

*Eleanor.**



the best care and support for families facing terminal illness.

QUALITY ACCOUNT

1 APRIL 2014 – 31 MARCH 2015

For the excellent care given, I thank you. For keeping his dignity, I thank you. For your sensitivity, I thank you. For your consideration to this family, we thank you. For your offer of continuing support to us, our thanks.

INTRODUCTION

From Tuesday 7 April, 2015, EllenorLions Hospices and chYps, our children's hospice at home service, will operate under the name of ellenor.

We have made this change in order to be clearer about who we are and what we do. We consulted widely as part of this project and were grateful to receive specialist marketing help given to us at no cost. We need to ensure we can reach out to and provide expert care for anyone who needs it, in the place of their choice, when they need it.

ellenor will continue to provide care for all ages. The charity needs to grow and develop services to meet the increasing demand for care. Reliant on our community for most of our funding, we need to raise more to be able to provide vital care in all settings for babies, children, adults and their families. This includes pain and symptom relief, end of life care, respite, bereavement support, and emotional and spiritual care.

ellenor's vision, mission and values remain the same:



MISSION – To lead and coordinate the best personalised care for all ages, sharing our expertise to ensure that all families facing terminal illness get the right support in the best place possible, enabling them to make the most of the time they have.

KEY MESSAGES

ellenor cares 24 hours a day, 365 days a year.

There's always someone there when you need them.

ellenor cares for people of all ages – babies, children and adults.

No-one is ever too young or too old.

ellenor cares for families in their place of choice.

With ellenor you get home from home support wherever you may be.

ellenor cares for the whole family.

We recognise that every member of the family needs support.

ellenor cares about reducing the fear and anxiety a diagnosis brings.

Our specialist team provides relief through expert care and support.

ellenor cares for families and is free at the point of use.

You never pay a penny as funds are raised from our generous local community.

ellenor cares about life and making the most of every second.

We care so you can have valuable time to build special memories that last forever.

ellenor cares for very sick children and adults at home.

Families can be together for longer in a place they know and love.



1. Part 1- Quality Statement from Chief Executive

Statement

A quality account is produced to inform the public about the quality of services that are delivered. The aim of this report is to demonstrate organisational accountability, including how we review our services, demonstrate our improvement plans, and provide data on the quality of care provided.

The organisation places quality and safety of care as of the utmost importance. We have a robust and open Clinical and Corporate Governance framework in place. The Board of Trustees have ultimate responsibility for ensuring that the highest standards of care are provided. Governance is managed through a structure of sub-committees, each chaired by a Trustee, and reporting directly to the Board. This includes a Clinical Governance committee which oversees the quality and safety of all aspects of patient care. A Governance and Risk committee meets quarterly and reviews the Risk Register for increasing or high-level risks. The Trustees are provided with the information they require to carry out their responsibilities, including regular reports from the Executive Team, a Dashboard of Key Performance Indicators, and ad hoc reporting as required. The Executive Team are in attendance at the Board and Sub Committee meetings and there is regular contact between the CEO and Chair of Trustees.

All complaints and incidents are investigated thoroughly. Policy and practice are amended as required as an outcome of learning, and performance is managed accordingly.

Patient and family experience is important to us, and every comment, however informal, is followed up. We strive to do the very best we can and are grateful to those who help us identify improvements in our care. We participate in the national hospice patient survey, as well as our own internal surveys, and have a suggestion box for comments. Over the past year a more robust approach has been taken to ensure that there is a clear framework for responding to feedback, both positive and negative.

Patient safety is ensured by a comprehensive programme of staff education and support. We work on a "no blame" culture and encourage staff to feel able to identify situations they are finding difficult. This is reflected in our policy and practices, which clearly demonstrate that staff are given training and support on the importance of raising concerns about poor practice. Where areas for improvement are identified, a training and support programme will be implemented with the individual staff member concerned. A robust safeguarding framework is in place, with a nominated Safeguarding Lead. The organisation achieved the Safe Networks Standards for safeguarding children in December 2013.

All health and safety guidance is observed, audited and a report is available at the Governance and Risk committee. A qualified Health and Safety Officer has recently been appointed to lead this area of work and to add specific expertise to the organisation.

In the role of Senior Information Risk Owner, I take overall responsibility for all aspects of Information Governance. All staff and volunteers have training as part of their regular updates and there are clear policies and procedures in place to ensure high levels of data protection and confidentiality.

Clinical effectiveness is assured through the leadership of senior clinicians, including the Director of Patient Care and the Lead Consultant. National guidance and best practice are followed, and research and audit results are utilised in the continuous improvement of practice. Clinical staff have regular training and update sessions, and follow a competency based framework relevant to their role.

I have overseen the production of this Quality Account, in my role as Chief Executive. I commend it to you as an honest and open account of some key aspects of our work, to the best of my knowledge.



Claire Cardy
Chief Executive
31 May 2015

I will never be able to truly express my gratitude to each and every one of you for helping me and my family during these past few weeks and helping us to allow him to pass away as peacefully as he did. For everyone who came to my home on many occasions and were so kind as well as honest and realistic, to all the lovely volunteers to all the nurses... You all do the most amazing job and I could not have coped without you.
"Without you we would have been lost"

I wanted to say a huge thank you first for your excellent care of my dad when was with you... You were so very kind and caring with him, allowing him to die with dignity and in comfort. As his closest family, you were all again so kind and caring with us, making sure we were ok when we were upset, listening to us and importantly leaving us alone to spend Dads closing hours together as a family. This is my first experience of a hospice, though I have worked in hospitals in the UK and Australia for over 30 years and I cannot express adequately how much admiration and respect I have for you all and the institution. Thank you so much.

2. Part 2- Priorities for Improvement

I. 2015-2016

We are part way through our current strategy, which runs from 2013 to 2018, and our key aims are to look at how we can extend our services to meet the growing needs of the local population, enabling more people to receive care in the place of their choice. We are the Lead Provider for end of life care in our locality and as such, play a key role in sharing our expertise with other health and social care professionals and influencing the development of local strategy to improve the care of everyone at the end of life.

The following top three quality improvement priorities for 2015/16 relate directly to our strategy and strategic objectives.

Priority 1- Reach more people in our area
We need to continue to reach out to and ensure expert care is provided for anyone who needs it, in the place of their choice, when they need it, to ensure they are able to achieve their preferences of care
<i>How was it identified</i>
Our strategy recognises that we do not currently care for as many of our local population at the end of life as we could. Our services had previously been more specialist and local people were dying without the support they needed. We were also advised by members of the public and other stakeholders that our messaging was confusing, as well as much confusion in how to access our services or their entitlement to access the services.
<i>How will it be achieved</i>
Through our re-branding and clearer message, we will minimise confusion of the services and areas we cover. Our new 'one point of referral' triage service that was piloted last year and implemented from early 2015 will also assist in a reduction of declined referrals. We are designing a number of services to meet the needs of patients with different conditions as well as targeting GPs to increase referrals, following our 'planning for change' pilot. We continue to operate our out of hours advice line and this remains part of our priority in reaching more people.
<i>How will progress be monitored and reported?</i>
Our progress will be monitored through increased referrals and reduced waiting times, as well as attendance at drop-in sessions and other new services. This will be reported to the clinical governance committee and board via a KPI dashboard. We will also monitor feedback received from other healthcare professionals about access to our services.

