Quality Account

2014/15

Hospice Mission Statement

St Leonard’s Hospice is committed to caring for local people over the age of 18, regardless of sex, race, colour or creed, who have active, progressive and advanced illnesses, their families and carers, without personal charge.
Quality Account

Part One

Statement from the Chief Executive

On behalf of the Board of Trustees and Executive Management Team it gives me great pleasure to present the Quality Account for St Leonard’s Hospice. The account looks back on progress that we have made during 2013-14, and outlines some of our key priorities for improvements to services for patients and families in 2014-15.

St Leonard’s Hospice is highly respected and has an excellent reputation in the community: it has outstanding public and business support and is well regarded by the health and social care communities. The strength of St Leonard’s Hospice is ‘the team’, and together with our Board of Trustees I would like to thank the clinical and support teams for their contribution to providing excellent patient care and for ensuring that our reputation continues.

“the staff are lovely.....they're very competent”

“They treat my mum like their own mum”

“They have really allowed us to stay in charge....they have listened to what we want”

Patient and family comments to CQC inspector (2013)

We were given a clean bill of health and a very positive Care Quality Commission (CQC) report following an unannounced visit in December 2013. For the first time our Hospice@Home service was inspected, and we were delighted that the CQC identified no shortfalls in the standard of services provided by St Leonard’s Hospice.

Here at St Leonard’s Hospice we have a culture of continually working to monitor and improve quality. We actively seek feedback from our patients and their families and staff are always encouraged to make suggestions and feedback to members of the Executive Team and Trustees. As partnership working with our colleagues in the Acute Trust and community and social care increases we are also looking to those areas to provide us with feedback on ways that care can be improved for patients.

One of the most exciting developments during the last twelve months has been the appointment of a Director of Clinical Quality and Effectiveness. This is a joint initiative with Saint Michaels Hospice, Harrogate and Barnsley Hospice and will be a key appointment for us as we look to continually improve quality within St Leonard’s Hospice services.

We are currently undergoing a period of significant refurbishment of our patient areas as we strive to enhance the quality of the physical environment for our patients and their families.
I am responsible for the preparation of this report and its contents. To the best of my knowledge, the information reported in this Quality Account is accurate and a fair representation of the quality of healthcare services provided by St Leonard's Hospice.

Martyn Callaghan
Chief Executive
Looking back at what we achieved in 2013/14.

1.1 Patient Safety

Priority One: Implement change to the model of care delivery across the In-Patient Unit (IPU) to reflect a more holistic patient centred approach to care

A new ‘total care’ model of nursing was rolled out in September 2013 following a proposal developed by the senior nursing team. The aim was to improve the amount of time nurses are able to spend on direct patient care though changes in documentation practices, medicines administration and shift patterns. The model is essentially similar to that of a named nurse process. The following changes were made:

* Overhaul of drug administration procedures to include single nurses administering non-controlled drugs, patient’s medication being kept at the bedside in a locker and allocation of the drug keys to every registered nurse on duty.
* Introduction of core care plans with a number of common symptom problems and a new ‘24h care record’ upon which care planning is reviewed and care delivered is documented.
* The presence of a senior nurse to co-ordinate the in-patient unit from 7.30am to 6pm to provide senior leadership, supervision and support for staff, patients and their families.
* Registered nurses and carers being allocated to a smaller number of patients for the shift, rather than a ‘team’ caring for up to 10 patients at a time, to improve holistic care of patients.

The changes were evaluated through a staff survey, audit of documentation, monitoring of patient and user feedback forms and the recording of clinical incidents. Staff evaluated the changes positively with the reduction in ‘team working’ being offset with the benefits of additional time released for patient care and attending the weekly patient Multi-disciplinary team (MDT) meetings. This was also reflected in patient and carer feedback, where it was felt patients were able to spend time with nurses who were also more familiar with them and their needs.

1.2 Patient Experience

Priority Two: Develop a competency based assessment document for staff within St Leonard’s Hospice.

A core competency framework and preceptorship programme for all new registered nursing staff has been developed based on an adaptation of an existing document used within the York Teaching Hospital Foundation Trust. This document draws on existing competency assessments from the acute hospital and community setting and also includes medical devices manufacturer’s recommended competency standards.
The document was piloted during 2013/14 with an experienced member of staff returning from prolonged sick leave and has subsequently been issued to several new staff nurses. The document will be reviewed annually and amended as appropriate in line with changes to the Nursing and Midwifery Code of Professional Conduct and the introduction of a revalidation process for registered nurses within the next 2 years.

