Quality Account

2011/2012

Part 1

Chief Executive's Statement

On behalf of the Board of Trustees, I would like to thank all of our staff and volunteers for their hard work and achievements over the past year. The provision of high quality care is paramount. It is the basis of our reputation and the financial support we receive from the NHS and the public.

The Operational Management Board is responsible for the preparation of this report and its contents. To the best of my knowledge, the information reported in this Quality Account is an accurate and fair representation of the quality of healthcare services provided by Pilgrims Hospices in East Kent.

Steve Auty
Chief Executive

Part 2

Pilgrims Hospices has declared itself compliant as part of the registration process with the Quality Care Commission to comply with the Health and Social Care Act 2008 and the CQC regulations 2009.

As part of the routine schedule of planned reviews our Canterbury Hospice was visited on 5th March 2012. The CQC report found Canterbury to be compliant against all outcomes reviewed.

Part 2.1

2.1 Priorities for improvement 2012/2013

The Board constantly reviews hospice activity to ensure that it is delivering increasing public benefit and value for money. For 2011/12, the following priorities have been agreed:

1. To pilot and develop a single point of access for people at the end of their lives thus ensuring they are provided with the right care at the right time and are supported to die in their place of choice. It will also make more efficient use of existing health and social services and resources at a time of increasing demand and reducing available budgets.

2. Develop outpatient service for patient for first assessment, follow up and symptom management. Link patient waiting into access to other complimentary services. Develop associated outpatient services. Counselling, Social Work, Complementary Therapy, Physiotherapy.

3. Develop new ways of delivering community services. Design and develop improved GSF support to practices, with regular associated meeting and joint visiting/clinics. Take a more interactive approach to referrals, consider the outcomes required and the needs of the patient/carer. Identify suitable approach and offer this being more directive to the primary carer rather than an unclear support action. Drive/influence early referrals to services by stakeholders and increase End Of Life care packages provided by hospice.

2.2 Feedback on the priorities for improvement 2010/2011

1. To increase the utilisation of our day services by improving access, extending choice and meeting individual needs.

Day Hospice services have continued to develop throughout the year. The is real evidence of how all sites have been creative in developing and improving access as well as responsive to patients needs, examples are -

- Development of a Day Hospice/Family Service outreach in both Deal and Dover
- Music for Health sessions are held monthly and are open to all
- Registered with the Kent Libraries Reminiscence Project and use of materials to promote discussions
- Pamper afternoons for patients and carers led by a qualified make up artist
- Introduction of an Occupational Therapist who is available to see patients in day hospice
- Attendance at KCH Oncology department every six to eight weeks to provide information and offer hand massage to attending patients as a way of raising Pilgrims Hospice profile and reducing potential resistance
- The Introduction of gym facilities to encourage some rehabilitation techniques and maintain a patient's physical abilities
- A ' Buddy service' had been established with the aim of supporting patients/carers throughout all elements of hospice care. Several buddies are in operation currently. This is a project being reviewed at present by both FSMs Maureen Griffin and Annie Hogben.

2. To raise awareness of our services with healthcare professionals and the public.
To continue to raise awareness of our services with healthcare professionals and the public. One of the key messages being that the hospices exist for all patients with a terminal condition, not solely cancer patients. This will build from the successful launch of the awareness campaign last year.

In April 2012, Pilgrims Hospices published the first edition of a newspaper supplement, included with Kent Messenger Group newspapers circulating in east Kent. This had the aim of reaching not only its supporters but informing a new audience about its services and fundraising work. A second supplement is due for publication in September.

Growing use of social networking sites such as Twitter and Facebook has enabled Pilgrims Hospices to build up a steady following and more work will continue to promote its events and services by these means as well as its own website.

The launch of the 24 hour service line and the associated changes in service delivery to patients will be actively supported during the coming year.

Work is ongoing to improve communication with the public via the shops, ensuring fundraising and services are actively promoted through the outlets.

3. In line with the End of Life Care Strategy, local commissioning intentions and the Hospice Plan we will be exploring how the hospice can bring improvements for patients with regards to a role in coordinating care.
This objective has been formalised into 'Project Invicta'. The fundamental aim is to facilitate the local healthcare economy to become coordinated in its delivery of responsive, high quality End of Life Care.

4. Following the appointment of a new Education and Training Manager, our education strategy will be reviewed with a view to providing comprehensive, continuing development for our own staff and offering opportunities for professionals across east Kent to develop their knowledge and skills in palliative and end of life care.

The new Education and Training Strategy was published in September 2011, setting out the direction of development, together with a new Education and Training policy.

A rolling programme of both statutory and mandatory training has been in place since August 2011, with sessions taking place regularly at each site, offering greater flexibility and opportunity for attendance across the organisation.

Efforts to improve reporting have resulted in a joint project with the Human Resources department to link training completions with staff records. This has only recently taken place and the Education and Training department is in the process of developing the system to best fit recording and reporting requirements of the organization.

2.3 Statements of assurance from the board relating to quality of NHS services provided

The following are a series of statements that all providers must include in their Quality Account. (Not all of these statements are directly applicable to specialist palliative care, including hospices, providers.)