Priority 2- Develop and deliver an accredited training model
As the Lead Provider for End of Life Care in our area, we aim to share our expertise with other health and social care providers to improve the quality of care for everyone.
<i>How was it identified</i>

It was identified within our strategy that we need to increase the amount and quality of education and training provided to external colleagues involved in end of life care. To ensure we are considered a leading provider in hospice care within Kent, we recognised the need to formalise our training offer, and obtain accreditation for the training we provide so that it is a recognised standard for other organisations to access.

How will it be achieved

We will work with an external provider and consortium of hospice education providers to develop an education programme with accredited modules at appropriate levels. We have taken steps to meet the criteria for our courses to become accredited for health and social care staff.

How will progress be monitored and reported?

This will be monitored through the HR and education group and reported to the Director of Patient Care, and subsequently to the Board. We will also be able to monitor the success of this through feedback from our delegates once the courses are established.

Priority 3- Improve our children's hospice care respite provision

We need to ensure equitable access to our respite provision across each of our areas with a clear concise framework of our offer.

How was it identified

We listened to feedback from families, and reviewed our service delivery, and recognised that our respite care does not always offer an equitable service to all of the children on our caseload, and this is often affected by geographical location, age or other factors.

How will it be achieved

We will review and clarify our respite referral and discharge criteria and processes, in order to be clearer about what level of service can be offered to which children. Respite provision will be tailored to the need and dependency. We will ensure that every child is assessed against the criteria fairly to enable greater equity of service based on need. We will also implement an assessment tool.

How will progress be monitored and reported?

Respite need will be monitored through the use of the assessment tool. Success will be demonstrated by an increased take-up and capacity of respite provision across all geographical areas, ages and conditions. Feedback will be obtained from families.

II. Priorities from 2014-2015

Priority 1- Review of referral criteria and process

The organisation recognised the need to review its referral criteria and process – in order to assess needs equitably on referral to provide a more responsive service to a wider population, with less specialist needs.

Update on last year

We reviewed our referral information and are in the process of adapting the criteria for referrals. To simplify and improve the process, we piloted a triage model during the latter part of the year which was successfully evaluated and

subsequently implemented prior to year end.

We operate regular outpatient clinics and the Triage Nurse sees new patients promptly in order to assess their needs. Due to a reduced amount of NHS winter funding, we were unable to increase our capacity for out of hours admissions onto the ward; however, we continued to work hard to care for people in the most appropriate place where possible.

Our triage evaluation showed that the numbers of referrals that are declined and the time to wait to see a professional have both reduced. 100% of GPs reported that the new system was 'very' or 'extremely effective'.

Any outstanding areas for 15/16

Outstanding areas from this priority include further developing the single point of access and enhancing our advice line. All of these are included in our priorities for this year to demonstrate our ongoing commitment to this.

Priority 2- Develop and introduce services in a 'hospice as a hub' model

The organisation is committed to provide a co-ordinated approach of assessment and care and we recognised the need to improve our accessibility and service provision in order to provide more flexible services to a wider population.

Update on last year

A small working group developed various service offers, and teams have been looking at ways they can enhance their current offer. We are looking into the feasibility of changing the operating times and varying the structure of our day therapy/ outpatient services.

We have implemented 'carers cuppa' (a drop-in support session for anyone caring for those with a life limiting illness) and this has proved popular and been well-evaluated by attendees.

We have developed a training programme for volunteers in patient-facing roles, to provide the skills and knowledge to deliver appropriate care and support to families.

We have appointed a lead therapist who is reviewing our complementary service and developing a programme of therapeutic intervention groups, including breathlessness clinics and seated exercise classes to commence from June 2015.

As part of partnership working, we have assigned nurses to integrated primary care teams to assist with developing the skills of our colleagues in the wider health economy. We are looking at developing joint clinics in 2015-16.

Any outstanding areas for 15/16

We will be implementing a broader range of therapeutic groups and activities to be accessed more widely.

Priority 3- Develop Service User Involvement Forum

The organisation recognised the need to ensure that service users inform and influence the development of services and provision of high quality care that meets their needs.

Update on last year

We completed research on which models of user involvement worked across each service. We found that nearby hospice user forums, had mostly bereaved relatives attend the user involvement forum. We felt this was not an accurate representation of our current users. As such we have developed a structured approach to review each of the services in a manner that is appropriate to the area.

In April 2015, we will be compiling a calendar approach to user involvement to ensure that views are heard throughout the year. We have already completed a number of user feedback surveys which can be found later within the quality account. We share our results with appropriate teams through the clinical practice group and have included user involvement within our monitoring for the CCG.

Any outstanding areas for 15/16

A timetable is being created for 15/16 and users are being regularly involved for specific service engagement.

We are exploring the use of social media as a means of gaining regular feedback.

III. Statements of assurance from the board.

The following are a series of statements that all providers must include in their Quality Account. Many of these statements are not directly applicable to hospices.

A. Review of Services

During 1 April 2014 – 31 March 2015, ellenor provided specialist palliative care in a range of settings, available 24 hours a day and 7 days a week. The provision comprised the following services:

For adults living in Dartford, Gravesham and Swanley:

- x In-Patient Ward (ages 14+)
- x Day Therapy
- x Out Patients Clinics
- x Hospice at Home including:
 - o Specialist Palliative Care
 - o Palliative Care Support Team
 - o Care Home Support
 - o End of Life Care Crisis Support

For children and young people in Dartford, Gravesham and Swanley, West Kent and the London Borough of Bexley:

- x Hospice at Home including:
 - o Specialist Palliative Care
 - o Community oncology care
- x Respite and Short Breaks
- x Family Drop In sessions and Day Care Facilities
- x Transition services including Youth Groups

ellenor has reviewed all the data available to them in the quality of care in all of its services. All these services are delivered by a multidisciplinary team, comprising nurses, doctors, allied health professionals, and psycho-social staff (including social workers, chaplains and counsellors). Patients and families under the care of the organisation receive regular assessment and review by an appropriate member of staff (or registered volunteer). Hospice at home services are provided 7 days a week with a 24 hour on call service staffed by Specialist Nurses and Doctors, and with access to other staff to visit and provide care as required.

B. Income Generated

ellenor receives funding from the NHS through grants from local CCGs and represents approximately 25–30% of the overall running costs of the organisation. The income generated by the NHS services in 2014–15 represents 100% of the total income generated from the provision of the NHS services by ellenor.

70–75% of the organisation’s income is provided by fundraising activities, including the generous support of the local community and businesses, legacies and shops. We confirm that all NHS income received by ellenor is used towards the cost of providing patient services.

C. Participation in National Clinical Audits

During 2014–15, ellenor participated in one national clinical audit which covered the hospice sector.