Priority Three: Undertake a formal patient and carer experience survey

Over the past year the hospice has ensured the views of patients and carers have been sought via a number of different sources. In addition a continual review of comments and complaints the hospice team have participated in additional regional and national projects to seek views and benchmark these against other hospices and hospitals.

A national audit initiated by the Association of Palliative Medicine using the FAMCARE questionnaire was conducted in August 2013 with 44 recently bereaved relatives being asked about how they felt their loved one was cared for in the last days of life. Overall feedback was very positive with over 90% of respondents being either satisfied or very satisfied with aspects of care including being treated with dignity and respect and management of symptoms.

The hospice has also participated in a medical student project run through Leeds University. This questionnaire sought the views of patients using Day Hospice facilities across Yorkshire, and whilst again feedback was positive, overall comparisons with other Yorkshire hospices are not available at the time of writing this account.

During the last quarter of 2013-14 a formal carer survey and survey of health professionals was undertaken for the Hospice@Home service as part of our review of the success of the pilot project to expand the hours of service. The survey was developed and analysed by the National Association for Hospice@Home (NAH@H).

Overall the feedback from families was excellent. We were shown to be 94.7% compliant against quality standards identified by the NAH@H when assessed by patients, and 83.3% complaint as assessed by health professionals. The key areas for future development and quality improvement from this survey relate to co-ordination of care across different services and also involvement of the community health professionals in policy development for H@H services.

The results of these surveys have allowed us to highlight areas of good practice and identify some areas where improvements are required. All of the reports are fed through the hospice governance committee and are discussed by the management team. It is expected that this additional information will help us deliver better care over the forthcoming 1-2 years.
As a result of a grant received from the Department of Health in 2013 we have been able to refurbish many of the areas within the Hospice to enhance the quality of the physical environment. We have also utilised legacy income to further improve the building and focus on energy efficiency and improved lighting.

We have successfully refurbished Daycare, our family areas such as quiet rooms and children’s rooms and the chapel. New energy efficient lighting has been installed in all offices and communal areas and we are currently refurbishing our in patient bedrooms.
Priority Five: Patient Record System – St Leonards will implement the use of a single electronic patient record system - SystmOne

This priority is a long term ambition of both the hospice and other Specialist palliative Care services across North Yorkshire. As such it was carried forward from our quality account last year and will also roll over to 2014/15.

SystmOne electronic records were initially introduced to assist with the national Palliative Care Funding Review pilot, which was completed in early 2014. It is a system used by around half of local GP practices and the majority of community healthcare services (such as district nursing). Despite these advantages SystmOne is not currently able to integrate with alternative IT systems used by other health and social services such as the hospital, other GP practices or emergency services (such as North Yorkshire Ambulance service or out-of-hours GP services).

Our ambition is to have a single IT system across the whole of Specialist Palliative Care, but with the hospital and community services unable to use S1 alternative solutions are currently being discussed with the CCG, hospital Trust and other community services.

Priority Six: Partnership Working

During 2013/14 St Leonards Hospice continued to demonstrate its commitment to partnership working in a variety of ways.

Part funding of a Lead Nurse for End of Life Care has continued for the full year and is also included in the financial plan and budget for 2014/15. The existing post holder has resigned from position but the Hospice has agreed to continue funding for a new recruit as we firmly believe this is an essential role for improving the care patients receive at the end of life.

Since the appointment of two new consultants in Palliative Medicine St Leonards Hospice has regular representation at the locality MDT and is also working collaboratively with the Acute Trust to provide medical cover to the hospital wards on a regular basis.

St Leonards Hospice is represented at both the End of Life Board and End of life forums held locally. Partner organisations such as the Acute Trust and social care are also represented, as are care homes and higher education.

During 2013/14 St Leonards was offered the opportunity to work with the CCG to obtain money to expand the existing Hospice@Home (H@H) service. This expansion was a pilot project for 3 months developed with the specific aim of reducing out-of-hours admissions/ presentations to the Emergency Department over winter. Over 115 patients were referred to the service during the hours of 6pm to 12 Midnight over the 12 week pilot period and required intervention from H@H staff. Staff members from H@H worked in close partnership with the community evening service and out of hours GP’s, and evidence from questionnaires demonstrates that the expansion evaluated very well.
Part Two

2. Priorities for Improvement and Statements of Assurance from the Board (as defined in regulation)

The hospice has a number of committees that are continually working towards improving the quality and safety of care for patients and the well being of staff.

