Weldmar Hospicecare
Caring for Dorset

Quality Account 2017-2018

Our Mission

- To ensure all patients needing palliative care in Dorset have access to excellent services delivered when and where needed whether by Weldmar Hospicecare, or by others supported by the Charity.
- To offer support to families and others affected by the patient's illness

Introduction

This is the eighth Quality Account of Weldmar Hospicecare and is produced as a statutory requirement because Weldmar receives money from the NHS[1] and, also, to help the users of our services and other stakeholders to see how we work to improve the service we give.

Our patients receive support from many different sources during their journey and the quality of the service they experience may be determined by the interaction of different providers as much as by any one provider alone. This report on activity in 2017/18 covers areas where we alone are responsible and it follows the statutory requirements of the regulatory authority. We hope it will be of interest to our community, our service users and commissioners.

More corporate information about Weldmar Hospicecare, including our latest Annual Report and Accounts, can be found on our website www.weld-hospice.org.uk

[1]At Weldmar Hospicecare, the NHS commissions a third of our beds and some 30% of the day and community work carried out by the Charity, but this report covers the whole of our work, the rest being funded from charitable fundraising, retail operations, investments and reserves. Our standards for patients are the same irrespective of the source of funds.

Contents

Part 1

1.1 Joint Statement from the Chairman and Chief Executive

The Board and staff of Weldmar Hospicecare take their responsibilities very seriously to ensure the care and support we provide for patients and their families/carers and those important to the patient remains outstanding.

During 2017/18 there were a number of changes in the operational delivery of services at Weldmar in line with the Charity's strategic direction set by the board of Trustees. These changes involved the reduction of administrative and managerial roles, changes to the provision of external education and the relaunch in August 2017 of the charity's day services. The Board's review confirmed the critical role Weldmar plays in supporting patients and their families in their own homes, community hospitals and at Joseph Weld Hospice. Working in partnership with the NHS and other providers remains vital in enabling patients and their families to receive all the support they need.

We are delighted that during 2017/18 we have increased the number of people we support and that we have achieved this whilst ensuring rigorous clinical governance systems, audit and financial management.

Our comprehensive assurance framework maps all Weldmar's activities including, but not exclusively, staff, finance, fundraising and patient services. We are also independently audited to ensure compliance with these assurance processes, and to identify any risks or required improvements.

We are fortunate to have the services of a Forum of Advisors whose expert knowledge enhances Weldmar's committees and inspections of our services.

We remain committed to ensuring the people of Dorset receive outstanding care and support for themselves and their loved ones as they approach the end of their lives. We are aware from reviewing the small number of complaints we receive that poor or inadequate communication is often at the root of the problem. Complex service provision by a variety of agencies, in which Weldmar is only one part, is another theme. We must continue to develop our skills in helping patients and their families/carers to navigate and understand these relationships, and ensure we are as clear as we can be where our own commitments and responsibilities start and end.

The Board and staff at Weldmar feel hugely privileged to be able to continue to support the people who need us in Dorset.

Stephen Baynard
Chairman of the Board of Trustees

Caroline Hamblett
Chief Executive

Part 2

2.1.1 Priorities for Improvement 2018-2019

This section looks at the priorities we have identified for improvement during the period 1.4.18 to 31.3.19. These have been informed by feedback from patients and their families/carers, our work with partners and commissioners, and are in line with our strategic direction as defined by our Board.

Priority 1: To investigate in partnership with local organisations reaching patients and their families who for whatever reason find it hard to access our services

- Working in partnership with local organisations to develop and deliver services to patients and their families who are homeless
- To continue with the Telehealth project to support patients and their families who are socially and/or geographically isolated

Priority 2: To offer specialist Weldmar services to patients and their families with Progressive Supra Nuclear Palsy (PSP)

- To work in collaboration with local Neurological services to support patients and their families with PSP
- Patients and their families with PSP to be supported by a Weldmar Community Nurse specialising in both MND and PSP.

Priority 3: To continue with the development of the Telehealth project to support patients and their families

- To develop the Skype facility to enable visual consultations in rural locations throughout Dorset
- To review the pilot project concluding in January 2019 and identify potential for future services

Priority 4: To deliver a 24/7 helpline facility for Weldmar Hospicecare patients and their families

- To recruit and train specialist staff to offer 24/7 advice to Weldmar patients and their families
- To review the implementation of this support and consider expansion if required

2.1.2 Progress against priorities 2017-2018

This section looks back at the priorities for improvement in 2017-18 identified in last year's quality account.

Priority 1: Services for patients living with neurological conditions

What we wanted to achieve

Quality of life for patients living with neurological conditions can be substantially improved by access to palliative care. During 2017/18 we sought to extend our specialist support to people with motor neurone disease (MND) and introduce support to people with other neurological conditions such as Progressive Supranuclear Palsy (PSP). We intended to report on:

- Number of MND patients and families/carers supported, and services provided
- Number of other neurological conditions supported, and services provided

What we have achieved

- We have successfully secured funding from the Dorset CCG for the MND Specialist Nurse to continue to support patients in the community
- We have continued to offer our patients a regular review at the joint neurology and palliative care MND clinics which are held at Joseph Weld Hospice. These clinics are now held on a bi-monthly basis.
- Facilitating a specific MND research project led by Poole Hospital Neurology Services involving MND patients who attend the joint clinic.
- Offer a hand therapy service to MND patients by our Occupational Health staff
- Our Physiotherapy team have improved IPU staff training in the use of respiratory equipment, and regularly liaise with the Respiratory Team at Southampton General Hospital to support patients using respiratory equipment in the community

Our plan for the future

- We plan to extend the role of our MND Specialist Nurse to also support patients with PSP in our area, working in collaboration with a Consultant Neurologist

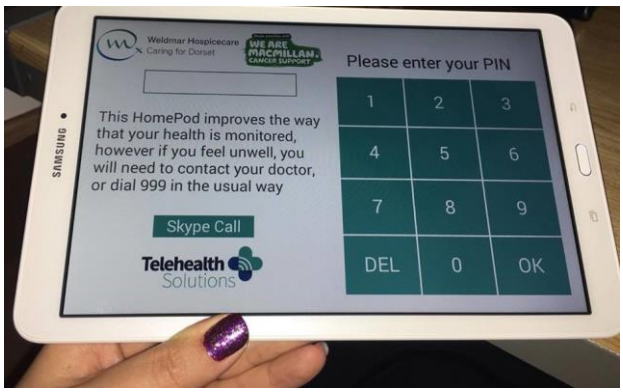
What our Patients say about us

Priority 2: Telehealth Project

What we wanted to achieve

As technology continues to support healthcare there is potentially a use within end of life care. During 2017/18 in partnership with Macmillan Cancer Support we planned to develop a Telehealth algorithm which may enable the most efficient allocation of specialist staff and enable patients to have fewer visits to healthcare establishments. We intended to:

- Test the technology within Dorset and ease of use for patients
- Obtain patient feedback



What we have achieved

15 Telehealth PODS were purchased and a protocol written and designed for their use. This uses recognised palliative care outcome measures - the Barthel Index and IPOS scoring system.