Audit	Actions
<p>FAMCARE– Data collected for Association of Palliative Medicine.</p> <p>Duration of service evaluation – 1 August 2014 to 30 September 2014 (covers deaths during the period 1st June 2014 to 30 August 2014) consecutive bereaved “main” carers of patients referred to the service for end-of life care</p>	<p>The results will be presented to the Hospice at Home team within 2015 to plan improvements</p>

D. Participation in Local Audits

We regularly undertake audits of our own services against national or local standards. All the Local audits were completed to check and to improve our current practice. In particular the medical team have undertaken audits and are due to present an oral presentation on our PPI research below and 8 posters at an International conference in Copenhagen on the following topics:

Audit	Actions
<p>Audit of Drug Chart Documentation and Usage to Re-design Drug Chart</p> <p><i>Retrospective chart analysis. 31 from inpatients during January 2014- December 2013. All the charts were obtained from Inflex (electronic patient notes).</i></p>	<p>This audit gave a snap shot insight of the documentation of drug charts. There are some areas in need of improvement as Recording of allergies (need to be 100%), usage of steroid box in case of steroid prescription. We also noticed that recording of reason for drug omitted, signing of communication by the doctors need to be improved.</p> <p>Some areas like instruction box for the medications need to be increased in size and the discretionary medication. The results to be presented at audit meeting, drug chart being redesigned and further audits are planned.</p>
<p>Audit of Documentation of End of Life Care Priorities in Patients under Local Hospice Services</p> <p><i>We checked the preferred place of care (PPoC), Resuscitation status (DNAR) and preferred place of death (PPoD) on 15 inpatients (IPU) and 15 Home care team patients (HCT) and 15 day therapy patients (DTU).</i></p> <p><i>Those patients seen at least 3 times by the professionals only included as some occasions might not be appropriate to discuss these on the first review.</i></p>	<p>The audit showed areas of good practice and also some need for improving of recording of these important indices. This was presented to the teams and further audits planned.</p>
<p>Audit of the Facilitation of Spiritual Care for Patients by Clinical Staff</p>	<p>Reflection on the demographic mix of the audit population and the potential</p>

<p><i>To assess whether some of the essential, basic elements of assessing and facilitating spiritual care for patients, were part of the standard practice of clinical teams at the Hospice. The following criteria were selected: Record of religious affiliation, exploration of spiritual needs (either conducted or considered), Consideration given to potential chaplaincy involvement.</i></p> <p><i>45 patients electronic records reviewed in total -15 each from inpatients- (IPU), Home care (HCT) and Day therapy (DTU).</i></p>	<p>effect on results suggest a number of interesting questions for future research regarding factors that might affect the assessment of spiritual care needs. We plan to re-audit further to this. We are also recruiting a new Chaplain / Spiritual Care Lead who will be able to follow up on the results of this audit in order to develop services accordingly.</p>
<p>Audit of Usage of Steroids in a Inpatient Hospice Patients against Local Guidelines</p> <p><i>Steroids are widely used in palliative care for a variety of indications. However, they are associated with significant side-effects and for this reason should be used with care. Their use should be reviewed on a frequent basis to ensure patients are receiving the minimum effective dose for the minimum required time.</i></p> <p><i>Retrospective drug chart and case notes review. March 2014- October 2013.</i></p>	<p>We conclude that those who have steroids started as inpatients have indication, review, and plans documented better than those admitted on steroids. However, those who were discharged on steroids lacked in documentation of plan in their discharge letter resulted in lack of follow up. We recommended Improved documentation of duration, dose, started by, benefits, side effects on admission and those who are started. Document plan, review of benefit, side effects, dose in daily review, Document a clear plan for steroids in the discharge letter and Repeat audit in 1 year.</p>
<p>Audit of Recording of Pulse and Recording of Atrial Fibrillation in an Inpatients Hospice</p> <p><i>To determine if AF is documented in Hospice in-patients. To determine if heart rate is assessed on admission.</i></p> <p><i>Computerised patients records, initial Doctors assessment and front of drug chart (Observations taken by nursing staff are documented on front of the chart) of 60 consecutive patients with</i></p>	<p>AF was documented in 9.7% of cancer inpatients which is consistent with the reported prevalence of AF (All patients over 75 years).Although HR was documented in over half of the patients admitted to the unit only 1.7% had documentation of rhythm. Given the lack of pulse rate documentation it is likely that in a proportion of patients the condition goes unrecognised. Unless diagnosis is thought about and symptoms of atrial fibrillation actively sought at assessment, consideration</p>

<p><i>a diagnosis of cancer admitted to the inpatient unit from October 2013. Data collection proforma used. Retrospective audit.</i></p>	<p>of specific treatment may not occur.</p> <p>We recommend that all patients admitted (except EoLC), have pulse rate and rhythm documented on admission. During the admission, if any symptoms (SOB, palpitation, chest pains), then AF to be considered if appropriate. This should be improved also during the admission (if indicated).</p>
<p>A Retrospective Study of Use of Methadone for Symptom Control in an Inpatient UK Hospice</p> <p><i>Methadone is used in palliative care for neuropathic/ complicated pain, neurotoxicity and renal failure.</i></p> <p><i>A retrospective case note and drug chart review undertaken of 21 patients started on methadone as a hospice inpatient during 2013-2014.</i></p>	<p>Good practice was identified in documenting initiation of methadone in the majority of cases. The method of initiation and titration was varied, and there was a lack of documentation of pain assessment on initiation and titration. Methadone appears to be a useful medication for pain with very few side effects. Further review of guidelines and review of practice is recommended.</p>

E. Research

The organisation supports appropriate research in palliative care with the aims of enhancing the experiences of patients and families. There is a research governance committee which approves the participation in all research studies as appropriate, to ensure good governance. All research undertaken within the hospice setting has received appropriate ethics approval. We are also part of the Kent and Medway Research Group.

Over the year we have encouraged staff to undertake research and audits where they can see a clinical need and to meet their own area of interest.

- a. Prognosis Prediction by Palliative Prognostic Index (PPI): Multi-centre Prospective Study -2 with Two Calculations of PPI in UK Hospice Patients

Background: Predicting prognosis accurately would help patients and clinicians to make informed decisions about treatment and referral to appropriate services. But user-friendly tools are lacking in clinical practice. The Palliative Prognostic Index (PPI), based on simple clinical indicators, has shown promise in several studies.

Aim: Following a previous multicentre study in the UK, the current prospective study involved 10 centres, to check centre-to-centre variability, and included a

second assessment of PPI score 3–5 days after admission to investigate whether incorporating changes in PPI lead to improve predictions.

Methods: PPI score was calculated on admission to inpatient hospice, and again 3–5 days later. Kaplan–Meier curves were constructed and predicted survival based on PPI was compared to actual survival, using standard measures.

Conclusion: PPI score is more accurate if calculated twice and the rate of change of PPI is useful.

- b. Ongoing data collection for the multi-centre research – OASis Trial– (An Observational study of the frequency of oral symptoms in patients with cancer)

This study is coordinated by Royal Surrey Hospital Research team, to devise an assessment tool for oral symptom assessment for patients with advanced cancer. This involves data collection using a structured questionnaire.