The Board of Trustees and Executive Management Team continue to support the development and improvement of services to ensure the care the hospice provides evolves to meet the needs of our patients and the demands of the changing context of healthcare provision.

The priorities for quality improvement we have identified for 2014/15 are outlined below. The priorities have been identified this year in conjunction with the Board and the Executive Management team. They will impact directly on the priority areas identified as contributing to high quality care as defined by Lord Darzi (reference: High Quality Care for All - NHS Next Stage Review, 2009)

- patient safety
- clinical effectiveness
- patient experience

The priorities also reflect St Leonard’s Hospice response to the Francis report (2013) and the Chief Nursing Officer for England’s vision for Nursing and the development of a culture of compassionate care.

Priorities for Improvement 2014/15 - Future Planning

2.1 Patient Safety

Further co-ordination and communication of patient care through computerised patient records

Why was this identified as a priority?

This priority recognises the need to continue with the work carried out since 2012 on improving the integration and co-ordination of IT (computer) patient records. Patients with life-limiting illnesses often spend significant amounts of their time in different care settings such as hospitals, care homes, hospices and the community, and need relevant information to be made accessible to health and social care professionals.

As highlighted in Priority 5 from 2013/14, progress on implementing a single IT system across the local area has been slow, with no one major organisation (either Hospital Trust or Clinical Commissioning Group - CCG) favouring a particular system. This problem is seen across the country with no single IT system being used across all care settings in any particular region. It is expected that in 2016 the CCG will put out to tender new bids to run and co-ordinate electronic patient record systems which may resolve some of the problems with existing systems having little
or no ‘inter-operability’. Until then local solutions to accessing and sharing relevant patient information need to develop further.

In addition to inputting individual patient information, further development of hospice IT systems will allow us to record our clinical activity. This will extend to the Hospice@Home service, Day Hospice and bereavement services. This allows the hospice to accurately measure what we do and plan our services for the future.

The hospice IT manager has also made good progress in ensuring compliance with the NHS Information Governance Toolkit. This is a voluntary set of standards and procedures to ensure all confidential data is handled, shared, stored and destroyed safely by the organisation. It is expected that this work will continue for the next 2 years.

How will this priority be achieved?

- On-going work to ensure compliance against the NHS Information Governance Toolkit
- Rationalising accident and incident reporting templates to minimise replication and maximise effective reporting
- Continuation of our discussions with other stakeholders to find a solution to sharing patient information safely and effectively using IT

How will progress be monitored and reported?

- Reporting on both information governance and IT systems to the Hospice Governance Committee

### 2.2 Patient Experience

| Expansion of the Hospice@Home (H@H) hours of working |

Why was this identified as a priority?

The St Leonard's Hospice H@H service was developed initially as a pilot project which commenced in December 2009.

The current criteria for referral to the service are outlined below:

1. Crisis intervention (to prevent acute admission to hospital), with a 72 hr package of care
2. Terminal care (support and care for patients in the last 1-2 weeks of life), for those who have a preference to be cared for at home at the end of life.
3. Discharge support (72 hr package of care to enable patients to be discharged home from hospital or hospice to die at home)
4. 72 hr package of care to support a patient while waiting for an in-patient bed at St Leonards Hospice
In January 2014 the H@H service was expanded from its existing 8am-6pm 7 day per week service to include 6pm-12MN 7 days per week for a period of 3 months. This expansion was funded by the CCG as a result of a successful bid for winter pressures money.

The overall numbers of patients receiving care increased significantly as a result of this pilot expansion. Patients who were referred during the out of hours period for crisis intervention or terminal care then required on-going support into the daytime and it became apparent early in the pilot that increased levels of staffing were required during daytime period would be required to support the ongoing care of patients.

In order to maintain the current levels of activity, whilst maintaining our high standard of care provided, the substantive staffing within the H@H will need to be increased.

How will this priority be achieved?

As a follow on from the pilot expansion a business case/proposal has been submitted to the CCG in an attempt to secure ‘Better care Fund’ monies for the future funding of an expanded H@H service. Approval of the bid will be required before any expansion will be undertaken, and before any staff recruitment would take place.

The Chief Executive, Medical Director and Director of Clinical Services are working closely with the Lead Commissioner for End of Life Care to secure funding for the future and agree activity/performance metrics.

