effective and patient led services by a well led group of multi professionals. The Clinical Governance Group reports to the Board of Trustees and covers all aspects of patient related care.

3.3 PATIENT, CARER, STAFF & VOLUNTEER EXPERIENCE

3.3.1 Increased Choices for Patients around Day Hospice/Day Care Services

A menu of activities was created to ensure that a wide range of options are available, taking into account the preference of individuals. Activity levels are detailed below:

- *Day Hospice attendance increased during the year from 361 booked attendances to 381, which is a 5.2% increase.

During 2017/18 the Commissioners highlighted that Day Hospice patients were using the service for symptom management considerably longer than the 6-8 week programme, with some patients exceeding 12 months. This has now significantly improved with on average the time frame being 6-8 weeks. Patients are reviewed informally on a weekly basis with a formal review after 6 weeks. In some cases patients do re-enter the programme for a further 6-8 weeks. This is generally as the patient is awaiting funding if they wish to access a social day. The only current exception to this is one patient who is approaching end of life who still attends when able. This is because the social day does not fulfil the patient's needs and the patient is deteriorating.

Social Day Care currently supports 10 clients on a Tuesday, 4 patients on a Thursday and 7 patients attend the Men's session on Fridays. These patients a funded through Continuing Healthcare, Direct Payments/Personal Budgets or private funding. Social Day Care support the social care needs of the local community, reducing isolation and offering a peer support approach, whilst allowing carers respite from their caring roles.

The Complex Social Day Care which Alice House Hospice introduced in March 2018 was cancelled in September 2018 as only three patients continued to access the services and due to their communication needs remained isolated. The service was also unviable as 8 patients were needed to enable the day to be financially viable. 2 of these patients remained in service until October 2018, there needs being met alongside Day Hospice patients where medical support was available.

3.3.2 **Staff Experience**

Alice House Hospice are committed to the welfare of its staff. The National Quality Board (NQB) Report 'how to ensure the right people, with the right skills, are in the right place at the right time' (published 19 November 2013) and the Government's commitments set out in 'Hard Truths' (see also 'Hard Truths Commitments Regarding the Publishing of Staffing Data', NHS England and Care Quality Commission) form the basis for the Hospice's Workforce Assurance Report which is prepared and submitted to Commissioners on a six-monthly basis. The Workforce Assurance Report focuses on sickness and absences, training, education and appraisals.

3.3.3 **Sickness and Absences**

Staff sickness is minimised through effective management and staff are supported to keep healthy and reduce the sickness burden on the organisation. Staff are kept aware of the cost and impact of sickness on the organisation in a non-accusatory way and are encouraged to identify solutions to reduce sickness. Patient Care staff and Catering staff have a higher percentage of sickness than other departments which can be partly due to infection control measures which do not allow them back to work for 48 hours after sickness bugs or to nurse patients if they have a cold or flu virus. We have a large number of clinical bank staff that we utilise for sickness to enable us to continue to deliver a high standard of patient care without interruption to delivery of service. Alice House Hospice offer all staff a confidential Employee Assistant Programme for them to access and also an option for them to opt into our Westfield Health Plan.

All staff absent due to sickness have regular welfare meetings with the HR department to identify ways of returning staff back to work as quickly as possible and also introduced to the Employee Assistance Programme.

The Hospice has also signed up to some new initiatives which include:

- The Better Health at Work Award to help with its objectives to reduce staff sickness levels. This award will recognise the efforts of employees and address health issues in the work place, along with promoting healthy

lifestyles and a health workforce. There are 4 levels to the Award including Bronze, Silver, Gold and Continuing Excellence.

- Introduction of Mental Health First Aiders to help staff to access support when it is needed for a faster recovery.