Dr Siva Subramaniam is the Principal Investigator for ellenor. We have recruited 10 patients up to March 2015 and aim to recruit 250 in total from 13 centres. We aim to complete the study by July 2015.

F. CQUIN Payment Framework

ellenor income during this reporting period was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation (CQUIN) payment framework because we do not possess a standard contract for our services.

G. What others say about us

ellenor is required to register with the Care Quality Commission (CQC) and it has current registration status. We have no conditions on our registration. We have not had an inspection during the year April 13 – March 14 and were asked to submit our Provider Information Return in October, which was successfully submitted on time. The Care Quality Commission has not taken any enforcement action against ellenor during 2014–15.

H. Data Quality

In accordance with the agreement with the Department of Health, ellenor submit a National Minimum Dataset (MDS) to the National Council for Palliative Care. We provide the MDS report and a copy of the quarterly activity report to the local commissioning organisations. A summary of the activity statistics can be found in Part 3.

Information on the number of patient records held by an organisation which includes NHS number and General Medical Practice Code: 633 out of 732 current patients/clients (87%) have an NHS number recorded. 87% have a GP practice recorded.

Number of errors introduced into a patient's notes: there were 183 reported errors in our patient documentation during the year 2014–15 which is an increase on 112 last year. This is due to an increased reporting rate through improved checking systems and processes, and is not thought to represent an actual increase in errors.

ellenor has taken the following actions to improve data quality:

- x A new governance framework for documentation has been implemented to ensure a high level of consistency and accuracy for recording clinical activity.
- x A clinical administration team manager has been appointed and will oversee and monitor the accuracy of data entry.
- x A data quality project has been initiated to improve the accuracy and timeliness of clinical information reporting for both internal and external stakeholders.
- x Our Information governance lead attends network meetings which act as a resource; sharing of information at a local and national level, sharing experiences and ideas surrounding health informatics within a hospice setting, including management/ development of electronic patient records and clinical data reporting, for the benefit of service improvement and supporting best practice.

I. Data Quality

The organisation is an NHS business partner and successfully achieved 71% compliance against the Information Governance toolkit N3 connection.

Assessment	Stage	Level 0	Level 1	Level 2	Level 3	Not Relevant	Total Req'ts	Overall Score	Self-assessed Grade ?	Reviewed Grade ?	Reason for Change of Grade ?
Version 12 (2014-2015)	Published	0	0	23	4	2	29	71%	Satisfactory	Satisfactory	n/a

J. Clinical Coding Error

The organisation is not subject to payment by results clinical coding audit.

3. Part 3- Review of Quality Performance

A. Minimum Data Set Comparison

Activity statistics are submitted as part of the Minimum Data Set (MDS) and the figures below are in accordance with these figures. National figures (median), are based on the National MDS 2013-14 (latest report available).

IN PATIENT WARD	2014-2015 No MDS comparison	2013- 2014
Number of patients admitted <i>S= 171</i>	249	255
% of new patients (i.e. admitted for the first time) <i>S= 90.3</i>	91.1	91.8
% of patients admitted within 24 hours of referral	76	81
% of patients with a non-cancer diagnosis <i>S= 11%</i>	12	19
Average length of stay <i>S= national between 10-13 days</i>	10	10
Infections	8 in total 7 CDiff 1 HepB	11 in total 5 CDiff 3 HIV 1 MRSA 1 Shingles 1 TB

We were classed as a small unit during the MDS year 2013-2014. I have provided the national comparison figures for small units as follows S=0.

We were not awarded additional monies as part of the winter funding initiative and this has impacted on the service that we are able to provide including the number of patients admitted within 24 hours and how many were admitted at weekends and out of hours. However, patients are still attended to within the community.

DAY THERAPY	2014-2015 No MDS comparison	2013-2014
<i>Number of patients</i> <i>M= 144</i>	172	178
<i>% attendance</i> <i>M= 71.3%</i>	68	66.6

<i>Average length of care</i> <i>M= 154.8 days</i>	265	350
<i>% of patients with a non-cancer diagnosis</i> <i>M=25</i>	22	22

We were classed as a medium unit this year. Therefore, we have provided the national comparison figures for medium units.

We do note that our lengths of stay for patients appear to be double that of the national average. We also understand our attendance is much lower than the national average and this is due to dependency of patients.

HOSPICE AT HOME FOR ADULTS INCLUDES CARE HOME SUPPORT	2014-2015 No MDS comparison	2013-2014
Number of new patients (national 596)	718	567
Total number of patients (national 832)	970	839
% of patients with a non-cancer diagnosis (national 17)	31	24
Average length of care in days (<i>national 87.9</i>)	101	133

We participated in a pilot case management project which increased our patient figures and those with a non-cancer diagnosis. This project was very successful and has been replicated Kent wide. We are also experiencing an increase in referrals from care homes.

CHILDREN'S HOSPICE CARE	2014-2015	2013-2014
Number of new patients	44	51
Total number of patients	149	155
% of patients with a non-cancer diagnosis	73	65
% of patients who die in their preferred place	100	100

B. Patient Safety

ellenor treats all complaints seriously and records all expressions of dissatisfaction, both verbal and written, as complaints. These are all reviewed by the Director of Patient Care for opportunities to learn and improve practice. A regular report is provided to the Board of Trustees.

Number received	Number upheld	Trends noted
17	11 (4 in part)	In response to the complaints we have: <ul style="list-style-type: none"> x Reviewed our internal communications systems x Simplified the access to our services x Added training issues to our mandatory training programme x Developed an Inpatient Ward discharge guideline

Our clinical incident learning is as follows:

- x Changed some medicine procedures and documentation, including a checking sheet and an adjustment to how controlled drugs are recorded
- x Reviewed and updated medicines policies
- x Implemented safer medicines protocol, including flagging high doses on discharge letters to GPs, and a message board to reduce interruptions
- x Appraised ward routines
- x Reviewed our manual handling procedures and piloting a falls assessment tool.
- x Reviewed our contractual arrangements with external suppliers
- x Liaised with external agencies as required and planning to review procedures for raising concerns with external organisations.
- x Identified staff support and training needs which are currently being implemented, including review of our communications and complaints training.
- x Implementation and recruitment of a reception co-ordinator to ensure messages are disseminated appropriately.
- x Share learning of incidents at staff training days
- x Reviewed MHRA reporting and implemented a new guideline
- x Reviewed our manager on-call system

A data quality project has been initiated to improve the accuracy and timeliness of clinical information and incident reporting for both internal and external.

We have also made some of the following improvements which will assist in maintaining patient safety:

FALLS

A new nationally used standardised falls assessment has been piloted in day therapy which scores the patients risk of falling and therefore can appropriately guide our care plans for the individual, and enable referrals on to

other NHS teams. The Patient information leaflet regarding falls is also being rewritten in April, taking on board guidance from other organisations.