How will progress be monitored and reported?

The proposal submitted to the CCG indicates clear performance metrics that would be submitted to the CCG and the Hospice Board of Trustees to outline key quantitative measures. This will also include the identification and reporting of quality measures such as percentage of patients who die in their preferred pace of care and also feedback questionnaire information from patients and families/carers/community health professionals.

Regular reporting will be undertaken to the Board of Trustees via board papers and discussion at the quarterly Service Development meeting scheduled within the Hospice, and chaired by a member of the Board of Trustees.

| Partnership working – Improving care for patients with a non-cancer diagnosis |

Why was this identified as a priority?

Currently the proportion of patients cared for in the hospice with a cancer diagnosis is 89%. The aim of the hospice is to care for any patient with a progressive life-limiting illness, and therefore a large proportion of patients with a non-cancer illness are not currently accessing our services. Such conditions may include heart failure, kidney failure, advanced bronchitis and emphysema and neurological conditions such as motor neurone disease.
One of the problems in accessing specialist palliative care for non-cancerous conditions is it can be difficult to identify those who may be nearing the end stages of their illness, especially when their illness can progress over many years. By working with other specialist teams to identify those who may benefit from our services we can then develop effective ways of supporting the patients though their illness.

**How will this priority be achieved?**

With better partnership working in the community and hospital we can work alongside other specialists to identify and support patients with a non-cancer diagnosis. Initial proposals are for a new joint cardiology/heart failure MDT meeting and the development of a monthly motor neurone disease team meeting and clinic with palliative care input.

**How will progress be monitored and reported?**

Hospice activity figures and patient demographic data with reporting to the Executive Management team and Board

2.3 Clinical Effectiveness

| Preparation for a research ‘ready’ hospice |

**Why was this identified as a priority?**

In October 2013 the Help the Hospices published “Research in Palliative Care: can hospices afford not to be involved?” as part of its Commission into the Future of Hospice Care. This paper highlights the need for high quality research into caring for patients and relatives at the end of life, set against a backdrop of many UK hospices having a limited understanding of current research and its implications. There are drives both nationally and locally for higher quality research to be co-ordinated by experts and conducted with larger numbers of patients in multiple care settings.

Regionally there are now two Chairs (Professors) in Palliative Care who are looking to enhance the strength and breadth of palliative care research, along with improved links with The University of York and Hull-York Medical School. This gives St Leonards Hospice a great opportunity to participate in clinical research and help drive up the quality of patient care.

**How will this priority be achieved?**

The Research Framework for Hospices published in 2012 provides guidance on how hospices should prepare and engage with clinical research. This begins with an enhanced level of awareness of research in all professional staff, followed by engagement in research generated by other external bodies (e.g. Universities or Hospital Trusts). Finally hospices can aspire to lead and develop their own research projects both in the hospice and other organisations.
In order to prepare the hospice for becoming more active in research design and participation we will ensure the following steps are taken:

- Incorporating research governance into current clinical governance structures to ensure any proposed research activity scrutinised and approved if deemed to benefit patient care
- Ensuring the hospice has access to a full range of electronic journals and text books to read and evaluate current published research, in addition to its existing library facilities
- Identify hospice staff and volunteers who wish to become more involved in research and set up a 'journal club' to review current research literature as part of on-going education programmes.

**How will progress be monitored and reported?**

Any proposed research activity will be reported via the hospice clinical governance committee which feeds ultimately into the Hospice Board of Trustees. All current and proposed activity will be monitored by the hospice Medical Director to ensure it is running smoothly and all outcomes will be shared with staff, patients and carers as appropriate.

All proposed improvements to the hospice library and access to journals must be costed and approved by the hospice Executive Management Team.

Research activity will be reported annually both in the hospice Annual General Meeting and Board meeting papers, along with future NHS Quality Accounts.

**Statement of Assurance From the Board**

The following are statements that all providers of healthcare must include in their Quality Account. Many of the statements are not directly applicable to a specialist palliative care providers and therefore explanations of what these statements mean are also given.

**Review of Services (Mandatory Statement)**

During 2013/14 St Leonard’s Hospice has provided for the NHS:

- In-Patient Care
- Daycare services
- Lymphoedema services – out-patient review and treatments
- Family Support and bereavement services – pre and post bereavement support
- Hospice@Home services
- Complementary therapies

**What this Means**

St Leonard’s Hospice is currently funded through a combination of an NHS grant and fundraising activity. The grant that is allocated from the VoYCCG represents approximately 27% of the Hospices’ total income.
The value of grant received by St Leonard’s Hospice from the NHS means that the services provided are substantially funded from charitable funds. The remaining income is generated through the Hospice retail outlets, community fundraising events, lottery activity and legacies.