Review of services

During 2011/12 the Pilgrims Hospices in East Kent (PHEK) provided the following services (based on 3 sites: Canterbury, Ashford, Margate):

- In-Patient Units
- Day hospice, including Living for Today programmes
- Outpatients
- Community Palliative Care Nurse Specialist Service
- Rapid response Hospice at Home Service

Pilgrims Hospices has reviewed all the data available to them on the quality of care in all of these services.

The income generated by the NHS services reviewed in 2011/12 represents 27 per cent of the total income required to provide the services which were delivered by PHEK in the reporting period 2010/11.

Participation in clinical audits

National audits and confidential enquiries

During 2011/12, no national clinical audits and no national confidential enquiries covered NHS services that PHEK provides. The PHEK only provides palliative care. Therefore, during that period, the PHEK was not eligible to participate in any national clinical audits or national confidential enquiries. As the PHEK was ineligible to participate in the national clinical audits and national confidential enquiries, there is no list below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of the audit or enquiry.

Local clinical audits

Feedback on local audit implementation during 2011/12

The following audits were reported in the 2011 Quality Account and the outcomes have been implemented as follows:

Infection Control

The audit in this period at each hospice demonstrated the value of cleaning supervisors who raised the standard of cleanliness across the three sites. This happened later in Canterbury so two audits took place in the period to monitor the improvements. Issues such as dirty fans are now a thing of the past. Two new areas of audit became available from the National Audit Tools Group (NATG) who provide the audit tools covering public areas and offices adjacent to patient areas so this will be the focus in the coming 12 months.

Mattresses

While the audit, as always, achieved its purpose of identifying and replacing inadequate stock, the method of audit has changed so that clinical or cleaning staff who replace mattresses after use audit them, then clean or replace all or part of the stock as necessary.

Accountable Officer for Controlled Drugs

The Accountable Officer's oversight is audited annually using the NATG Tool. Oversight is sound. The relevant CQC reports remain to be submitted by the new registered providers when they receive confirmation of their appointment

Controlled Drugs (NATG Audit)

In all controlled drug registers, procurement books and records the habit of crossing out rather than bracketing errors needs to be improved. Apart from this, controlled drugs are well managed by staff at all three sites.

Patient Preference Audits

The auditing of patient preference has been superseded by research into our Hospice at Home service and monitoring of preference recording is part of the research which will be concluded this September and published.

Use of sedation

Guidance on the use of sedation has been reviewed for clinical staff.

Bereavement risk assessment

Bereavement risk/needs training has taken place following a rationalisation of the recording in the medical software (Infoflex). The accuracy of recording levels of risk is quite high and the next step is to audit bereavement support follow up.

Completed Local Audits in 2010/11			
Audit Title	**Sample size and method**	**Participation**	**Recommendations**
Liverpool Care Pathway	The Case notes of 10 consecutive deaths of inpatients in reverse chronological order from 30th June 2010 on the Liverpool Care Pathway from each hospice extracted from Infoflex medical software	All three sites	Exploration of the reasons underlying missing data and a plan for sustained improvement is required. Continued re-audit
Anti-secretories Usage	All the patients who died in the inpatient unit between January and May 2011 (n=72)	Ashford Hospice	Improve documentation regarding: **a.** Re-positioning or gentle suctioning of patient experiencing secretions **b.** Re-assuring the family regarding distressing noises The use of glycopyrronium should continue
Steroid management	Enough inpatients discharged to provide data on min 30 with dexamethasone from 3rd April 2011 in reverse chronological order	Ashford Hospice	Introduction of: • steroid card • space for steroids in the drug chart • re-audit in 1 year
Management Of Peripheral Intravenous Cannulae	The documentation relating to 10 consecutive intravenous cannula insertions was recorded. Ward staff were blinded to this to minimise observation bias. The documentation for each cannula was assessed retrospectively against the	Canterbury Hospice	New documentation created: • Peripheral Cannula Insertion Record (PCIR) • Infusion prescription sheet • Meetings at all three hospice sites for feedback on project and documentation • Two month trial (July & August 2011) of agreed documentation

Completed Local Audits in 2010/11			
	standards using a data collection proforma		
Management Of Peripheral Intravenous Cannulae (re-audit	Over 6 weeks, all cannula insertions across the three hospice sites were recorded by the respective Speciality Registrars. These were again assessed retrospectively, as in the baseline audit.	All three sites	• Design documentation and educate nurses and doctors on updated guidance for care of cannulas/IV lines and required documentation. • Order updated cannula packs. • Re-audit • Decide whether documentation would be paper or infoflex
Patient allergies to prescribing	Inpatients between 1st April and 31st July 2011 entries on Prescriptions Charts and Infoflex for allergies/sensitivities	Thanet Hospice	Patient allergy status must be checked by the admitting doctor and/or nurse/HCA then recorded on the prescription chart and updated on infoflex. Highlight to staff the need to record allergies, the standard procedure that should be followed. Nurses not to administer medicines unless something is written in the allergy box (allergy or NKDA). When checking the allergy box if nothing is written confirm allergies with the patient. Treat an empty Prescription Chart Allergy Box and/or allergy Sensitivity Infoflex Box as a clinical incident and fill out an error form.
Patients entering the service	Infoflex referral data identifies all patients who have not had a first encounter. Records indicating those who have not had the first encounter have declined the service or died within 2 or 5 days depending on the referral. Patients who have been referred from 1st August 2011 for three successive months	Thanet Hospice	Audit finding made available to Project Invicta team as the referral process will change in the near future.