Since September 2017 16 patients have used the Telehealth PODS in their own homes.

The process for a patient being started on the Telehealth POD at home is:

- Weldmar community nurse team (WCN) will have initial discussions with patients on their caseload about using the Telehealth POD. Patient is then referred to the Telehealth Project Manager.
- Telehealth project manager visits the patient at home and gives a demonstration of using the POD and assigns the POD to the patient so they can use every day.
- WCN can either access the information remotely from their PC or can look at the History tab on the POD which stores all the results.

Questionnaires were sent out in January 2018 seeking feedback from the 11 patients who had taken part in the pilot at that stage. There was a 100% response rate with high levels of mainly very positive feedback from patients, but also helpfully highlighted some areas for development, particularly in relation to the specific questions being measured. There have also been several patient stories of the positive impact the Telehealth pilot is having in lowering anxiety of patients.

The Telehealth project manager has made links and continues to share learning with Dorset Healthcare University NHSFT who have a Telehealth service for patients with COPD and heart failure.

There has been interest from other hospices keen to develop the service they offer to their community patients.

An abstract about the Telehealth pilot was also submitted to the Annual APM Supportive and Palliative Care Conference and this was accepted for poster display. The poster was displayed at the conference in March 2018 outlining the details of the Telehealth pilot, and was promoted by the Telehealth project manager.

A Steering Group which includes a representative from Macmillan meets on a quarterly basis to review the pilot project outcomes.

Our plan for the future

We aim to continue to increase the number of patients using the Telehealth PODS in their own homes, to maximise the learning available from this pilot project.

We aim to trial Skype calls between patients and clinicians using the Telehealth PODS where it is appropriate to do so. We will analyse the outcomes which we hope will include improved efficiency for both patients and clinicians, as well as provide cost savings in terms of reduced travelling time and costs.

We will continue to network with other hospices and interested parties to share the learning from the Telehealth pilot.

Priority 3: Psychological support within community hospitals

What we wanted to achieve

Specialist psychologist support can improve the experience of people with cancer and the end of life experience for patients and their families. Weldmar's psychologist in conjunction with Macmillan Cancer Support has trialled psychological support in a local community hospital (Blandford) and had offered further support in a second community hospital (Sherborne). We intended to:

- Run a programme designed to support people in developing self-management skills – open to anyone in Dorset with a cancer or other conditions with a palliative diagnosis who was experiencing psychological difficulties directly relating to their diagnosis and/or treatment
- Obtain patient and family/carer feedback
- Perform an analysis and assess impact of interventions

What we have achieved

An initial eight session group programme was held at Blandford Community Hospital from September – November 2017. There were eight attendees from across the county. Two people had to withdraw so did not compete the sessions. Of those that completed the course all gave feedback stating that it had been a useful and effective programme:

- Being able to talk to people going through the same experience. Not been able to do this before.
- Enjoyed relaxation start. Learnt a lot about myself today and hopefully can use some of the strategies discussed.
- Good to hear other people's experiences.
- Very thought-provoking and logical.
- Lots of strategies to help overcome anxiety. Nice to talk to people who have been through same experiences.
- Being able to talk about strategies that are making a difference [is helpful]
- The most valuable part was the general discussion and exchange of ideas
- Very interesting to listen to other people and hear some of their strategies. Reassuring to know people have the same anxieties as me!
- It has been great to meet others in a similar position, very helpful
- I have thoroughly enjoyed the Keeping Emotionally Fit sessions and have used several techniques to support my mental health when I feel negative about my situation and can alter my thoughts and feelings to my advantage, giving me a renewed sense of 'hope'.
- This group has helped me to improve my coping strategies and adopt 'new ones'

- I have learned so many different ways of keeping emotionally fit. I feel privileged to have been given the opportunity to join the group sessions
- I do hope that you keep the course going as I do consider it extremely helpful for those going through the various stages of cancer
- I would certainly support work done and really hope it can be brought in [across] the county on a regular basis to help sufferers

Other feedback included the suggestion that each session be slightly longer and that there be more unstructured time for attendees to talk with each other.

Two quantitative outcome measures were used with the group: the Patient Health Questionnaire-9 (PHQ-9) which screens for the presence and severity of depression, and the Generalised Anxiety Disorder-7 (GAD-7). These measures assess only the previous two weeks and most people remark that upcoming scans or treatments can have a significant impact on their scores from one day to the next.

At the beginning of the programme, the majority of attendees scored in the moderate range for anxiety and mild for depression. At the end there was little obvious difference in the scores except for a couple of people who scored far lower on the PHQ-9 than they had initially. The number of attendees was too low to draw any significant conclusions.

A second group was scheduled to run at the Yeatman Community Hospital in Sherborne in January 2018 but had to be cancelled due to the low number of referrals. A teaching session designed to facilitate the recognition of complex grief was run for staff and volunteers at the Yeatman Hospital in December 2017.

Our plan for the future

The Psychology Steering Group which guides and monitors this aspect of the work of the Macmillan Specialist Clinical Psychologist has concluded that the provision of individual work with patients / clients should now be prioritised over group work. Groups can be an efficient way of working with a greater number of people; however, the value of the psychologist is not in providing interventions at this level and will be better demonstrated through working directly with, or consulting with healthcare professionals regarding those who are experiencing particularly complex psychological difficulties.

Clinical supervision may be offered to a greater number of community hospital staff in the future along with further teaching sessions regarding psychological assessment skills for non-psychologically trained healthcare professionals.