Participation in Clinical Audit (Mandatory Statement)

During the year 2013-14, St Leonard’s Hospice was not eligible to participate in any national clinical audits or national confidential enquiries.

What this means

St Leonard’s Hospice has not been eligible to participate in any National audit or National Confidential enquiries because it is a provider of specialist palliative care. There were no audits or enquiries on a National level that examined specialist palliative care services.

At the time of writing the Quality Account St Leonard’s Hospice is not intending to participate in any national confidential enquiries for the same reason.

During 2013/14 St Leonard’s Hospice participated as a pilot site for the National Palliative Care Funding Review. This work was completed in March 2014 with a total of 5 hospices, 2 acute hospitals and 6 community teams providing data on care on a total of 950 patient ‘spells’ in North Yorkshire. This information was fed back to the Department of Health along with data from other pilot site areas to consider if a national tariff for palliative care services can be developed. The Department of Health is due to report on their proposals this summer.

A rolling programme of audit projects has been developed by the Medical Director and Director of Clinical Services to ensure all aspects of patient care are assessed against set standards. This will enable to hospice to keep track on current clinical care and compare our results against previous performances and other organisations where possible.

Audit tools developed by Help the Hospices and supported by the Kairos electronic audit system will continue to be utilised. Results from St Leonard’s Hospice will be benchmarked against peer organisations from around the Yorkshire region. Results are reported through the Hospice Governance structure.

The End of Life Care Pathway was reviewed in 2013 following the Neuberger report into the Liverpool Care Pathway. This was revised and re-implemented as a care plan and audit of the success of that document was undertaken in June 2013. The hospice continues to use this care plan for those thought to be in the last days of life and will await any further guidance from national bodies e.g. NICE.

Prescribing Standards Audit

Monthly audit of standards of medicine prescribing indicate a high standard of documentation. Generally prescribing standards are excellent, and the audits have not identified areas for immediate concern.
Research

The number of patients receiving services from St Leonard’s Hospice in 2013/14 that were recruited during that period to participate in research approved by a research ethics committee was zero.

NHS Quality Improvement and Innovation Goals (Mandatory Statement)

The grant received by St Leonard’s Hospice was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework (CQUINS).

What this means

As a third sector/voluntary organisation St Leonard’s Hospice was not eligible to participate in the CQUINS payment scheme during the reporting period.

We do produce activity figures for the PCT that are required as a condition of the grant received. Over a full year in-patient unit occupancy is required to average over 70%.

The Programme of internal audit that was undertaken during the reporting period outlines quality improvement standards set within the Hospice and is submitted to the Care Quality Commission during inspection.

What others say about us (Mandatory Statement)

St Leonard’s Hospice employs 151 members of staff across the main Hospice site and the retail outlets. During 2013/14 there were 14 staff leavers and 28 new recruits. In addition to this there are approximately 470 volunteers who give time to the various departments within the Hospice and retail outlets.

St Leonards Hospice is required to be registered with the Care Quality Commission (CQC). The current registration is as a provider of the following services:

1. Nursing Care

Terms of this registration relating to carrying out this regulated activity

The Registered Provider must ensure that the regulated activity nursing care is managed by an individual who is registered as a manager in respect of the activity, as carried on at or from St Leonard’s Hospice.

2. Treatment of Disease, Disorder or Injury

Terms of this registration relating to carrying out this regulated activity

The Registered Provider must ensure that the regulated activity treatment of disease, disorder or injury is managed by an individual who is registered as a manager in respect of the activity, as carried on at or from the location St Leonard’s Hospice.
3. Diagnostic and Screening Procedures

Terms of this registration relating to carrying out this regulated activity
The Registered Provider must ensure that the regulated activity diagnostic and screening procedures are managed by an individual who is registered as a manager in respect of the activity, as carried on at or from St Leonard’s Hospice.

4. Personal Care

Terms of this registration relating to carrying out this regulated activity
The Registered Provider must ensure that the regulated activity personal care is managed by an individual who is registered as a manager in respect of the activity, as carried on at or from St Leonard’s Hospice.