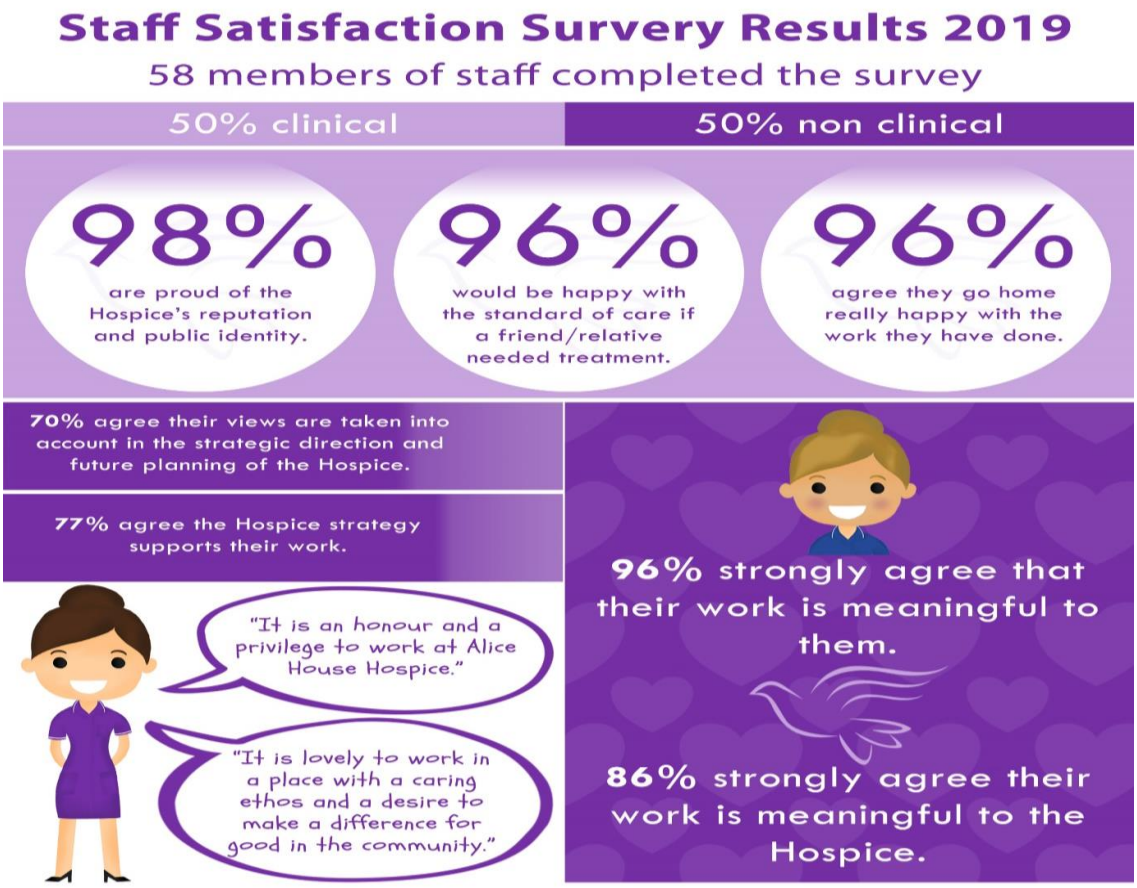
- Menopause Awareness, introducing a policy on the menopause to help our female staff to feel supportive by putting in measures to make their working environment more comfortable for them. Helping break the taboo surrounding the menopause to encourage woman to speak openly about the effect it has on them.

STAFF SICKNESS RATES	Hospice % 2018/2019	In comparison to NHS figures
9622 hours absence from 144,113 contracted hours	6.68%	4.51%

The Hospice hopes to reduce their sickness figure with the help of the new initiatives mentioned above and also introducing reduced Terms and Conditions in relations to sickness in staff contracts.

3.3.4 Staff Satisfaction

An Annual Staff Satisfaction Survey is given out to all staff members to complete. This year 58 members of staff completed the survey with the following results:



3.3.5 **Mandatory Training**

The Hospice ensures its staff are appropriately trained and educated for their role and each individual will be supported to achieve their greatest potential in line with organisational objectives.

Mandatory training is delivered to all staff on an annual basis with four sessions a year put on to capture all existing staff and new staff. As well as annual mandatory training, the Hospice provides clinical staff with a rolling programme of education every three months to keep their skills up to date. We capture all staff by incorporating the rolling programme of education into their off duty.