Priority 4: Preferred Place of Care at End of Life

What we wanted to achieve

Although new initiatives remain an important part of Weldmar's work, ensuring excellent care and support for patients and their families is always Weldmar's highest priority. During 2017/18 we ensured that patients' preferences for place of care at the end of life were supported where possible. We intended to report on:

- Percentage of Preferred Place of Care met
- Analysis and action for Preferred Place of Care not met

What we have achieved

- Each patient death is discussed at the Multi-Disciplinary Team Meeting. In order to accurately capture whether the patient's Preferred Place of Care was met, the Clinical Leadership Group redesigned the MDTM documentation window in the clinical records during 2017. The reasons why the Preferred Place of Care was not met is also documented and discussed.
- During 2017/18 79% of Weldmar's patients died in their Preferred Place of Care. These statistics are reported to the CCG on a quarterly basis.

Our plan for the future

- We will continue to lobby and feedback to CHC and CCG where there are issues with the provision of care packages in the community
- To continue to monitor the percentage of Preferred Place of Care met through MDTMs discussions and documentation.

2.2 Statement of Assurance from the Board

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

2.2.1 Review of Services

During the period 1 April 2017 - 31 March 2018 Weldmar Hospicecare provided the following services to the NHS:

- Inpatient Unit – 4 beds (*or 1,482 bed nights*)
- Day Hospice - *(2,036 attendances)*
- Community Specialist Palliative Care service - *(5,090 community contacts)*
- Occupational Therapy, Physiotherapy,
- Complementary and Creative Therapies
- Family, Carer and Psychological Support Services, including bereavement support

The quality of these services - which represent some 30% of the patient care given by Weldmar Hospicecare - has been reviewed and is covered by these Quality Accounts.

Weldmar Hospicecare has reviewed all the data available to them on the quality of care in all of these NHS services. The income generated by the NHS services reviewed between 1 April 2017 and 31 March 2018 represents 100 per cent of the total income generated from the provision of NHS services by Weldmar Hospicecare for the period 1 April 2017 - 31 March 2018.

2.2.2 Income generated

Weldmar Hospicecare was partly funded through an NHS contract for 2017 -2018. The funding allocated by NHS Dorset CCG represents approximately 25% of the Charity's total income (30% of clinical costs). The remaining income is generated through fundraising, legacies, our range of shops & outlets, lottery activity and investments.

2.2.3 Participation in Clinical Audit

- During 2017/18 no national clinical audits or confidential enquiries covered NHS services provided by Weldmar Hospicecare.
- During the period Weldmar Hospicecare participated in no (0%) national clinical audits and no (0%) confidential enquiries of the national clinical audits and national confidential enquiries it was eligible to participate in.
- The national clinical audits and national confidential enquiries that Weldmar Hospicecare was eligible to participate in during 2017/18 are as follows: NONE
- The national clinical audits and national confidential enquiries that Weldmar Hospicecare participated in during 2017/18 are as follows: NONE
- The national clinical audits and national confidential enquiries that Weldmar Hospicecare participated in and for which data collection was completed during 2017/18 are listed 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 that audit or enquiry. NONE
- Weldmar Hospicecare was not eligible in 2017/18 to participate in any national clinical audits or national confidential enquiries and therefore there is no information to submit.

What this means: As a provider of specialist palliative care, Weldmar Hospicecare is not eligible to participate in any of the national clinical audits or national confidential enquiries. This is because none of the 2017/18 audits or enquiries related to specialist palliative care. Weldmar Hospicecare will not be eligible to take part in any national audit or confidential enquiry in 2018/19 for the same reason.

2.2.4 Local Clinical Audits

Clinical Audits have taken place within Weldmar Hospicecare throughout the year and form part of the annual audit cycle programme within the Clinical Governance Structure. The clinical audit cycle includes audits such as Falls, Medication errors & Pressure Sores, Discharge Planning and Infection Control. (Further details of these audits are included in section 3.1.5.)

Any changes to practice that are recommended following the audits are monitored by the Clinical Governance Committee and Clinical Governance Steering Group to ensure care delivery is safe and effective.

2.2.5 Research

No patients receiving relevant health services provided or sub-contracted by Weldmar Hospicecare in 2017/18 were recruited during that period to participate in research approved by a research ethics committee.

2.2.6 Use of CQUIN payment framework

A small proportion of Weldmar Hospicecare income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between Weldmar Hospicecare and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework. Further details of the agreed goals for 2017/18 are available electronically via www.weld-hospice.org.uk

2.2.7 The Care Quality Commission (CQC)

Weldmar Hospicecare is required to register with the Care Quality Commission and its current registration status is Independent Hospital, Hospice for Adults. Weldmar Hospicecare has the following conditions on registration:

- The service may only be provided for persons aged 18 years or over
- A maximum of 18 patients may be accommodated overnight
- Notification in writing must be provided to the Care Quality Commission at least one month prior to providing treatment or services not detailed in our Statement of Purpose

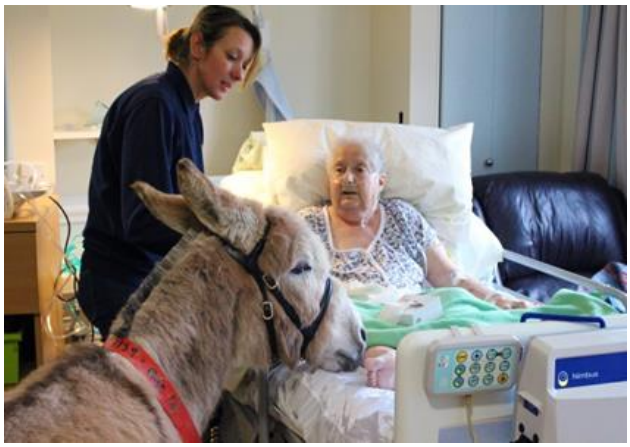
Weldmar Hospicecare is subject to periodic reviews by the Care Quality Commission (CQC). The most recent CQC inspection of Weldmar Hospicecare was carried out in March 2016, and a grading of 'Outstanding' was given.

Ratings	
Overall rating for this service	Outstanding ☆
Is the service safe?	Good ●
Is the service effective?	Outstanding ☆
Is the service caring?	Outstanding ☆
Is the service responsive?	Outstanding ☆
Is the service well-led?	Good ●

2.2.8 Data Quality

Weldmar Hospicecare did not submit records during 2017-2018 to the Secondary Users service for inclusion in the Hospital Episode Statistics, as the Hospice is not eligible to participate in this scheme.