INFECTION CONTROL

Our infections during the year are as follows:

Infections	Jun	Sep	Nov	Dec	Feb	Mar
CDIF	2	1	1	2	1	
Hep B						1
Total Infections	2	1	1	2	1	1

Following the review of our processes at the beginning of 2013, the team have been busy updating the policies and completing the actions that had come to light. The outcomes are:

- x a fully refurbished sluice area;
- x laundry and housekeeping facilities have been upgraded
- x and a comprehensive planned preventative maintenance program has been agreed and implemented.

We have recognised the significant importance of the infection control lead role and have identified a full time Registered Nurse on the ward to receive extended training and to lead on this important area of work. We have also established an infection control working group who will monitor the quality and oversee the outcomes of this action plan plus future audit outcomes.

HOUSEKEEPING

100% of deep and regular cleans were completed as timetabled and a schedule is in place at all times.

C. Clinical Effectiveness

We undertook other audits including:

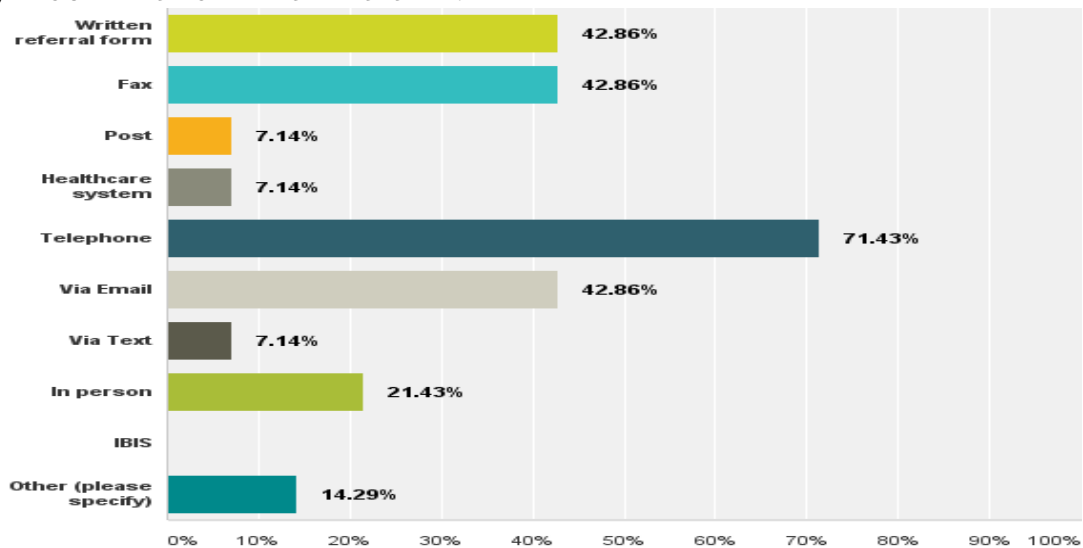
- x Documentation audits reviewed:
 - o Number of service referrals accepted and followed through.
 - o Extent of clinical assessments completed
 - o Consent documented for sharing patient information
- x Flu vaccine audit for staff – showed 87% of those who replied had received the flu vaccine.
- x Volunteer experience of working at the Hospice – showed over 90% reported as having good or excellent working relationships and over 70% say that training is good or excellent.

- x Patients' in Day Therapy were asked their views on opening hours at Christmas – which led to increased opening of service.
- x Carers' views were audited on support needs – this has led to an extension of our carer's support developing an informal session where they can meet for peer support.

TRIAGE ROLE

We completed a review of the Pilot Triage Nurse role which demonstrated a 75% reduction in the number of referrals declined, indicating that we are providing support to a growing range of patients than previously.

As part of the triage evaluation, we asked our referring colleagues to answer questions to assist in creating a service that worked for them including how they would like to make a referral:



From this, we have made a telephone line our first point of referral. We implemented this as part of our re-brand with the times that they requested.

EDUCATION

During the year, training was delivered to over 20 external groups, reaching in excess of 250 staff. This was evaluated as good, or excellent by 100% of attendees. 95% of clinical staff are up to date with their statutory and mandatory training. In the coming year, we aim to extend our training packages for external staff, promoting accredited courses where possible.

Internally, we have identified a need to improve training capacity appointing a Head of Development and Quality to review our training needs across the organisation. The scoping work clarified a need to review our delivery and training materials for our statutory and mandatory training, to ensure we have staff who are competent and confident within their roles, as well as being able to evidence the outcomes of the training delivered.

For this purpose, we invested in training the trainers, with 14 staff across a wide range of services attending an accredited Level 2 Assessment in Education and Training course. This has enriched our capacity to update the training we are delivering and is preparing the team to develop and deliver accredited training in our core area of specialism, Palliative Care. We are supporting a number of staff internally to achieve level 3 apprenticeships in Health and Social Care with Long Term Conditions, as we recognise the need to engage with developing current staff to achieve to their full potential.



Our previous CEO, Carol Stone was presented with a life time achievement award presented in November 2014 by Hospice UK for service to the Hospice movement over the last 25 years.

COMPLEMENTARY THERAPIES

Therapists are completing an outcome assessment measure with every new patient. MYCAW: Measure Yourself Concerns and Wellbeing, is an individualised questionnaire that has been designed for evaluating complementary therapies in cancer support care. This will allow us to measure benefit to patients of the Complementary Therapy and audit the service to ensure we continue to improve.

CLINICAL NETWORKS

Our lead consultant attends the south east coast strategic clinical networks palliative care and end of life care clinical advisory group which looks at end of life care across all the 4 strategic clinical networks. The 4 networks are 1. Cardiovascular including heart, stroke, renal and diabetes, 2. cancer, 3. dementia, mental health and neurological conditions and 4. maternity, children and young persons. The group comprises a wide membership from across the south east coast of providers, commissioners, patient, carer and third sector members. It provides a forum for bringing together and agreeing the end of life care strategic work programme. The group will aim to influence and advise on the commissioning of end of life care services which address the whole patient pathway and deliver the required patient outcomes.

Our lead consultant also attends the Kent and Medway Children and Young People Palliative Care Network meetings. This group brings together providers,

commissioners and third sector members from across Kent and Medway to look at palliative care and end of life care provision. The group has been working on an end of life care pathway, advance care plans, symptom management and drug charts, mental capacity and looking at education gaps and the possible delivery of a yearly network education event.

The Director Of Patient Care attends the 'Executive Clinical Leads in Hospice and Palliative Care (ECLiHP). This is a forum which shares good practice and discusses issues relevant to palliative care.

The Childrens Hospices across London (CHAL) registered managers meeting is attended by the Director Of Patient Care and Head of Childrens Service. This forum is used to develop best practice initiatives.

D. Boards commitment to Quality

The Board of Trustees regularly review the performance measures and this year a new Dashboard has been produced to enable clearer reports. One of the Trustees undertakes an annual visit. During visits, the Trustee visits different parts of the organisation and speaks to patients and staff. There is a Clinical Governance Sub-Committee chaired by a Trustee, focusing on care services. It thoroughly reviews varied information relating to the quality of care provided, including statistics relating to any staff shortages or concerns in clinical areas. Senior members of clinical staff attend this meeting to discuss current issues in an open and transparent environment. A report is sent to the Full Board meeting regularly. In this way, the Board has knowledge of the quality of the service provided, through regular reporting. The Board is confident that the treatment and care provided by the Hospice is of high quality and is cost effective.