Mandatory Training includes:

- Fire Training
- Health & Safety
- Infection Control
- Food Hygiene
- Emergency First Aid
- Equality & Diversity
- Moving & Handling
- Adult Abuse
- Clinical Manual Handling
- Lone Worker
- Bereavement Training
- Radicalisation Training
- Leadership Training
- Safeguarding Adults
- Mental capacity Act
- Deprivation of Liberty Safeguards
- Awareness of Child/Adult Sexual Exploitation
- Working with adults who self-neglect
- Safeguarding children

3.3.6 **Clinical Supervision**

Staff are offered the opportunity for 1:1 supervision with a Volunteer Occupational Development Consultant who provides techniques to change practice, support to steer concerns, guidance with time management and personal development.

It is standard practice for clinical staff to receive clinical supervision from their Line Manager but there are also opportunities for specialist practitioners to have prescribing supervision. Any staff that may require additional support in practice are supported with on the job clinical supervision. External supervision is provided for specific roles such as Counsellors.

The Hospice routinely provide reflective practice sessions for clinical and supporting staff. The topics are identified by the team and recommendations agreed in how to improve service delivery and clinical practice.

3.3.7 **Board Development**

The Hospice holds a public Annual General Meeting, which takes place every September. This is delivered by the Chair of Trustees in partnership with the Board of Trustees and the Senior Management Team. This gives the opportunity to present to the public and Hospice employees, volunteers and stakeholders a reflection of the previous financial year and future aspirations for service improvements.

The Board of Trustees undertake annual re-election to ensure that they remain appropriate panel members and provide a range of skills and expertise. The vote is agreed at the Annual General Meeting by the Hospice Members.

The Board of Trustees bring a range of skills to the Hospice including specialist areas in finance, accounting, legal, clinical, marketing, local authority and corporate.

The Hospice has a well-structured and strong Senior Management Team who complement and support the Chief Executive to steer services in a positive direction.

The following roles are in place within the Hospice to ensure regulatory compliance is achieved:

- Chief Executive
- Deputy Chief Executive
- Registered Manager (Care Quality Commission)
- Accountable Officer (Care Quality Commission)
- Nominated Individual (Care Quality Commission)
- Responsible Individual
- Caldicott Guardian
- Senior Information Risk Owner
- Safeguarding & Prevent Lead
- Child Sexual Abuse & Exploitation Lead
- Mental Capacity & Deprivation of Liberty Lead
- Information Governance Lead
- Freedom to Speak Up Guardian

3.3.8 **Volunteers' Experience**

There are 220 Volunteers working throughout the organisation 50 of which work within the Clinical areas; namely Inpatient Unit, Long Term Care Unit, Day Hospice, Day Care, Counselling, Catering, Housekeeping, Reception/Administration, Gardening and Driving.

All Volunteers are required to attend an induction in the area they will be working. They are also required to undertake mandatory training which supports them and ensures that safety is maintained when conducting their role.

Feedback from volunteers includes the following comments:

Wellbeing Centre Reception Volunteer

"I have been volunteering for 3½ years now. I wanted to volunteer at the Hospice after my brother-in-law died here. I felt I wanted to give something back. The best thing about volunteering at the Hospice is the patients, meeting people and helping people. My role is administration but I do get to meet the patients as they come in and I get to chat with them over a cuppa."

Social Day Care Volunteer

"I have been volunteering for 3½ years now. I was looking to do some volunteering for my local community. I heard there was an open day at the Hospice and thought I would have a look at what type of volunteering would be needed. I was afraid of how I would handle this but staff in the Day Hospice said they would support me through any difficult times that I would encounter and they have. The patients make my day, the staff too. I look forward to Tuesdays. I also hope that when my children are able to care for themselves I will be able to offer more time."

Patient Care Volunteer

"I always said when my grandchildren don't need me anymore I would like to do some kind of volunteer work. When that time came I chose Alice House Hospice.