In addition to the terms of registration outlined above St Leonard’s Hospice can accommodate up to a maximum of 20 patients on the in-patient unit and a maximum 14 patients within the Daycare unit each day.

The CQC has not taken any enforcement action against St Leonard’s Hospice during 2013/14.

St Leonard’s Hospice has not participated in any special reviews or investigations by the CQC during the reporting period 2013/14.

During 2013/14 St Leonards Hospice volunteered as a pilot site the first wave of inspections carried out under the revised inspection framework. An unannounced inspection took place on 29th April 2014. No formal report or performance rating has been received by the Hospice at the time of writing this report.

The inspection was based on the new CQC Inspection Framework and focussed on the five Key Lines of Enquiry (KLOE):

- Safe
- Effective
- Caring
- Responsive
- Well Led
During 2013/14 St Leonards Hospice was subject to an inspection of the Hospice@Home service. This was the first time the service had been inspected and it was found to be meeting the essential standards of care for the outcomes that were assessed. The inspection was announced with 48 hours’ notice to the Registered Manager and the inspection took place in December 2013.

The outcomes assessed during the visit were:

- 02 Consent to care and treatment
- 04 Care and welfare of people who use the service
- 08 Cleanliness and infection control
- 12 Requirements relating to workers
- 17 Complaints

Feedback to CQC Inspector from Health Professionals

“The service works really well with the patient and their family”

“The service is quick to act and reports back updates and other relevant information promptly and effectively”

“The service works very well with other professionals. They (the staff) provide really good care and they keep us up to date with the patients’ current health position”

Feedback to CQC Inspector from Families

“The care my relative received was fantastic … worldclass”

“My relative wants to die at home in their own bed and Hospice@Home are letting that happen. We are so grateful”

“They (the staff) treat my mum like she’s their own mum”
Data Quality (Mandatory Statement)

St Leonard’s Hospice did not submit records during 2012/13 to the Secondary Users service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

What this means

As a specialist palliative care unit St Leonard’s Hospice is not eligible to participate in submission of data to the Secondary Users Service for inclusion in the Hospital Episode Statistics.

St Leonard’s Hospice has a system in place for monitoring the quality of data through the use of the electronic information system SystmOne.

With the patient’s consent we share data with other relevant health professionals to support the care of patients in the community and acute hospitals.

St Leonard’s Hospice normally submits a National Minimum Dataset (MDS) to the National Council for Palliative Care. This year however due to changes in IT systems and reporting mechanisms the hospice decided not to submit these figures.

St Leonard’s Hospice has continued to provide monthly and quarterly activity data to the local CCG.

St Leonard’s Hospices score for 2012/13 for quality and Records Management was not assessed using the Information Governance Toolkit. This toolkit is not applicable to palliative care but this is an area that the Hospice will continue to develop as stated in our forthcoming quality measures.

Clinical Coding Error Rate

St Leonard’s Hospice was not subject to the payment by results clinical coding audit during 2012/13 by the Audit Commission. This is because St Leonard’s Hospice receives payment under a block grant system and not through tariff and therefore clinical coding is not relevant.

Part Three

Review of Quality Performance

This section of the account will present the information for St Leonard’s Hospice. This is in keeping with the activity data collected nationally on Hospice activity as part of the Minimum Data Set (MDS).
### Inpatient Unit Services

<table>
<thead>
<tr>
<th></th>
<th>2012/13</th>
<th>National Figures for 2012/13 (median)</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number of patients</td>
<td>298</td>
<td>366</td>
<td>332</td>
</tr>
<tr>
<td>% new patients</td>
<td>79 %</td>
<td>88 %</td>
<td>79 %</td>
</tr>
<tr>
<td>% re-referred patients</td>
<td>4.7 %</td>
<td>6.0 %</td>
<td>20 %</td>
</tr>
<tr>
<td>% Occupancy</td>
<td>78 %</td>
<td>79 %</td>
<td>74 %</td>
</tr>
<tr>
<td>% patients returning home</td>
<td>35 %</td>
<td>38 %</td>
<td>43 %</td>
</tr>
<tr>
<td>Average length of stay- cancer patients</td>
<td>18 days</td>
<td>15 days</td>
<td>15 days</td>
</tr>
<tr>
<td>Average length of stay – non-cancer patients</td>
<td>13 days</td>
<td>13 days</td>
<td>13 days</td>
</tr>
</tbody>
</table>

For the purpose of comparison with National figures St Leonard’s Hospice is in the category large Hospice (over 16 beds)

The number of patients treated on the IPU has remained relatively unchanged since 2012/13 and is consistent with the National median figures for 2012/13.