E. Patient Experience

As one of our priorities last year, we said we would create a forum for reviewing and reporting feedback from patients and families. So far, we have completed a number of surveys and feedback requests.

CARERS SUPPORT

We attended our carers course which runs across a 7 week period and completed an evaluation of the sessions. We asked why they attended the course. Responses were along similar lines:

- x Getting more information on illnesses and what to expect
- x To meet others in a similar position
- x The course content looked interesting and helpful
- x To see how other carers coped
- x Knowing you are not the only person in the world managing

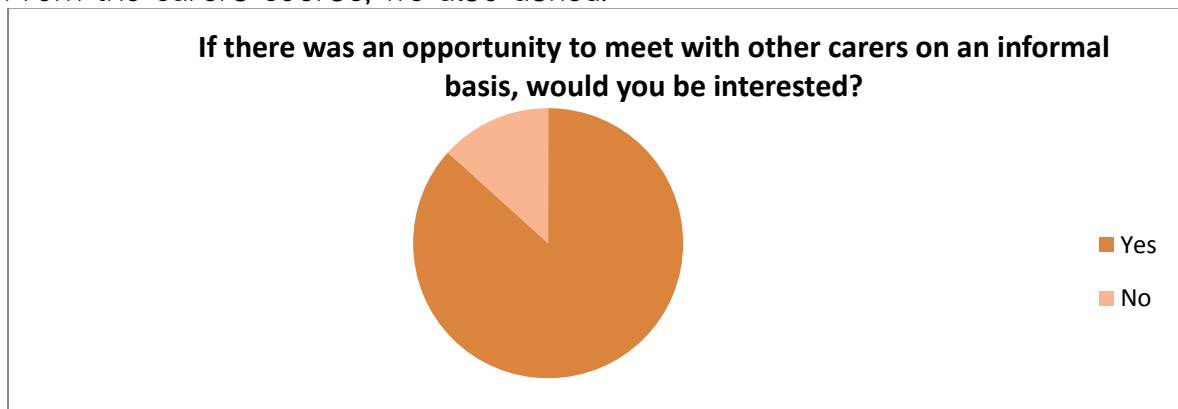
We also asked what we did well and respondents advised that the whole course was informative and understandable. They liked that it was in plain, simple language that everyone understood. Many advised that they had learned a lot, and that the atmosphere, cups of tea and content was perfect!

100% of those that attended would recommend the course to other carers!

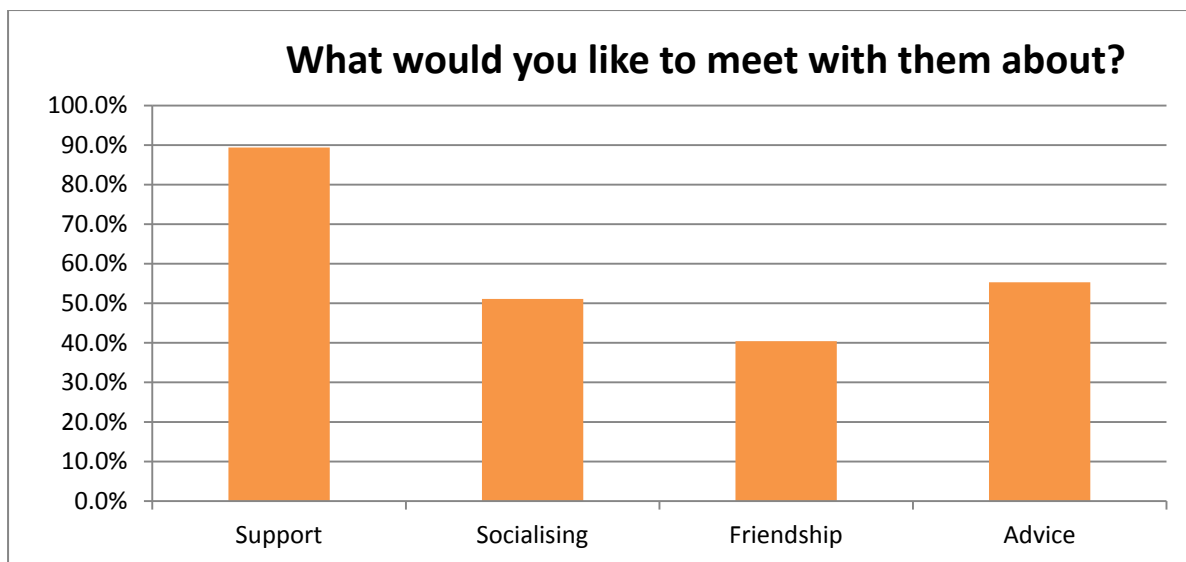
Some comments include:

- x Learnt a lot and met some lovely people in a similar situation
- x Please keep up this work and self help groups, they are worth their weight in gold.

From the carers course, we also asked:



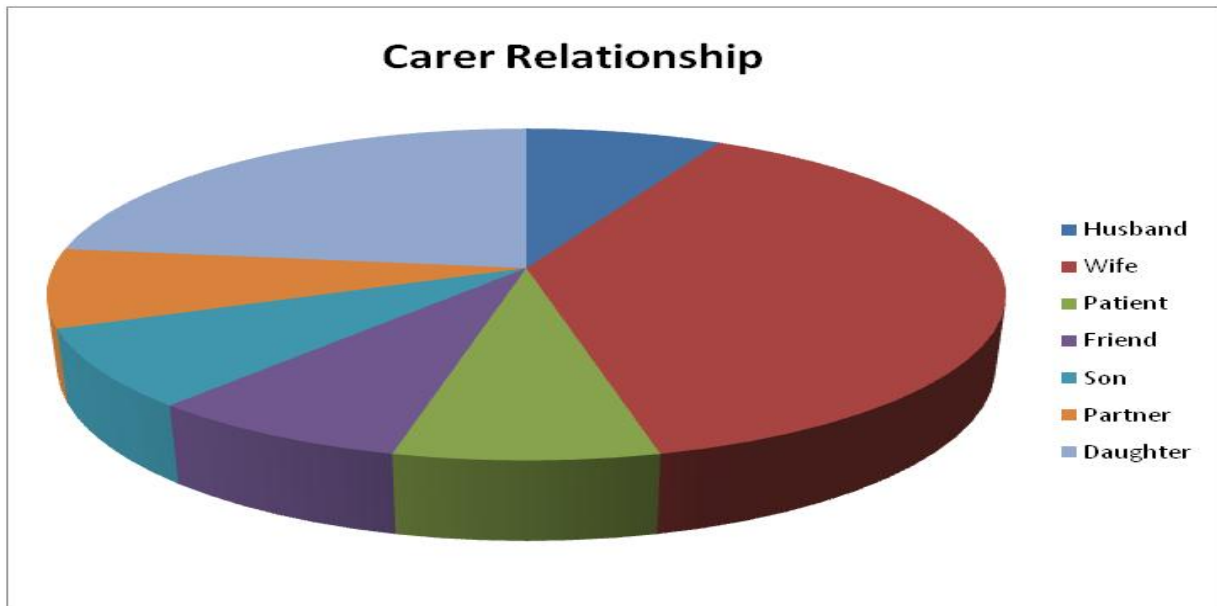
And:



From this, we created Carers Cuppa, a safe, supportive environment, where people can get advice and perhaps friendship from others in a similar position. We varied the times between the most popular days. 15% of the attendees to the sessions held so far are new to the organisation. We agreed that this should be an evaluated group to ensure that it meets the needs of the carers attending. We advertised for free in local papers, sent the flyers to

local GP surgeries, posted information in and around our buildings, sent to our shops to display, posted on our Facebook page and on Twitter.