It makes a difference to all staff having help. Making the patients a cup of tea, keeping the kitchen clean and stocked – it all helps in my eyes."

Laundry Volunteer

"I have been volunteering for 21 years. I wanted to help and first started volunteering in the old Hospice in Hutton Avenue. The best part about what we do is the help we give."

Kitchen Volunteer

"After the Hospice cared for my late husband I wanted to be able to give something back. I give my time to help in the Kitchen and also spend time in the Inpatient Unit helping the other Volunteers and those patients who need help with their food."

3.3.9 Education & Training

Alice House Hospice are driving education and training forward and are committed to providing it both internally and externally. In 2014/2015 all staff had access to leadership training, which has continued throughout 2015/16, 2016/17, 2017/18 and 2018/19 for new staff. Clinical staff attend two rolling programmes of clinical education on an annual basis. The Hospice has invested in government agenda items such as advanced training in safeguarding for clinical staff.

The Hospice participated in the Education Alliance Project which commenced in January 2017. The project is a collaborative alliance approach to palliative and end of life education across all care homes within Hartlepool & Stockton, involving the Mental Health Teams, the Falls Teams, North Tees & Hartlepool NHS Trust and Alice House Hospice. The aim of the project is to reduce hospital admissions from care homes and help patients achieve their Preferred Place of Care (PPC). Further funding has

been secured from the Education Alliance Project to deliver training during 2018/19 and 2019/20 on End of Life Care and Advanced Care Planning to local care homes.

It is paramount that the Hospice continues to explore new opportunities to increase knowledge of the future of health and hospice care. The Hospice is currently represented on the following steering groups:

- Specialist Palliative Multi-Disciplinary Team, North Tees & Hartlepool NHS Trust
- Health & Wellbeing Board (representing voluntary sector), NHS Hartlepool & Stockton-on-Tees CCG
- Controlled Drug Local Intelligence Network (CDLIN), NHS North of England Commissioning Support
- End of Life & Palliative Care Group, Durham Dales, Easington & Sedgefield CCG
- Palliative Care Transformation & Locality Group, NHS Hartlepool & Stockton-on-Tees CCG
- Independent Registered Managers' Group, North East Cancer Network
- Journal Club
- Outcome Assessment & Complexity Collaborative (OACC) Specialist Palliative Care Task & Finish Group (chaired by North Tees & Hartlepool NHS Foundation Trust).
- Northern Regional Palliative Care Physicians Group.
- Speciality Training Committee.

As a Consultant led specialist palliative care unit, we offer training and support to Foundation Doctors. We also provide placements for Specialist Registrar Trainees who are training to become Consultants in Palliative Care and offer placements to GP Trainees who require additional experience in caring for patients with a palliative diagnosis. This continues to support the Hospice in promoting its services to potential referrers and builds on partnership working.

3.3.10 **Awards**

The Hospice feels that it is vital that staff and volunteers are rewarded for their efforts and especially when they have achieved a personal professional achievement. These achievements are noted at the Hospice's Annual General Meeting. Staff vote annually for their colleagues to be recognised for their achievements and awards are given to two members of staff at the Annual General Meeting, one clinical and one non-clinical member of staff.

The Chief Executive's award is also presented at the Annual General Meeting. This award reflects a drive to changing practice within the organisation and innovation for service delivery.

In our last AGM we invited a service user to talk about her care needs from her perspective and this was welcomed by the whole organisation as being a positive feedback and verification model of endorsing our care.

The Hospice has again received a 5 Star Food Hygiene rating from the Food Standards Agency of Hartlepool Borough Council. During 2017/18 the Hospice recognised the limitations of the kitchen opening hours and the need to pre-order meals, which did not meet the needs of patients' visitors and their families. Following extensive kitchen refurbishment works, a new Bistro/Café was opened at the beginning of March 2018 with extended opening hours from 7.00 a.m. to 7.00 p.m., seven days a week. The menu was also expanded to include a varied selection of home cooked meals, breakfast options, paninis, jacket potatoes with a wide range of fillings, salads and cakes alongside healthy smoothies, milkshakes and 'bean to cup' speciality coffees. The Bistro/Café is also open to the general public and the menu choices and quality of produce, all of which is locally sourced, has proved extremely successful and popular.