*NATG refers to the National Audit Tools Group sponsored by Help the Hospices that produces audit tools for Hospice Inpatient and Day care units. Community Tools are also under development.

Research

The number of patients receiving NHS services provided or sub-contracted by PHEK in the period 1 April 2011 – 31 March 2012 who were recruited during that period to take part in research approved by a research ethics committee was 298.

National cross-cutting projects and initiatives aimed at improving quality – Pilgrims Hospices activity in National Portfolio Research studies:

Dr Claire Butler (Consultant and Director of Medicine and Research) is the chief investigator for a research project funded by the NHS, Research for Patient Benefit scheme (PB-PG-0808-16126). This evaluation of Pilgrims Hospices Rapid Response Hospice at Home Service is running over 35 months from 1st December 2009 (a six month, no cost extension was agreed in April 2012). The research is being delivered by a team from the PHEK and the Centre for Health Services Studies at the University of Kent. The project has received ethics approval and is under the research governance systems of the East Kent Hospitals University NHS Foundation Trust.

The research has benefitted immeasurably from the support and input of a group of service users who have helped to shape and feedback on the research.

Other National Portfolio research studies

Pilgrims is screening patients (provided they are under a Consultant Oncologist) for participation in recruitment to national portfolio study:
Modafinil for the Treatment of Fatigue in Advanced Lung Cancer
Eudract Number: 2008-006486-88; Protocol Number: Modafinil/lung/01.
The study has closed to recruitment and we have successfully recruited eight to the trial.
The study aims to report in the coming months.

A further portfolio study Pilgrims is joining in the Spring of 2012 is: A randomised trial of high versus low intensity training in breathing techniques for breathlessness in patients with malignant lung disease: early intervention
Short Title: SOB:LC II: Shortness of Breath in Lung Cancer
ISRCTN49387307
REC Ref. No: 10/H1308/66
R&D Ref: 2012/PALL/03

Pilgrims Hospice Research Facilitation Forum

This group has been running since December 2008. It meets approximately quarterly with email communication in between.

It provides a research governance function for the organisation in addition to encouraging and facilitating research.

During the period of this report, research activity at Pilgrims has been growing steadily.

Summary of published audit/research/completed MSc dissertations 2011/12 (Pilgrims staff highlighted in bold)

<u>Peer reviewed journal publications</u>

McCartney A, **Butler C**, Acreman S. Exploring access to rehabilitation services from allied health professionals for patients with primary high-grade brain tumours. Palliative Medicine, December 2011, 25(8):788-796

Cawley D and Pinnock H. Palliative Care in Chronic Obstructive Pulmonary Disease. European Respiratory Journal March 2012

Posters presented at the European Association for Palliative Care Congress.
Lisbon May 2011

Cawley D, Marshall J, Dand P. Is the pen mightier than the sword?
Prescribing PRN 'as required' medication.

Jeyakumar J, Henson L, Fleming J, Thorns A.
Palliative Care Patients' Attitudes to Participating in Research Trials

Lobo P, Newens P, Read P, **Fisher S**, Herndon G, **Thorns A**
A Comparison Audit of Patients Dying from Chronic Lung Disease in a Hospital and Specialist Palliative Care Unit.

Lobo P, Caulkin R, Osborne T, Thorns A
When is it acceptable for palliative patients to participate in clinical trials? A survey of palliative care professionals.

Thirukkumaran T, Thorns A. The Factors Influencing the Formulation of 'Clinical Prediction of Survival' in Advanced Cancer: An exploratory qualitative study of experienced palliative medicine physicians' views and experiences.

Posters presented at the 9th Palliative Care Congress March 2012

Comparing the use of Edmonton Symptom Assessment System (ESAS-r) in hospice & oncology outpatients
Subramaniam S, Burcombe R and **Cawley D**

An audit on 'death rattle' (noisy breathing at the end of life) and usage of antisecretory medication
Thirukumaran T, **Subramaniam S**, **Cawley D and Fisher S**

Comparison of management of noisy breathing at the end of life in two Hospices in the U.K.
Subramaniam S, Thirukumaran T, Cawley D, McGee H, Parker G and **Fisher S**

Audit on NHS fast tract applications: prognostic prediction & preferred place of care/death
Thirukkumaran T, Subramaniam T, de Nogla S, Cawley D and Fisher S

What others say about us

Statements from the CQC
Pilgrims Hospices is required to register with the Care Quality Commission (CQC) and has gained appropriate registration status agreed by the CQC. PHEK has no conditions imposed on its registration.

The Care Quality Commission has not taken any enforcement action against PHEK during 2011/12.

Pilgrims Hospices has not participated in any special reviews or investigations by the CQC during the reporting period.

Registered provider visits

As part of the requirements of CQC registration, the Chairman of Trustees undertakes an annual provider visit to each hospice.

The reports this year included the following statements:

I, Dr Richard Morey as chairman of the Board of Trustees undertook visits to all three Pilgrims sites on:

- 14th May 2012 Pilgrims Hospice Thanet
- 17th May 2012 Pilgrims Hospice Canterbury
- 23rd May 2012 Pilgrims Hospice Ashford

“I am able to report the building fabric is in good order in all three hospices.