However Weldmar Hospicecare continues to compile the Minimum Data Set (MDS) for Specialist Palliative Care Services which was previously collected by National Council for Palliative Care for use by Weldmar with the aim of providing an accurate picture of hospice and specialist palliative care service activity. A snapshot of this activity is included within Part 3 of this report.



A visit to the hospice at Christmas from a four-legged friend

Part 3: Other Information

3.1 Quality Markers

In addition to the quality measures in the national data set for palliative care (detailed in 3.1.1 below), we actively participate in the national Hospice UK quality benchmarking reporting (detailed in 3.1.2 below). This provides a comparison with other similar hospices on occupancy, falls and medication errors with agreed common descriptors. We have our own set of Key Performance Indicators (KPIs) which are reviewed on a monthly basis by our management team, and also our Board. We also maintain the quarterly NHS Dorset Clinical Commissioning Group monitoring scorecard (detailed at 3.1.3 below).

Any accidents, incidents or near misses are reported through our AIRs system, to enable us to learn from these and make changes as necessary. Details are included at 3.1.4 below.

Details of the local clinical audits and their outcomes are also included at 3.1.5 below.

3.1.1 Minimum Data Sets (MDS) – Hospice UK

	2017/18	2016/17	2015/16	2014/15	2013/14	2012/13	2011/12
Inpatient Unit							
Total number of patients	213	193	174	202	218	241	236
New patients	193	179	162	176	191	211	208
% Occupancy	72.8%	66.10%	61.10%	73.68%	72.80%	80.50%	71.60%
% returning home	36.5%	38.60%	36%	40.10%	30.30%	35.70%	34.10%
Average LOS (days)	14.1	14.5	15.6	14.8 days	15.9	14.2	12.9
Day Hospice							
Total number of patients	125	116	97	123	139	136	125
Sessions held	260	302	231	254	310	302	364
Attendances	1,337	1,650	1,753	1,623	1,961	2,205	2,011
Average length of care (days)	261.3	320.6	201.4	181.6	243.5	225	239.6
Community Service							
Total number of patients	1,139	1,085	1,020	1008	988	976	970
Total contacts face to face	8,031*	7,034*	6,829*	7,972	8,474	4,850	5,698
Total contacts telephone	12,798	10,815*	11,514*	12,372	11,150	10,219	10,242
Average length of care	122.7	124.5	130.4	109 days	99.7 days	95.2 days	90.4 days
Family /Carer Support							
Total number of clients	238	271	170	189	193	181	298
Total contacts	1,499	1,913	1,172	1,355	1,204	1,034	1804
Average length of care (days)	213	218.3	283.1	248.2	215.8	159.7	133.2
Other							
Outpatients	70	130	103	72	151	149	144

** no longer included in MDS*

3.1.2 Hospice UK Benchmarking

Weldmar Hospicecare actively participate in the national Hospice UK quality benchmarking reporting. Data is submitted and analysed on a quarterly basis, and this provides a comparison with other similar hospices on falls and medication error incidences with agreed common descriptors as indicated below:-

1.4.17 – 31.3.18			Weldmar			Cat C hospices (11 - 15 beds)		All Adult Hospices	
			No.	%	Avg No.	Avg No.	Avg %	Avg No.	Avg %
Bed Days	Available		5,124		1,281.0	1,289.5		1,363.1	
	Occupied		3,718	72.6%	929.5	1,005.3	79.4%	1,036.1	79.0%
Falls	No Harm		15	51.7%	3.8	6.2	59.8%	6.7	62.3%
	Low Harm		14	48.3%	3.5	3.9	37.2%	3.7	34.6%
	Moderate Harm		0	0.0%	0.0	0.3	2.6%	0.3	2.6%
	Severe Harm		0	0.0%	0.0	0.1	0.5%	0.1	0.5%
	Death		0	0.0%	0.0	0.0	0.0%	0.0	0.0%
	Total		**29**		**7.3**	**10.4**		**10.8**	
		per 1000 OBDs	**7.8**			**10.4**		**10.4**	
Medication Incidents	Level 0		0	0.0%	0.0	3.2	28.1%	3.6	33.0%
	Level 1		9	56.3%	2.3	6.8	59.6%	6.2	57.4%
	Level 2		5	31.3%	1.3	1.1	9.7%	0.8	7.7%
	Level 3		2	12.5%	0.5	0.2	2.0%	0.2	1.6%
	Level 4		0	0.0%	0.0	0.1	0.5%	0.0	0.3%
	Level 5		0	0.0%	0.0	0.0	0.0%	0.0	0.0%
	Level 6		0	0.0%	0.0	0.0	0.0%	0.0	0.0%
	Total		**16**		**4.0**	**11.4**		**10.8**	
		per 1000 OBDs	**4.3**			**11.3**		**10.4**	

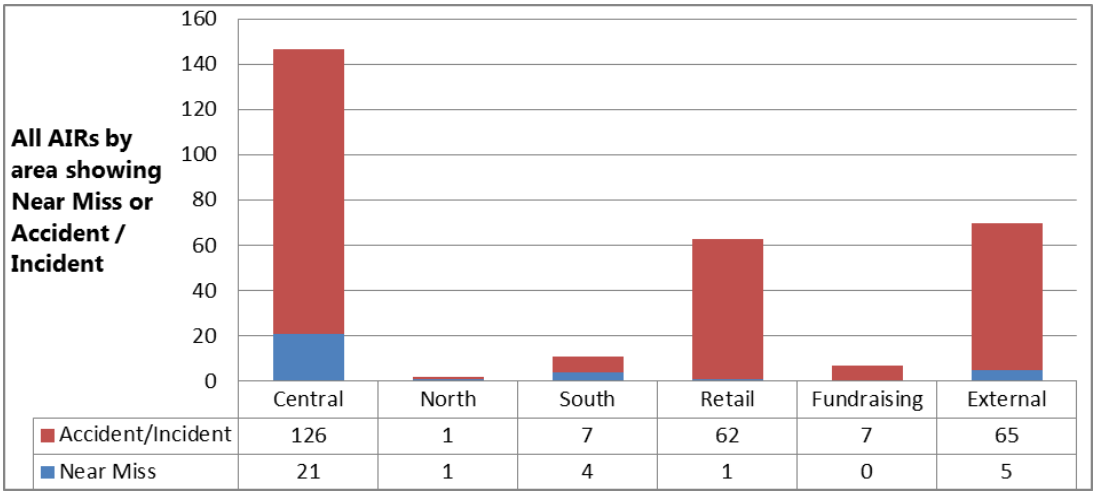
3.1.3 Accident, Incident & Risk Reporting (AIRs)

Staff and volunteers are encouraged to complete AIRs if they feel there is a concern regarding health and safety or a threat to quality, as well as when there is an actual incident. This allows Weldmar Hospicecare to be proactive in reducing risk. In response to feedback from staff specific online AIRs training for managers is now available, as well as generic AIRs training. This online training can be used as a tool at any point should a staff member or manager require additional support in completing AIRs.