However, due to work capacity, it has been difficult to ensure that each of the building locations is advertising this. The majority of attendees to our carers cuppa were caring for their partners.



At present this is co-ordinated and hosted by a clinical member of our family support team. We are looking to recruit volunteers to host this in the future under the supervision of the lead. We provide refreshments of coffee, tea and biscuits. There is minimal paper work, we have posters and feedback forms.

This has been a success at our Gravesend site with regular attendees. Our Dartford site has had fewer attendees. We are now in the process of setting dates for the next six months looking at Saturday sessions, mid week sessions and evening sessions. These sessions will be run weekly in the future.

We are working closely with Carers' First in order to sign-post efficiently. We are also using our triage post for any potential self referrals to ellenor. This service has also able to sign post to the Carers Cuppa, which has worked well.

DAY THERAPY

We were unsure if the name 'day therapy' gave the right impression for our patients, therefore, we asked them. The majority of the patients felt that the name 'day therapy' described what it does, although those that didn't were unsure of another name.

We asked our patients what day therapy meant to them:

- x It is a place to take their minds off of what is wrong with their health

- x Meeting people that are in a similar situation
- x Getting out of the house, less isolation
- x Giving their partner a break
- x Place to come for support, emotional and friendship
- x Talk about concerns
- x Understanding how others feel about their illness

We asked if it could be called something different and many felt that it was more of a social club for those with similar conditions, and that the health and condition monitoring were an added bonus.

We asked what would improve day therapy:

- x Finding out what is on offer and when- visual availability of activities.
- x Perhaps rethinking the layout of the chairs.
- x Less separation of activities, i.e more completed together.
- x Would like to come more often.

Other comments include:

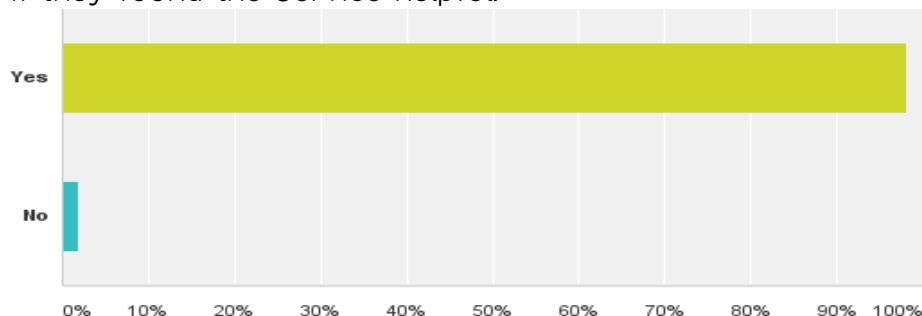
- x The staff are kind and helpful
- x There is a good choice of lunch.
- x Everybody is friendly.

This feedback was fed into the 'hospice as a hub' development working groups.

FINANCIAL SERVICES

To monitor how our users are finding the financial service, we ask each of them to complete a survey; the results are as follows:

We asked if they found the service helpful.



We also asked if the service reduced their stress and anxiety. Over 95% said it had. To ensure our service is meeting the needs, we asked if they would recommend this service to others. 100% said that they definitely would.

Unfortunately, due to the anonymity of the surveys- we are unable to establish the reasons behind any of the 'no' as comments were not left.

Rather than implementing a regular forum, we will be completing ad-hoc user forums to ensure our feedback remains current. All services are encouraged to seek and use the views of the people who use them. We are implementing a user involvement timetable to ensure this is a priority for teams.

We receive a lot of compliments for our service, which all mean so much to the ellenor family. It is hard to pick just a few for this, however,

Not only were you there for mum, but you were there for myself, family and friends who spent hours with you all. You made us tea, dried our eyes and gave us the most amazing advice and support. I will never forget any of you. Much love.

To our wonderful charlie's angels— words could never be enough on how you helped my brother. Thank you so much for your kindness, your compassion and your guidance, we will miss you as much as him x forever in our hearts

We would like you to know how we appreciate the care you gave mum in her final days of her life. We were comforted to know that she was well looked after and felt safe being with you. Thank you also for the kindness you showed us and the support to help us through this sad time. Keep up the good work.

I would like to say thank you to the doctors and nurses on the ward that cared for my mum while she was in the hospice for symptom control relief. Unfortunately, mum passed away at the end of October. I would like to thank you for your help and honesty! Mum got to meet her granddaughter before she passed away. I would also like to thank you for all of your help and support from when I first called for advice until mums final days.

Time has now passed since my husband's death. As a family, we want to express our thanks for the wonderful support and care you gave him over the last 18 months of his life. Each one of the team demonstrates outstanding empathy, kindness and care. We felt the Dr supported him in his final weeks on this earth, all those who visited our home and provided support via the phone— all helped to ease his emotional needs and that of family members. We have to say a special thank you to those who helped us through the final days— as well as those who worked so well with us as a family. It would be unfair not to mention the carer's course programme leaders, who prepared me so well for weeks and months ahead in the progression of his illness. Thank you to each and every one of you, we all hear of the wonderful work hospices deliver but it is not until it is experienced firsthand that one realises just how wonderful that is.

We cannot put into words how much we appreciate the way you treated her with so much respect and dignity in her final weeks. You made us feel comfortable leaving her in your care, and we knew you would look after her when we weren't there. Thank you for all the love and support you gave her as well as her family and friends. you do an amazing job and we can't thank you enough!

To all the staff, we would like to express our thanks and gratitude for all the care and kindness you showed to our mum during her final few days. Your compassion and consideration to mum and us all was beyond compare and we thank you all from the bottom of our hearts. At this very sad time for us it is a great comfort that mum was treated with such dignity. You are all true angels!

To all of the nursing, staff, carers, volunteers and doctors. On behalf of family and friends, please can I say an enormous Thank you. The sincerity of the caring, the clear, kind communication; the peaceful setting and calm, at such a difficult time; words cannot express how grateful we are.

Thank you does not even begin to convey how we feel about the care and support you gave to my lovely dad in the last days of his wonderful life. He deserved to have his wishes carried out and you all made that possible for him with the endless care, dignity and compassion you gave. Alongside all that you still found time to also care for us, the other patients and their families too. The work you do is amazing. You are all Angels.