General themes from all units

- There was enthusiasm for the coordination centre reorganization with a recognition that the aim of facilitating a fast efficient service to EoL patients 24/7 in their preferred place of care was correct.
- There was concern expressed as to whether the navigation centre would be able to cope with demand. Another aspect of concern was that the IT system, Infoflex, would be responsive enough to handle the call load. The way our counselling and chaplaincy services will fit into urgent assessments was discussed and it was mooted that there was some misunderstanding around the role of counselling in emergency situations.
- The recruitment of trainee advanced nurse practitioners has been disappointing but almost a full quota of palliative specialist nurses has been appointed. These concerns have been passed to the Project Board.
- The recent introduction of Hospice Managers for each unit with a new team comprising Manager, Consultant, Senior Nurse Manager and Family Services Manager was widely welcomed and felt to improve significantly rapid, responsive management decisions. The management teams were praised on all three sites for abilities and communication skills.
- Most staff felt well supported by line managers especially in terms of emotional support which is crucial in a hospice environment.
- The general impression is that work load has increased with inpatient occupancy well over 85% on many occasions and the attendance at the day centres had increased.
- The catering departments were commended by both patients and staff for excellent food and in particular their individual attention to patient requirements.
- There were some concerns from allied support staff that terms and conditions required attention, and a workforce job evaluation exercise is planned.
- It was felt by most clinicians that an overall Clinical Governance Committee (as existed before the management changes) should be reinstated.
- I noticed a much greater degree of flexibility with regard to patient demand, assessments and admissions with excellent coordination between the Rapid Response Hospice at Home Teams and the community and inpatient teams. Patients are being admitted at all times of the day and weekends and if they cannot be quickly accommodated the Hospice at Home service will assist. The rigidity of the past has evaporated.
- Patients, relatives and carers were generous in their praise of the care they were receiving and appreciative of the expert medical and nursing attention.
- Volunteers were content and pleased with the ability to relate to hospice managers when required. I encouraged them to use the online Pilgrims intranet to familiarise themselves with Pilgrim’s strategic plans and developments.
- The importance of continuity of patient care was stressed by a number of clinicians and some concern expressed because of the numbers of part time clinical staff that might run counter to this aim. The ownership of patients by staff is important and continuity of staff attendance at GSF meetings in GP surgeries is crucial. We must all have continuity as a high priority and work towards ways of maintaining and strengthening it.
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- The recent establishment of an OT service was much appreciated and it was felt this had facilitated a more efficient and rapid discharge system for patients when required.
- Clinicians were concerned that we must continue to develop our nurse skills and that nurse education by mentoring/apprenticing could be integrated into the new system.
- Social work assessments are often achieving fast track care packages which is a great advantage to our patients. A lack of space for the family service team at PHC is being addressed.
- A different approach to non cancer cases, especially COPD, was discussed and felt to be of importance.
- I noticed wonderful enthusiasm and team work in the day centres and great innovation especially in the field of art therapy with the use of iPads for painting.
- The expansion of complementary therapy is progressing well and many volunteer therapists are now working for Pilgrims. Reiki therapy is being pioneered at PHA.
- There may be a need for chiropody treatment provision.
- I was also encouraged by the provision of outreach services for example in Sandgate Road surgery and the Hawkinge House Nursing Home.
- I was pleased to hear about the Regift campaign to recycle unwanted gifts as a fundraising effort.

These visits are invigorating for me and offer a method of communicating the workings and vision of the Board of Trustees to many members of staff and volunteers. It is also an opportunity for me to thank these wonderfully committed people for their enthusiasm and hard work that establishes the reputation which is crucial to maintaining our charitable funding.

Dr Richard Morey, Chairman of the Trustees.

Quality improvement and innovation goals agreed with our commissioners

PHEK NHS income in 2011/12 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework.

An agreed framework for reporting performance to the commissioners is being implemented for the financial year 2012/13.

Data quality

In accordance with agreement with the Department of Health, the PHEK submits a National Minimum Dataset (MDS) to the National Council for Palliative Care. The PHEK provides the MDS to the local Primary Care Trust.

PHEK has been accredited and has maintained an N3 connection which required the satisfaction of 29 requirements which are specified in the NHS Information Governance toolkit for third party business partners which includes hospices.

The Payment by Results clinical coding system is not applicable to PHEK services.

Part 3

Review of Quality Performance

Clinical Governance system development to Integrated Governance system
An Integrated Governance process is now embedded within all hospices. Integrated governance operates weekly at each of the three hospice sites on a 12 week cycle.

The system:
• monitors the performance of the hospice ensuring excellence of care and a focus on patient safety
• provides direction for the operational strategy of the hospice
• integrates the hospice with internal and external organisations
• acts as a forum for local decisions.

The topics covered by the integrated governance cycle are as follows:

Clinical risk - To review all clinical incidents; To identify key risks, how they can be minimised and to identify learning; To identify and manage potential risks; To translate where necessary risk into policy or procedures to support the reduction of the identified risk.

Clinical practice - To ensure policies, procedures, guidelines and protocols are updated with regular audit to identify gaps in practice; To provide an ongoing assessment of the local audit programme and the impact on clinical/non clinical care.

Infection control and wound care management - To oversee the development and implementation of a hospice-wide plan to ensure all staff are updated and trained in infection control issues; To ensure that infection prevention and control are at the core of all hospice practice; To provide a forum for wound care management to be optimised within the hospice; To review issues and risks identified within our patient /carer group; To consider supportive equipment requirements and support ongoing wound care management.