AIRs involving other organisations are also reported through the Weldmar Hospicecare online reporting system. Direct liaison takes place with the other organisation as soon as is practicably possible, in order that Weldmar Hospicecare can work in partnership with others to reduce risk. Other monitoring bodies i.e. CQC, NHS Dorset Clinical Commissioning Group are involved as appropriate.

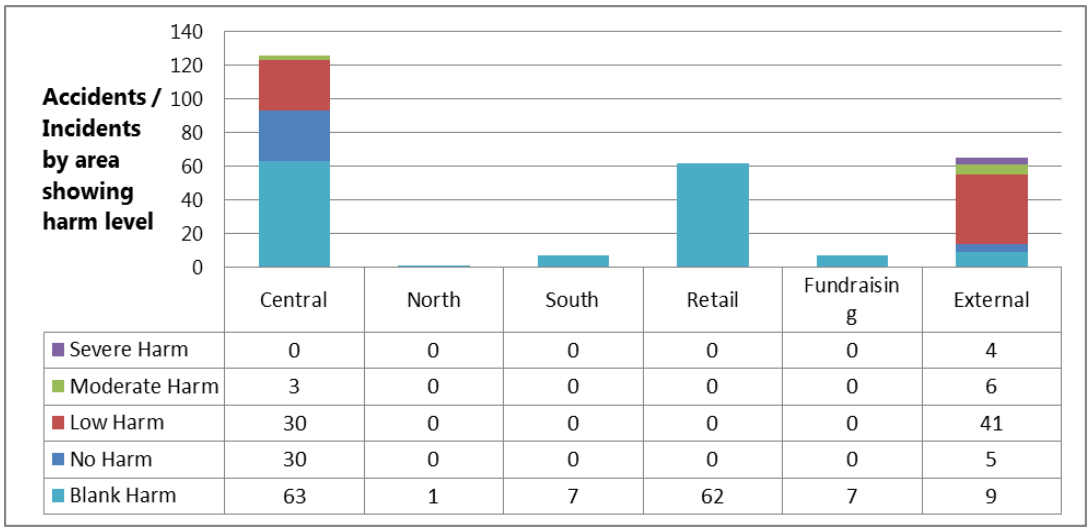
Summary of AIRs (1.4.17 – 31.3.18)

The table below shows all AIRs reported, differentiating between those identified as a near miss and those which were an accident or incident. The Central area includes the AIRs raised within the inpatient unit and is therefore higher than the other geographical areas.



	Central	North	South	Retail	Fundraising	External
Accident/Incident	126	1	7	62	7	65
Near Miss	21	1	4	1	0	5

The table below breaks down the accidents and incidents reported to detail the level of harm (where appropriate). The level of harm is usually associated with falls / pressure sores and medication errors, and is not used in all cases (hence some harm levels appear as blanks)



	Central	North	South	Retail	Fundraising	External
Severe Harm	0	0	0	0	0	4
Moderate Harm	3	0	0	0	0	6
Low Harm	30	0	0	0	0	41
No Harm	30	0	0	0	0	5
Blank Harm	63	1	7	62	7	9

Supporting families in bereavement at a monthly Coffee Morning

3.1.4 NHS Dorset CCG Monitoring

Area of Practice	Quality Requirement	2017-18
Risk Assessments and Screening	% of FALLS assessments completed within 24 hrs of admission	98%
	% of NUTRITION assessments undertaken within 24 hrs of admission	98%
	% of PRESSURE ULCER risk assessments completed within 6hrs of adm.	96%
Infection Control	MRSA Bacteraemia	0
	Clostridium Difficile	0
	MSSA	0
	E-coli	0
	Norovirus	0
Pressure Ulcers - hospice acquired	Grade 1	2
	Grade 2	7
	Grade 3	2
Medication Errors	No Harm (Level 0)	14
	No Harm (Level 1)	11
	Low Harm (Level 2)	3
	Moderate Harm (Level 3)	1
	Severe Harm (Level 4)	1
Falls	No Harm	12
	Low Harm	16
Incidents *(NB: these numbers include med errors, PUs, falls also shown separately above)*	No Harm	75
	Low Harm	51
	Moderate Harm	8
	Severe Harm	1
Referrals	No. of new referrals	868
	% non-malignant referrals	18.1%
Statistics - Inpatient Unit (IPU)	IPU occupancy (bed nights - excluding respite)	3,718
	% IPU occupancy (excluding respite)	73%
	Number of IPU referrals unfulfilled	21
Length of Stay (IPU) (excl hospice respite)	Total days stayed	3,718
	Total number of patient stays	252
	Average length of stay (days)	14.10
	No. of patients staying more than 30 days	31
	No. of days for patients staying more than 30 days	1,337
Patients on an End of Life (EOL) pathway who have an appropriate personalised care plan	Number of deaths recorded (IPU)	160
	Number of IEOLCP recorded	145
	% of deaths on IPU with IEOLCP recorded	91%
Advance Care Plan (ACP) undertaken whilst with the Service	No. of patients with an ACP undertaken whilst with the service	570
	% of total with ACP undertaken whilst with the service	65%
Statistics - Community	Community face-to face (FTF) contacts	8,031
	Community Telephone contacts	12,798
	Community Total contacts	20,829
Gold Standards Framwork (GSF) meetings	No. of GSF meetings attended by WHT staff	250
	% of GSF meetings attended by WHT staff	74%
Statistics - Wellbeing	Day services attendances	1,416
End of Life	% of people supported to die in their preferred place (PPC)	79%
NHS Friends & Family Test (FFT)	FFT - "Extremely likely to recommend service to Friends & Family"	85%
Complaints	Number of complaints received	8
	% complaints acknowledged within 3 operational days	100%
	% complaints responded to within agreed timescales (20 working days)	100%
	No. of complaints referred to the Ombudsman	0
	Date when last complaints summary published on website	Oct-17
Staffing	Clinical Staff turnover	16%
	Clinical Staff appraisal rate	98%
	Clinical Staff Mandatory training rate	84%
	Clinical Staff Sickness rate	5.10%
Safeguarding Training	Percentage of eligible staff trained in Level 1 Safeguarding Children	100%
	Percentage of eligible staff trained in Level 2 Safeguarding Children	100%
	Percentage of eligible staff trained in Level 3 Safeguarding Children	100%
	Percentage staff trained in Safeguarding Adults	83%
	Percentage staff trained in relation to Mental Capacity Act and DOLs	81%
Duty of Candour	Number of times duty of candour used	0
Mixed Sex accomodation Breach	Number of non-clinically indicated mixed sex accomodation breaches	0
Confidentiality / info. security	Number of Incidents and breaches	0
Serious Incidents	Number of serious incidents relating to Pressure Ulcers	0
	Number of serious incidents relating to Falls	0
	Number of serious incidents - other	1
Never Events	Number of Never Events	0