3.3.11 **Complaints**

Alice House Hospice seeks feedback from service users, staff and stakeholders. This feedback supports the Hospice in shaping its services and implementing changes where they are deemed appropriate. Service users are made aware of how to log a formal complaint through a variety of means such as the Hospice's Complaints Policy & Procedure which is included in all Patient & Visitors' Information Files and the Compliments, Comments & Concerns Leaflet which is displayed in all public areas. The Hospice's complaints literature also advertises external stakeholders such as the local Clinical Commissioning Groups, Care Quality Commission and Local Authorities who can be approached with any concerns in relation to the Hospice.

The Hospice maintains a Complaints Register and during 2018/19 there were 2 clinical complaints.

Brief Details of Incident	**Outcome**
Incident relating to a community patient using the Hospice's Homecare Service. The patient raised concerns around the number of staff attending her call, staff not having access to transport, request to review if staff are able to action financial transactions, staff wearing their uniform when attending her call, request to self-administer medications and comments made between staff members regarding her emotional state.	A full investigation was conducted both internally and externally. As a result of the Hospice's internal investigation the following areas for improvement were identified: • The request from the client to have staff arrive not in uniform is not an element of the care package that can be guaranteed. Whilst every effort is made to keep this to an absolute minimum it is not possible to guarantee. A section to document client requests should be available on the initial referral or care package agreement paperwork, which both the client and Alice House retain a copy of. • Amendments to the care package should be documented in the client's notes or care package agreement i.e. the inclusion of transport to appointments. • If a staff member appointed does not have access to a vehicle yet the client requires transport to an appointment a taxi should be booked with a taxi firm that Alice House has an account with.

	• The procedure for addressing incidents involving clients in the Community should be clearly written and a copy kept in a designated place within each clinical area within Alice House Hospice. • If the staff member at the client's house was aware that a member of staff was not rostered to administer medication earlier this incident may have been avoided. Review if it is possible to have a copy of the client's roster with the notes at the client's house. • The Clinical Services Manager should write to the client acknowledging the request for financial assistance and the current situation of this request.
A comment was placed on social media by a relative on 22 December 2018 regarding her father's care during a 4 day respite stay stating that during her father's assessment he was promised a daily shower, shave and to be taken outside for fresh air. The complaint stated that he was not given a daily bed bath and a meal was left in his room for 30/40 minutes. The relative also stated her father returned home in the same clothes he had arrived in and "in a right mess."	A full investigation was conducted both internally and externally. As a result of the Hospice's internal investigation the following areas for improvement were identified: • Pre-assessment needs to be conducted by experienced staff and limitations explained to patient and family. Respite information must be given to patient and family. • The white board in patient's room to be used to highlight were appropriate patient's preference, for example an estimation when the patient would like the opportunity to have a cigarette. • Detailed documentation why actions within care plan were not adhered to and what has been put in place to address barriers. • IPOS comments to be promptly addressed and reported to Clinical Lead and Senior Manager Clinical Services. • Patient and family to be consulted to establish what could be done to improve patient/family experience and acted upon where possible.

3.3.12 **Other Comments from Partners & Stakeholders**

A selection of comments received are listed below:

You recently had a patient stay with you by the name of XXXX, who was our uncle. His daughter XXXX told me that XXXX's last days were made comfortable and peaceful for both he and the family because of the amazing care given by the staff at your hospice. XXXX could not speak highly enough about how your staff went above and beyond the call of duty to make sure both XXXX and the family were cared for during a difficult time. As we are a long way from Hartlepool it was lovely to hear our family had been treated with such care and kindness. We have made a donation to the hospice today as a very small token of our appreciation for the wonderful work you do and will you please pass on our thanks to all involved for being such great people. Kind regards XXXX

Dear XXXX Thank you for your letter and news update. Please accept the enclosed donation from myself and my Dad in memory of my Mum, XXXX. It was her birthday today and we are now at the stage where we can look back and smile at the birthdays we shared with her. We will always be grateful to Alice House being there for all our family in our time of need. Thank you again, XXXX and XXXX.