Complaints and information governance -To formally review and report on all complaints; To extract and disseminate appropriate outcomes; To disseminate information changes or new rules; To ensure we are meeting the required standards for information governance; To review any concerns around information governance.

Medicines management - To review all medicines management issues/incidents; To identify key risks, how they can be minimised and to identify learning; To identify and manage potential future risks; To consider any recent MHRA/NPSA notices and confirm actions for these.

Spirituality and user focus - To ensure there are clear pathways to feedback on patients/family experience of care and learn from it; To ensure that existing and new services are responsive to patient and carer needs. Ensure that the holistic needs of staff and stakeholders are met.

Training and development - To devise, implement and monitor the hospice's training programme; To approve for the board staff applying for external training courses; To monitor appraisal performance.

Health and safety - To review and report on all health and safety issues relevant to the hospice premises, staff, patients and visitors.

Finance and operations - review and report on all patient activity and management accounts

Human Resource management - To review and report on all recruitment and retention activity and key HR issues; To ensure recruitment, management and retention of volunteers.

Marketing, communications and fundraising - To provide a platform to build the reputation and activity of the hospice within the local community; To ensure the hospice enables choice to patients and their carers while providing high quality care; To provide a platform to build the local fundraising requirements for the local hospice community; To provide a platform to patient/carer support groups as well as local fundraising within the local community. To ensure the hospice income is maximised with the fundraising teams having suitable support from clinicians and the senior management team in helping the wider community understand our core business.

Quality Report for Education & Training

For 2011/12 the education and training department identified gaps in the provision of mandatory and statutory training completions by site and staff group. A significant effort was put into providing the relevant training sessions and ensuring that staff attended.

Evidence suggests a vast improvement for training completions in several areas, including:
Infection Control, Induction Training, Infoflex training and Moving & Handling of people. Reviewing the progress from last year has highlighted the limitations of the current database systems in place for Education and Training to accurately record and report on staff training completions. We therefore are working with the Director of Finance and the IT department to identify a more effective database system, to ensure future reporting requirements are more easily met.

Patient Safety

Hospital acquired infections and outbreaks, 1st April 2011 to 31st March 2012

Pilgrims Hospice site	**Outbreak of infectious illness**	**MRSA**	**Clostridium difficile**	**E. coli bacteraemia**
Ashford	None	None	1 case - admitted from hospital, present upon admission	None
Canterbury	None	None	2 cases - both antigen positive, toxin negative	None
Thanet	None	None	None	None

Critical Incidents reported 1st April 2011 to 31st March 2012

	This reporting year	Last reported year for comparison
Patient accidents	172	135
Near Miss	0	0
Other Critical incidents	24	6

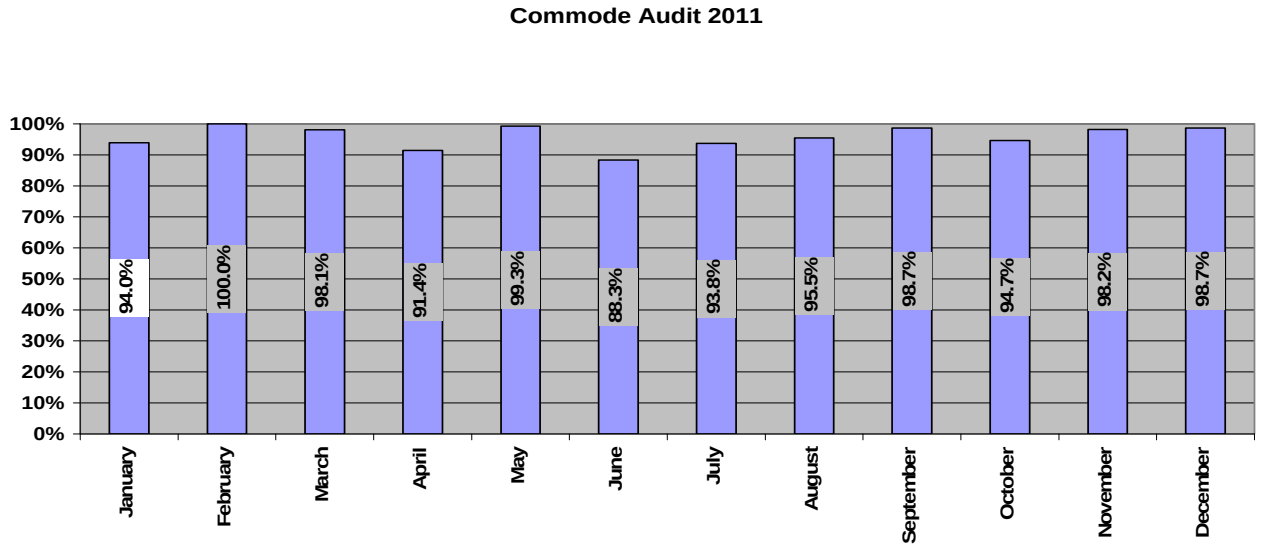
N.B. These data do not take account of occupancy levels

Patients near the end of their lives for whom quality of life and freedom of expression are important should not be unduly restrained. While some falls may well be unavoidable, it is incumbent on the organisation to prevent injury and loss of confidence to patients and distress to loved ones.