3.1.5 Local Clinical Audits

The following table provides a summary and outcomes of the local clinical audits undertaken during the period 1.4.17 – 31.3.18

Hospice UK: Occupancy, Falls and Medication Errors	Benchmarking nationally and within the south west continues using the national benchmarking tool via Hospice UK, and their report can be seen earlier in this document.
Falls	Falls Audits have continued in line with Hospice UK guidelines. During the year an average of 98% of patients were risk assessed within 24hrs of admission in line with guidelines, and resulting actions taken to reduce risks. During the year there were 29 falls within the inpatient unit, 12 of which resulted in no harm to the patient, and the remaining 17 falls resulted in low harm that required first aid, minor treatment, extra observation or medication. The training programme for staff has been reviewed to incorporate NICE guidelines and will be included within manual handling training. Manual handling has also been added to the handover sheet to ensure staff awareness of varying mobility.
Pressure Area & Waterlow Assessments	Pressure Ulcer Audits have continued to be completed as per Hospice UK guidelines and over the last year it has highlighted further significant improvements in reducing hospice acquired pressure ulcers within the IPU. The Hospice UK Audit showed that during 2016/17 there were 15 hospice acquired pressure ulcers, with two of these identified as avoidable. During 2017/18 we had 11 patients with hospice acquired pressure ulcers with only one of these identified as avoidable. These improvements have been due to fundamental changes in IPU assessments, documentation, communication, education and hospice equipment. A poster about this work was submitted to the Annual APM Supportive and Palliative Care Conference and was displayed at the conference in March 2018 and promoted by the Tissue Viability Nurse Champion. In May 2017 the hospice held a "Comfort Appeal" to enable the hospice to fund new air mattresses. This exceeded our expectations raising funds within two months to buy 12 high specification air mattresses and six pressure relieving cushions for chairs. This has made a huge difference to our patients and is illustrated through the audit findings at the end of the financial year with a clear decrease in hospice acquired pressure ulcers, and indeed some ulcers healing when patients admitted with a pressure sore. The aim for future improvements is to eliminate all avoidable hospice acquired pressure ulcers, through further education opportunities, increased detailed assessments including the Waterlow system, and improved multidisciplinary working.
Medication Errors	During 2017/18 there were 26 errors recorded within the inpatient unit, and a further nine external errors (by external pharmacies, transport providers etc). All of these errors were monitored by the Medicines Management Group and reported in line with guidelines through our Clinical Governance structure, as well as to Hospice UK and our commissioners – NHS Dorset CCG. Development work has continued throughout the year in relation to medication issues including Non-Medical prescribing, Electronic prescribing; supporting staff following a drug error, HCA management of syringe drivers. In addition the quarterly meetings with our pharmacy provider have been reinstated to ensure best practice.

Management of Controlled Drugs	Management of Controlled Drugs audit tool by Hospice UK completed on 19 December 2017. Overall a 95% compliance rate was achieved, with an action to ensure name as well as signature is documented when destroying CDs.
Controlled Drugs Accountable Officer	The Controlled Drugs Accountable Officer (CDAO) Audit was completed on 15 December 2017. The only actions arising were mainly as a consequence of the change in personnel following the restructure i.e. CQC to be informed of change in CDAO and notifications required of LIN meetings. Weldmar is now fully up to date with best practice in governance related to Controlled drugs.
Individual End of Life Care Plan (IEOLCP)	Every month every patient who has died within the inpatient unit is audited to see if they commenced on the individualised end of life care plan, and reasons reviewed if not. 91% of patients were commenced on this IEOLCP. The nationally used Liverpool care pathway received negative reviews in recent years, and we therefore amended our approach. Clearer explanations given to family and next of kin relating to this plan, which helped to reassure that it was used as a reminder to nursing staff to provide good holistic care. We are unable to prevent medical emergencies occurring, and these patients unfortunately do not commence the end of life care plan. We have identified that additional training was needed for new and bank staff in this regard. Another change is that the nursing team are able to place on the end of life care plan in the absence of the medical team, and follow it up subsequently. This year it is intended to further review the end of life care plan, in particular to improve the layout.
Delirium	Delirium (acute confusion) is very common in palliative care patients (75% of all patients). Good practice dictates that we should try and detect delirium as early as possible - this allows appropriate treatment to be started sooner rather than later, thereby often preventing a crisis. This can potentially make a big difference to patients' and carers' quality of life, and can reduce risk to patients, carers and staff. Data was collected on the assessment of delirium over a 3 month period in January 2016. This showed that 39% of 41 patients admitted to the IPU were identified as having acute confusion at some point. Generally, documentation pertaining to important aspects of the assessment of delirium was poor. It was concluded that a major contributory factor to this was the lack of a specified section on Crosscare where staff could document their findings. A new section on Crosscare was created which incorporated the use of the Confusion Assessment Method (CAM), in order to aid in the early detection of delirium. A comprehensive programme of teaching was undertaken across the inpatient unit and at multi-disciplinary team meetings, in order to implement the changes in documentation and also to raise the profile and HCPs' understanding of delirium. Data was collected again in March 2017. Over the 3 month period 1/12/16 to 1/3/17 there was a significant improvement in 6 of 7 of the audited criteria. Overall, there was documentation of a detailed assessment of delirium in 62% of cases versus 24% of cases in the previous data collection. Teaching on delirium is ongoing and there will be further data collected in July 2018.
Discharge Planning	During 2017/18 there were 14 delayed discharges from the inpatient unit which totalled 334 days. Of these three patients were delayed for more than 50 days and a further two patients for more than 30 days. This compares to seven patients delayed during 2016/17 for a total of 58 days.