Thank you for all the care you all gave to my husband XXXX. He was only here a short while, we as his family appreciate everything you done for XXXX. Thank you to all the staff for the support you gave to our family. XXXX's one wish was to be back in Hartlepool with his family and to be with his daughter XXXX who is in Alice House in your care. XXXX had his wish home and to see his family all together. Thank you a small word but heart fully spoken to you all Doctors, Nurses, Carers and all staff of Alice House.

On behalf of my family after the sad loss of my mother XXXX I would like to give my praise and gratitude to your staff who cared for her to the very highest level showing true passion, compassion, dignity, and respect too patient and family, this includes all staff from cleaners through nursing staff to doctors both onwards, catering (bistro) and admin from volunteers to staff. As for the facilities both inside and out which I also must praise as with the staff was to the highest standard twenty four hours a day all week. Thank you does not express our gratitude and respect for all staff strong enough for their care professionalism and courtesy in our difficult times. THANK YOU TO Everyone

Dear everyone, I can't tell you how much we appreciated all you special love, care and support during XXXX's time in Alice House Hospice. XXXX always felt very safe and comfortable with you all. You were wonderful keeping him as pain free as you could. Thank you so much for everything lots of love and great big hugs XXXX. You were all so kind, loving, caring and supportive to XXXX and me and all the family. You are all just so wonderful.

3.4 SUPPORTING STATEMENTS FROM PARTNERS & STAKEHOLDERS

Supporting statements are being sought from the following partners and stakeholders and will be included in the Quality Accounts when they are received:

- NHS Hartlepool & Stockton-on-Tees CCG
- Durham Dales, Easington & Sedgefield CCG
- NHS Hartlepool & Stockton-on-Tees CCG's Health & Wellbeing Board (representing voluntary sector)
- Healthwatch
- Hartlepool Borough Council
- Durham County Council

3.4.1 **Supporting Statement from Durham Dales, Easington & Sedgefield CCG**

NHS
Durham Dales, Easington and Sedgefield
Clinical Commissioning Group

Statement from Durham Dales, Easington and Sedgefield Clinical Commissioning Group, for Alice House Hospice Quality Account 2018/19.

The CCG welcomes the opportunity to review and comment on the Quality Account for Alice House Hospice for 2018/19 and would like to offer the following commentary:

As commissioners Durham Dales, Easington and Sedgefield CCG are committed to commissioning high quality services from Alice House Hospice.

Overall, the CCG felt that the report was very well presented and written in a meaningful way for both stakeholders and users. The report provides an accurate representation of the services provided during 2018/19 within the Hospice.

The CCG recognises the significant work that the Hospice has undertaken to drive quality improvements throughout the year. It is disappointing that the hospice have been unable to reduce the staff sickness levels as identified as an aspirational improvement, however, Commissioners acknowledge the individual issues and are pleased to see that the Hospice has further plans to address ongoing issues.

The work undertaken to raise clinical standards is welcome and the continued work to review incidents and drive improvement provides assurance to commissioners. Commissioners would, however, like to see a continued improvement in the recording of NMC numbers in clinical records.

It is encouraging to see that the hospice has been developing services for Carers and Commissioners are pleased to see that the Hospice are continually reviewing ways of accessing Carers in different ways.

The comprehensive coverage of incident management and the delivery of key performance indicators are welcomed by the CCG and demonstrate a clear understanding of performance by the hospice.

The CCG supports the priority areas for 2019/120 identified as: Developing key Link roles, increasing services within the community and opening up hospice care to harder to reach groups.

The CCG looks forward to continuing to work in partnership with the Hospice to assure the quality of services commissioned in 2019/20.

G Findley

Gillian Findley
Director of Nursing
Durham Dales, Easington and Sedgefield CCG