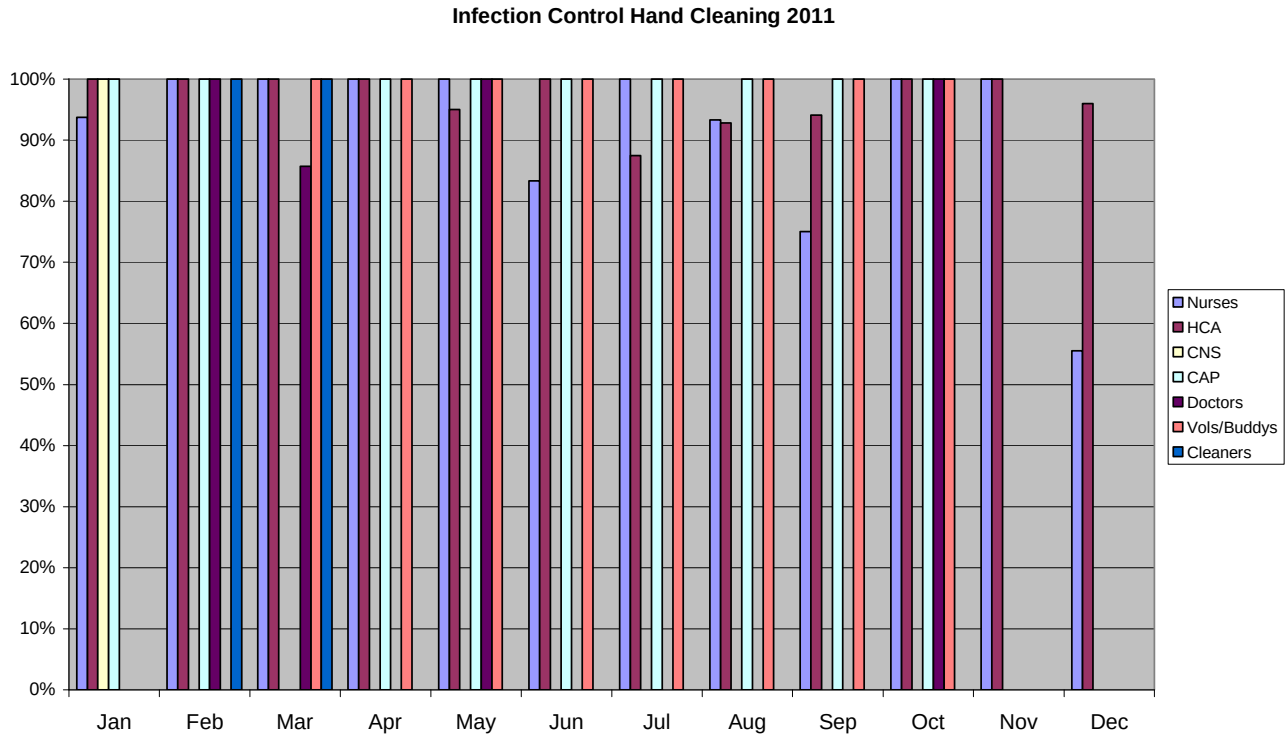
Medication incidents and errors on hospice inpatient units
During the period April 10 - end March 11 there were 0.4 errors per occupied bed per year reported to the Medicines Management Group (as compared with 1.45 in the previous year). This figure compares favourably with a benchmarking exercise undertaken in 2009 (see References below).

During the reporting period, we have been auditing some areas of particular importance to patient safety on a monthly basis.

Cleanliness of commodes



Staff hand-washing

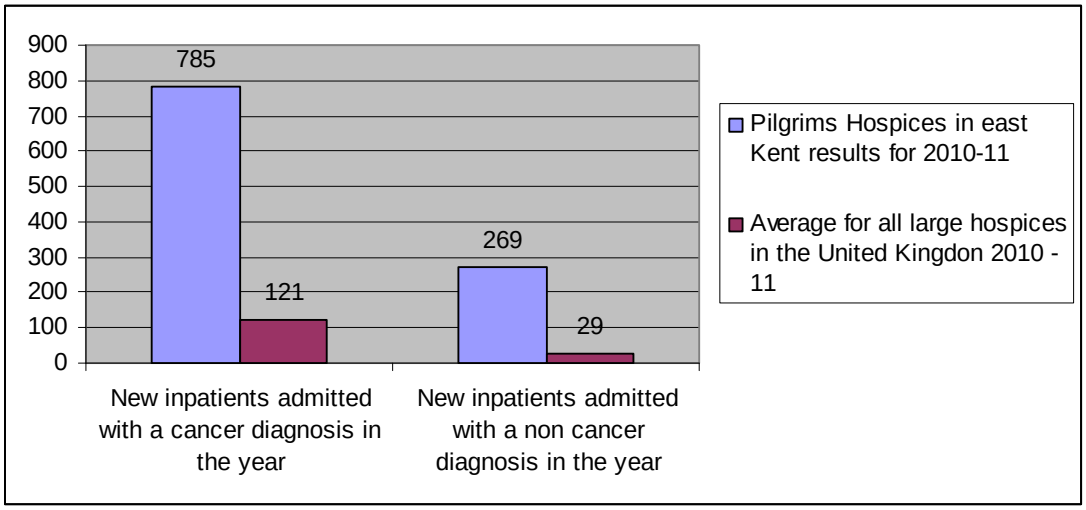


Clinical effectiveness
Many issues of clinical effectiveness have been presented in Part 2 of this report.