Words will never be able to express our gratitude for the care and dignity you gave our Dad. It is so difficult saying goodbye to a loved one. You made the unbearable, bearable.
We truly thank you.

Tomorrow we are saying goodbye to him. We wanted to thank you all so much for the kindness, care and compassion that you showed him and us during the last few weeks of his life. You do an amazing job in such difficult circumstances. He was so grateful for that and so were we.

There are no words that will ever be adequate to thank every single person (paid and unpaid) who work at the beautiful place that is "ellenor". You are all truly remarkable people, this we have realised while sitting for many hours over the last 5 weeks. We know she would be so thankful to you all for the loving care she received... These past weeks have been traumatic but with the support and friendliness shown by you all we got through... I will remember you all with affection and I will miss you, as you became a big part of my life... Always there with a smile, a tissue and comforting words when needed.

Thank you for your time, advice and help you gave to my lovely dad. You made such a difference every time you came to see him, he looked forward to your visits and he always said he felt so much better after your little chats. It's such a wonderful thing you did to make dad feel better in himself when there was no hope of him getting better. He got his last wish to be at home with no extra help, just us! My mum and I would also like to thank you for all your help, support and advice you gave us too. Wishing you all the very best and many thanks.

On behalf of our family, I am writing to extend our heartfelt thanks for the care and treatment that our brother has received from you since the onset of his severe illness. Your specialist skills, extensive knowledge and empathy have been more appreciated than we are able to express and relieved much suffering. In addition, we have very much valued your kindness, support and sensitivity, together with the practical help you have set up towards our (amazing) sister in law; you have mindfully known exactly what is needed and when. Bringing these aspects together has created a sense of trust and a strong base for the service provided to be more effective. We have also been grateful for the skill and time that the dry committed. Generally, this has been at a stage in the human life cycle where we are floundering in relation to the untimely personal tragedy (to say the least) that has beset our dearest brother and his family.

Thank you all so much for looking after him in the last few days of his life. The Hospice I an amazing place and your kindness and support was overwhelming. You supported us and we all cannot find enough words to express our gratitude at this very sad and difficult time. Your care and compassion was exceptional and his end of life care was calm and peaceful. I shall be ever thankful to you all.

To all the amazing nurses, doctors and staff. Words really can't describe just how thankful we are for all the care you gave to our dear mum and us. You truly are such an amazing bunch of caring people that supported us through such a difficult and life changing time in our lives. We have had some laughs along the way which helped more than you could ever know. Nothing has ever been too much trouble and you have all been there 24/7 for us which we again can't thank you enough. You should all be very proud of who you are and keep up the amazing work you do, it means so much families facing this illness, keep smiling. We would have been truly lost without you all. XXX xx x

To the wonderful ellenor team. Just to say a big thank you for looking after my mother in law during her illness and also for all the support and kindness you gave us. It has been a very distressing time for our family but, because of you lovely people, we were able to keep her at home as she wished. Without you we would never have managed!

To everyone that cared for him, we would like to say a huge thank you for all of you hard work, looking after and caring for my dad. We feel so lucky and privileged to have met each and every one of you. As a family, we all feel that you made dad feel so greatly looked after, comfortable and secure which was so important to us- he felt so safe knowing he had the support of the staff near. Thank you so much for all your help- we don't know what we would have done without you all. Much love.

F. Health Statements

As part of the requirements for the Quality Account, we are required to ask our commissioners and the local Healthwatch for a statement on our quality account.

Dartford, Gravesham and Swanley CCG Statement

Ellenor's draft Quality Accounts document was sent to Clinical Commissioning Groups (CCGs) for consultation and comment. The CCG's have a responsibility to review Quality Accounts each year, using the Department of Health's Quality Accounts checklist tool to ascertain whether all of the required elements are included within the document.

The CCG has now completed its review and is pleased to confirm that the necessary data requirements have been included and that the account contains accurate information in relation to the NHS Services provided.

This is the organisation's 2nd year at completing a Quality Account document which is well written, structured, clear and concise; it follows a consistent format throughout the whole document in line with national requirements.

The organisation has made strides in establishing Key performance indicators (KPIs) collaboratively with the CCG, and ongoing work is underway to embed a robust data reporting system. For 2015/16 ellenor has identified clear and focussed priorities which are in alignment with their current strategy that aims 'to meet the growing needs of the local population, enabling more people to receive care in the place of their choice'.

All 3 priorities for 2014/15 were successfully achieved and further elements for development have been incorporated in the 2015/16 priorities. Overall there is notable evidence of improved quality services for patients, carers and their families, for instance the telephone line which has been implemented now as first point of the referral process, following a review of the Triage Nurse Role Pilot. It is apparent patient preferences and choice have been and continue to be taken seriously by the organisation and will remain a key focus during 2015/16.

Ellenor is an organisation that evidently listens to its patients and/or families, as is illustrated in the included feedback and comments within the Quality account. It would however be useful as indicated in last years' (2014/15) CCG Statement, to include in future Quality Accounts, the process that the organisation has in place to act on both positive and negative comments to ensure that if necessary, actions are put in place to further improve services.

In conclusion, the CCG can see that the organisation puts the patient at the forefront of its service provision and pro-actively ensures that quality is a key priority area. A lot of commendable work and engagement has gone into the setting up of KPIs and quality assurance mechanisms. Once again the CCG thanks Ellenor for the opportunity to comment on this document and it looks forward to the ongoing work with the established NHS infrastructure.

Healthwatch Kent

As the independent champion for the views of patients and social care users in Kent we have read the Quality Accounts with great interest.

Our role is to help patients and the public to get the best out of their local health and social care services and the Quality Account report is a key tool for enabling the public to understand how their services are being improved. With this in mind, we enlisted members of the public and Healthwatch staff and volunteers to read, digest and comment on your Quality Account to ensure we have a full and balanced commentary which represents the view of the public.

On reading the Account, our first suggestion, as has been with all the other Quality Accounts we have read, would be to produce a separate summary document to make the information more accessible to the public. Despite this, the account is very readable and the lack of jargon means that people will be able to easily understand what has been written. It may also help to have a more organised structure with priorities from last year coming before priorities for the future.

There is a clear statement of priorities for improvement in 2015–16 which are evidence based and clearly state both how they will be achieved and how progress will be monitored. We particularly welcome the elements of these priorities which have been developed from the feedback ellenor have received (e.g. the need for clearer messages). It seems as though there is a real effort to absorb different types of feedback and act on it, a prime example being the creation of “Carers Cuppa”. It is also encouraging to see that staff are urged to feedback on situations they have found difficult or areas they believe need improving.

It is noted that efforts to reach out to more of the community are a priority for the next year. We would especially be interested in the ways in which the organisation plans to involve seldom heard communities and hard to reach groups in the feedback they are getting.

In summary, we would like to see more detail about how you involve patients and the public from all seldom heard communities in decisions about the provision, development and quality of the services you provide. We hope to continue and develop our relationship with ellenor to ensure we can help you with this.

END OF QUALITY ACCOUNT