The numbers of patients being discharged home has increased significantly and is now above the national average. This may be due to a more pro-active approach taken by our dedicated discharge facilitators to enable patients to be discharged back to their preferred place of care.

### Day Care Services

<table>
<thead>
<tr>
<th></th>
<th>2012/13</th>
<th>National Figures for 2012/13 (median)</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of patients</td>
<td>148</td>
<td>140</td>
<td>152</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-----</td>
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<td>-----</td>
</tr>
<tr>
<td>% new patients</td>
<td>61.5%</td>
<td>63.2%</td>
<td>70%</td>
</tr>
<tr>
<td>% places booked but not used</td>
<td>24.6%</td>
<td>28.1%</td>
<td>27.9%</td>
</tr>
</tbody>
</table>

For the purpose of comparison with National figures St Leonard’s Hospice is in the category medium size (between 126 and 179 patients)

2013/14 saw a static number of patients attending Day Care at St Leonard’s Hospice as compared to 2012/13.

There is a general feeling that the patients attending Day Care are more dependent and are being referred for care later in the disease process, this may be an explanation of why the number of cancelled sessions is increasing. There was also a period over winter when Day Care was shut for refurbishment.

Only a few patients are currently discharged from Day Care as the model at St Leonard’s is a social Day Care model. This number has however increased with the introduction of MDT meetings. Over the next year it is anticipated that there will be further adjustments to the model of delivery, with a greater emphasis on medical supervision and outpatient drop-in sessions.

**Hospice@Home Service**

<table>
<thead>
<tr>
<th>Total number of patients</th>
<th>2012/13</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>171</td>
<td>290</td>
</tr>
</tbody>
</table>

**Note:** For the purpose of comparison with National figures St Leonard’s Hospice has been benchmarked in the small category (fewer than 129 patients) – this requires amendment for future years.

The St Leonard’s Hospice @ Home service has continued to increase service provision; however it continues to be felt that there is scope for further development. This is due to a combination of on-going factors that are being dealt with by senior managers from both the Hospice and the wider community services.
There had been a trend since 2011/12 for an increase in requests for unregistered nurse support – this does not reflect the way the service was set up, however careful monitoring of referral patterns is required to ensure that the service meets the patient demand and requirements and the workforce develops to reflect this.

The large variance between national data and the local average length of care episode will reflect the variance in referral criteria to Hospice @ Home services.

A lack of consistent approach to utilising SystmOne to collect activity data makes extraction of data for MDS reporting very difficult and this year we are not in a position to submit as much data as we had hoped. This situation will be improved with training and improved access for staff over the year 2013/14.

**Bereavement Services**

<table>
<thead>
<tr>
<th></th>
<th>2012/13</th>
<th>National Figures for 2012/13 (median)</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total service users (cases closed in year)</td>
<td>591</td>
<td>486</td>
<td>305</td>
</tr>
<tr>
<td>Average length of support (days)</td>
<td>341.9</td>
<td>151.5</td>
<td>89</td>
</tr>
</tbody>
</table>

**Note:** For the purpose of comparison with National figures St Leonard’s Hospice is in the category large service (more than 300 patients)

The outstanding observation from the data presented for bereavement services relates to the large difference in figures submitted for 2013/14 compared to 2012/13. There has been no change to service specification in this time and therefore the assumption that is being made is that the counting and data submission method must have changed within the period. Further analysis is currently being done in relation to this to ensure that information and data supplied in the future is consistent and accurate.

A review of the bereavement service is currently underway at St Leonard’s Hospice. It is of particular importance that the service is reviewed since bereavement services are currently not included in the proposed changes to palliative care funding and therefore going forward is likely to be a service funded purely by charitable donations.

Currently the service provides a luncheon club for people who are being supported that encourages people to remain in contact with their supporter up to and including the
anniversary of the death of their family member. This could be one explanation for the length of support time. Another explanation may be that the service is supported by volunteers who may perhaps be more reluctant to 'discharge' people they are supporting, although this is purely a hypothesis and further work is clearly required in this area.

Quality markers we have chosen to measure

Complaints

In addition to the limited amount of quality data submitted as part of the minimum data set, St Leonard’s Hospice also monitors the number of complaints received by the service as a measure of quality.

During the period 2013/14 St Leonard’s Hospice received no formal written complaints.