The National Council For Palliative Care: Minimum Data Sets For Palliative Care
Pilgrims hospices returns for 2011 – 2012

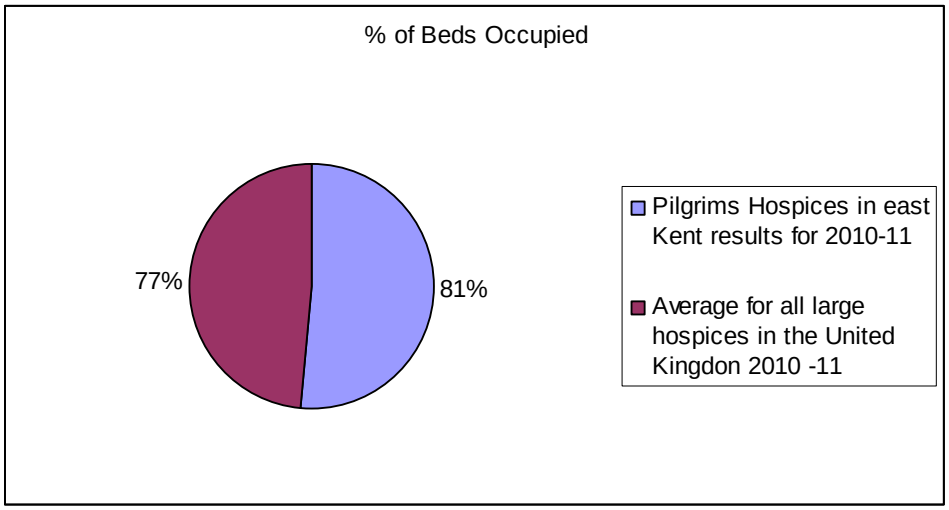
This data is presented with data from all UK hospices for comparison.

Inpatients
Previous comparisons within the MDS have been made against all hospices (146 in this year's research). To provide a more accurate assessment Pilgrims Hospice's has been placed in the large category and measured against 44 other units with more than 16 beds. Pilgrims Hospices has 48 beds, 16 at each of our three sites. Pilgrims is one of the largest hospices in the UK.



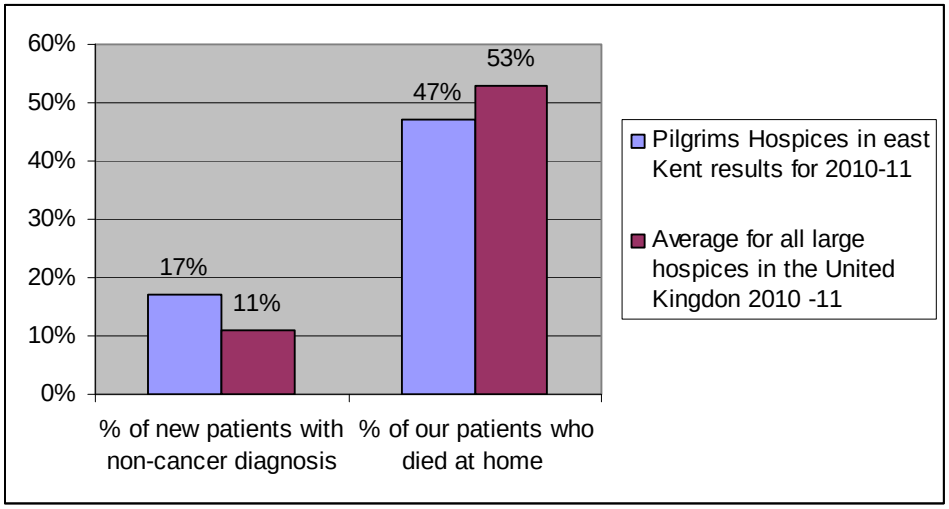
Our outreach to non-cancer inpatients is greater than other hospices in the UK. This chart reflects the larger size of our inpatient units.

Bed occupancy



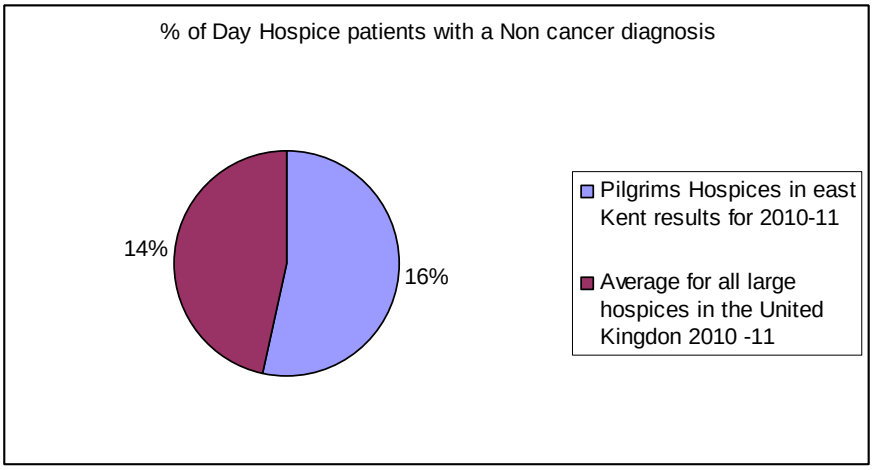
In comparison to last year and based upon regularly reported occupancy levels Pilrgims Hospices believes it is able to balance the economy of a high occupancy against the ability to be reactive to a changing patient need.