	Reasons for these delays included: • Care package availability at home • Care Home placement availability • CHC response times • Provision of equipment/works delays • Patient expectations/changes in requirements • Specialist equipment training • No alternative placement Discharges can be complex and very time consuming, and Weldmar has worked hard to ensure this activity is managed. The IPU now has two permanent discharge facilitators in post, who share the role between them to ensure continuity. Discharge information is included in the nurse handover sheet and on the discharge board in the nurses' station to keep the team updated on discharge planning. There is also a daily MDT brief patient update meeting to highlight issues/plans.

Infection Prevention & Control Audits Actions 2017/18

Findings	Actions
Bed and Mattresses This continues on a 3 monthly rolling audit. All beds clean and in good working order. Mattresses remain easily identifiable.	• One mattress condemned and replaced after failing the water penetration test • New mattresses are in place due to pressure area requirements
Catheters If patients have a catheter on admission staff are recording this on Crosscare. Out of 123 catheters, 10 were not documented for reason for insertion. Seven of the 123 had a catheter associated urinary tract infection (UTI)	• Staff reminded to complete Crosscare via letter/email and verbal discussions • Antibiotics were used appropriately • Urine samples were sent on occasions as well as clinical symptoms used to diagnose a UTI
Decontamination Most areas clean at time of audit Minimal items rusty	• Perching stool purchased due to excessive rust • Keyboards are cleaner due to introduction of new cleanable keyboards
Sharps Temporary closure: not closed A mean of 91% compliance	• Temporary closure, remind staff at all times • There were two sharps bin champions but one has retired, and the other has moved to work in the community, and this needs to be reallocated.
Commodes Audit showed an increase in cleaning standards Therefore it was discussed with the Director of Infection Prevention and Control (DIPC) and this will no longer be an audit, but will continue to be observed.	• Training session was given to all members of the nursing team
Hand hygiene	• Blue plasters – staff were unaware where these were located • People were reminded not to wear stoned rings and to keep nails short. • Alcohol pump in the South was running slowly, it was reported at time of the audit.

3.2 Staff & Volunteers

3.2.1 Staff Turnover

This report covers the twelve months ending 31 March 2018 and analyses the numbers of joiners and leavers for the period. The total number of full and part time permanent staff employed at 31 March 2018 was 225. There were 45 joiners and 48 leavers during the twelve months, giving a staff turnover rate of 21.15%. For comparative purposes, the staff turnover rate for 2016/17 was 16.45% (which included the outcome of a strategic review of non-clinical services during this period.)

A breakdown of the above data is shown below.

Staff Group	Staff Numbers	Joiners	Leavers	Staff Turnover
Clinical Staff	79	7	11	13.58%
Retail Staff	83	26	19	23.75%
Hotel Services	16	3	4	23.53%
Admin/Mgt.	47	9	14	28.28%
Total	**225**	**45**	**48**	**21.15%**

3.2.2 Patient Care Volunteer Activity (1.4.17 – 31.3.18)

	Tasks Undertaken	Hours Worked	(average)
Community:			
Admin duties (incl Finance, governance groups, ward clerk, office support)	434	1,302	2-3 hrs
Befriending	11	792	3 hrs for 24 weeks
Bereavement Support (emotional support)	1	1	1 hr
Carers' Support Group	6	12	2 hrs
Chaplaincy (incl events / services)	33	79	1-3 hrs
Chiropody	3	3	1 hr
Collecting prescriptions	1	1	1 hr
Companion	20	1,140	3 hrs for 24 weeks
Complementary Therapy (qualified practitioners)	33	198	1 hr for 6 wks
Dog Walking	1	24	1hr for 24 wks
Gardening	1	3	3 hrs
HH Reception	249	498	2 hrs
Jam Che (Gentle Touch) Bereavement Coffee Morning	5	10	2 hrs
Refreshments	1	2	2 hrs
Shopping	2	48	1hr for 24 wks
Sitting	9	432	2 hrs for 24 wks
Transport (own car)	58	116	2 hrs
Day Services:			
Arts Therapy (includes Creative Therapy)	168	336	2 hrs
Chaplaincy	37	74	2 hrs
Daycare Help (includes Meal Assistant)	114	342	3 hrs
Hair Dressing	50	100	2 hrs
Hand & Nail Care	0	0	2 hrs
Hotel Services	0	0	4 hrs

Jam Che (Gentle Touch)	81	162	2 hrs
Minibus & Caddy	16	32	2 hrs
Reception (John Greener)	6	12	2 hrs
Recreational Activities	16	64	4 hrs
Transport (own car)	89	178	2 hrs
In-Patient Unit:			
Bereavement Support (qualified counsellors & coffee mornings / events)	22	26	1-3 hrs
Chaplaincy	14	42	3 hrs
Flower Arranging	257	514	2 hrs
Hand & Nail Care	0	0	2 hrs
Gardening	0	0	2 hrs
Hotel Services	10	30	2-4 hrs
Jam Che (Gentle Touch)	42	84	2 hrs
Pets As Therapy	59	59	1 hr
Reception	898	2,694	3 hrs
Sitting	2	4	2 hrs
Ward (includes Meal Assistant)	757	2,271	3 hrs
Totals	**3,506**	**11,685**	