No complaints were received by the CQC or the CCG in relation to the care of patients at St Leonard’s Hospice.

Patient Safety Indicators

<table>
<thead>
<tr>
<th></th>
<th>2012/13</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patient slips, trips and falls</td>
<td>64</td>
<td>59</td>
</tr>
<tr>
<td>Number of falls resulting in fracture</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Number of patients who were admitted with pressure ulcers reportable to the CQC</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Number of patients who develop pressure ulcers in our care</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Number of patients who developed a healthcare acquired infection in our care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. MRSA</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2. Clostridium difficile infection</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Responses to St Leonard’s Hospice Quality Account 2014/15:

**Healthwatch York**

Thank you for giving Healthwatch York the opportunity to review and comment on your Quality Account. We found the document to be clearly presented and easy to understand.

The progress you have made on your priorities for improving patient experience is very good and clearly demonstrates your commitment to putting patients at the heart of your services. In particular we congratulate you on the excellent feedback you have received from patients, families and carers.

It was encouraging to see that St Leonard’s partnership work with the Vale of York Clinical Commissioning Group (CCG) led to the expansion of the Hospice@Home service, giving more patients choice over their preferred place of care. The positive feedback to the Care Quality Commission (CQC) during their inspection shows that Hospice@Home is working well and is highly valued. We hope you are successful in securing future funding for this service.

We are pleased to see that the effective communication and co-ordination of patient information has been identified as a priority for patient safety, and work on improving the integration of computerised patient records is continuing in 2014/15.

We look forward to any opportunities to work with St Leonards in the coming year.

**Vale of York Clinical Commissioning Group**

NHS Vale of York Clinical Commissioning Group is the lead Commissioner for St Leonard’s Hospice and I am pleased to be able to review and comment on the Quality Account for 2014/15.

The Quality Account provides a clear and concise summary of the invaluable work of the staff and volunteers at St Leonard’s Hospice over the past 12 months and the CCG is especially pleased to note the following achievements:-

- Improving holistic care of patients by increasing the amount of time nurses are able to spend on direct patient care through changes in documentation practices, medicines administration and shift patterns.
- Results from the national audit undertaken the Association of Palliative Medicine stated that 90% of bereaved relatives, who were asked about how they felt their loved one was cared for in the last days of life, were either satisfied or very satisfied with aspects of care including being treated with dignity and respect and management of symptoms.
- Expansion of the Hospice@Home Service.
- Very positive Care Quality Commission report in December 2013.
- During the period 2013/14 St Leonard’s Hospice received no formal complaints.

The priorities identified in the Quality Account for 2014/15 clearly identify and focus on the three elements of quality:

**Patient Safety**
• Co-ordination and communication of patient care through computerised patient records

Patient Experience
• Expansion of the Hospice@Home Service to provide care 7 days per week

Clinical Effectiveness
• Preparation for a research ‘ready’ hospice focusing on Palliative Care

As the Quality Lead for Vale of York Clinical Commissioning Group I commend this Quality Account for its accuracy, honesty, and openness. I recognise that St Leonard’s delivers good quality palliative and end of life care for patients, and I look forward to working with the hospice to bring about further service developments and improvements in quality during 2014.

Lucy Botting
Chief Nurse
NHS Vale of York Clinical Commissioning Group

The East Riding of Yorkshire Clinical Commissioning Group

The East Riding of Yorkshire CCG Commissioner provide an annual grant in the region of £21,000 to St Leonards Hospice, we appreciate the opportunity to comment on the quality accounts. We are supportive of the priority areas identified by the hospice and the continued focus on improving patient experience. It is encouraging to see the Hospice’s commitment to partnership working and the continuous review of the services offered in line with patient need. The emphasis on patient safety in relation to the Francis report is promising and the continued work to underpin this.

The information in relation to research is positive and how the hospice is becoming more active in research design and participation in research projects.

The CQC inspection has been acknowledged within the report and it is encouraging to see that the hospice was found to be meeting the essential standards of care for the outcomes that were assessed.

Commissioners can confirm that to the best of our knowledge, the report is a true and accurate reflection of the quality of care delivered by St Leonard’s Hospice and the data and information contained in the report is accurate. The Clinical Commissioning Group is looking forward to working with the Hospice in the future to improve the quality of services available for our patients and continually improve the patient experience.

Johanne S Evans
Head of Community Care Development
East Riding of Yorkshire Clinical Commissioning Group