Community patients

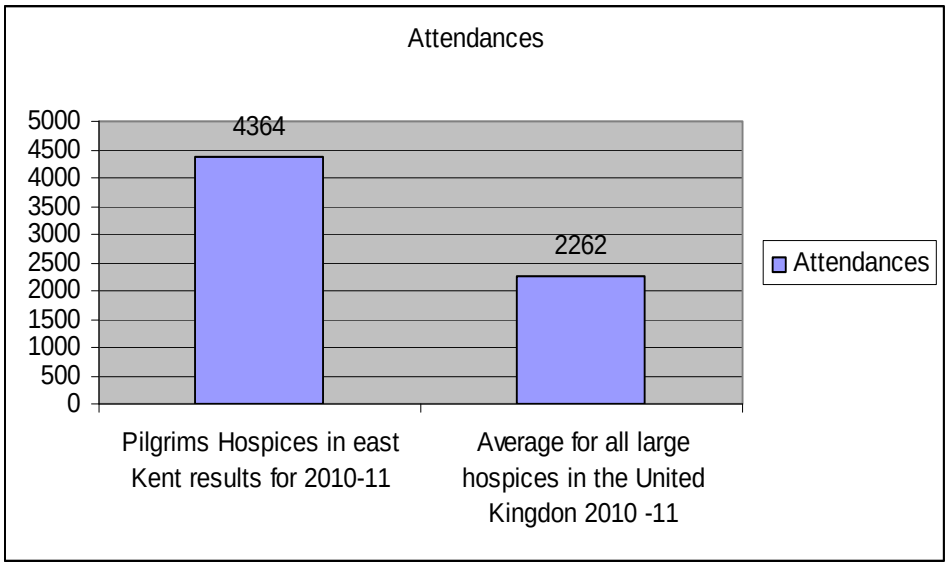


The percentage of Pilgrims patients dying at home has increased from 30% in 2008/9, 35% in 2010/11 to 47% in 2011/12

Day hospice patients



In common with our other services we are expanding our services to the many people who have a non-cancer terminal disease.



Patient Experience

Patient satisfaction with PHEK services
A patient satisfaction survey has not taken place for this reporting period however there are a number of evaluations of Hospices services that have included gathering feedback from patients, below are extracts of patient comments

Extract from CQC report – "What people who use the service experienced and told us"
Some people told us how they had talked about their care to staff when they first arrived in the hospice. They said that they had been asked what they liked and disliked. They said they were given lots of choice around the care to be given and options available.

People said friends and relations were made to feel comfortable visiting the hospice to enable them the opportunity to support their relative. They said that at all times they were treated with respect. One person said: "The staff are very good; they make sure I have my privacy."

People said the staff were always polite and when asked if staff upheld their privacy and dignity. Comments were as follows: "Oh yes always". Another said "Yes, very much so."

Complaints
The organisation has a robust complaints procedure including the collection of verbal complaints to ensure that issues of concern are investigated and dealt with at an early stage.

Analysis of written, formal complaints dated 1st April 2011 to 31st March 2012
The number of complaints received are as follows:

Type of Complaint	Number received
Written – Care Services	8
Adverse Verbal – Care services	26
Written – Non-care Services	5
Adverse Verbal – Non-care Services	2

Of the written complaints concerning care services one was not upheld, four were upheld, two were partially upheld, one was unable to be assessed due to the incident happening in 2006:

Themes and actions
Clarity of communication and understanding of hospice services and systems were issues. The hospice operates in a wider healthcare system and it is not always clear to users which elements of services the hospice is responsible for.

Letters and cards received at Pilgrims Hospices
It is a source of great pleasure and satisfaction to staff and volunteers alike when patients and/or their families write to thank the organisation for its services. Approximately 150 such letters and cards are received across the sites each month and these are shared widely and displayed on notice boards. We also get regular feedback from our website contact email address and comments on news articles as well as via Facebook and Twitter.

What the PCT says about the organisation

What the LINKs say about the organisation

What the overview and scrutiny committee say about the organisation

References

“The doctors and nurses gave me back something else, not only made me feel better physically. They helped me with my mental state. I will go home feeling much stronger. I cannot fault my treatment or praise ALL the staff highly enough.”
“Could not fault any aspect of my stay from the cleaners, cooks nursing staff and Drs and of course the volunteers and poor (another patient) who had to put up with me when I was down.”
A National Patient Survey provided by Help the Hospices for our Inpatients on discharge and Day Hospice patients was conducted starting on the 1st September 2010 until the end of April 2011. At least 50 completed inpatient and 50 day hospice patient are required to be returned to the Centre for Health Studies at the University of Kent. This is a benchmarking exercise with other hospices. We have achieved our target of 50 in each category and await the report from the Centre in October 2011.Category Number of complaints upheld 1, communication professional to professional 12, clinical care 13, communication professional to patient/carer 25, facilities issues/ administration 48, Placement issues 1.