Volunteers supporting patient activities in day services at Joseph Weld Hospice

Our volunteer companions support patients and their families in the community

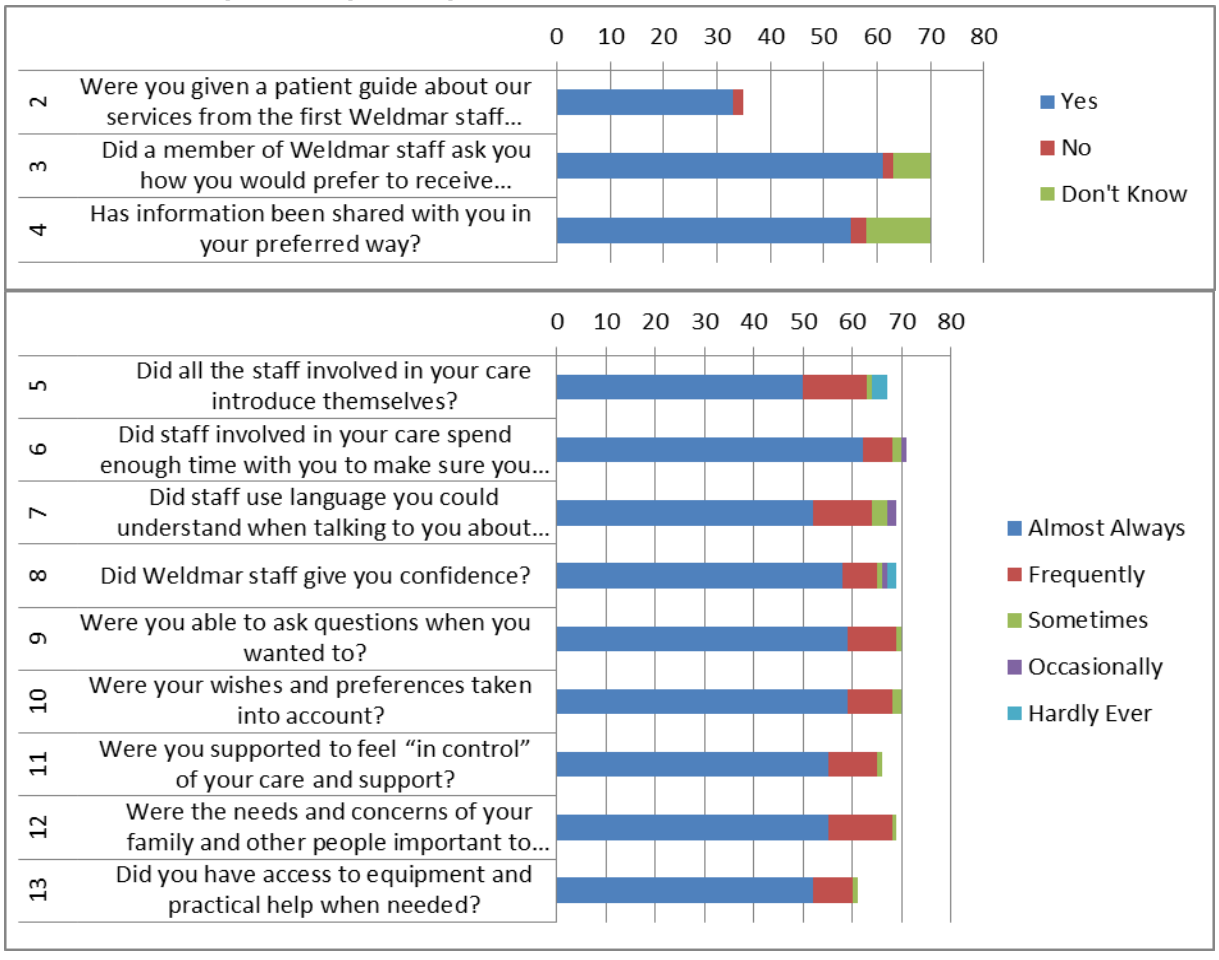
3.3 Feedback from Patients / Carers

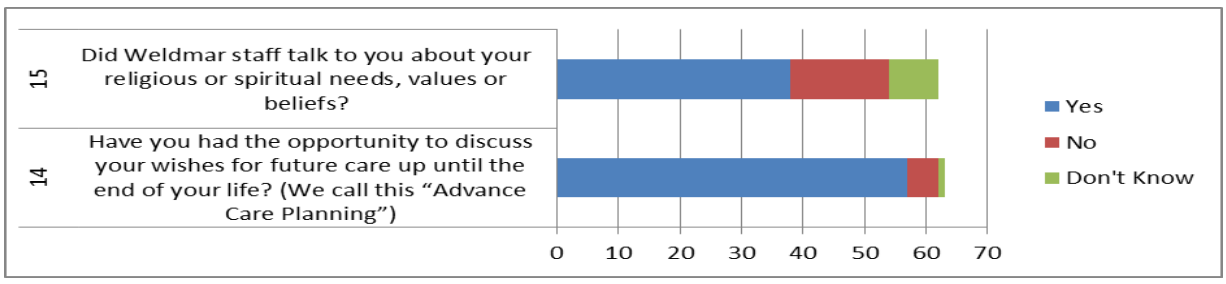
3.3.1 Patient Experience Questionnaire

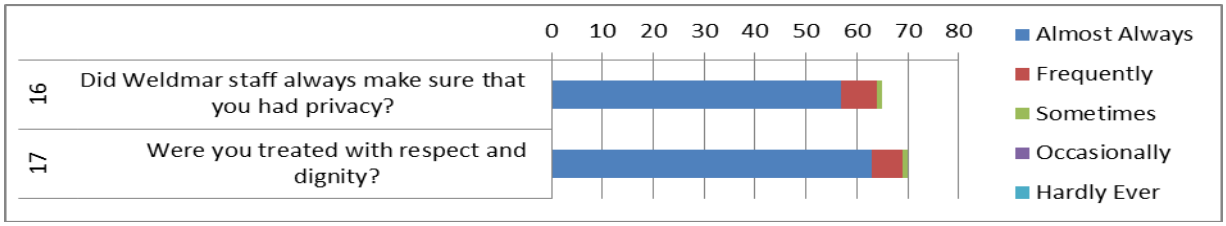
We want to know how we are doing in relation to the things we know are important to people who use our services, and we therefore regularly send out our patient experience questionnaire to a range of our patients, and it is also available on our website for anyone to complete.

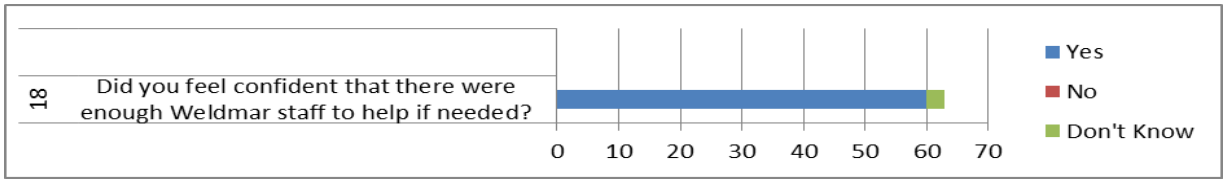
Following feedback we revised the questionnaire during the year, and introduced a new streamlined version in October 2017, and therefore two sets of responses tabled below. During 2017/18 a total of 149 questionnaire responses were received.

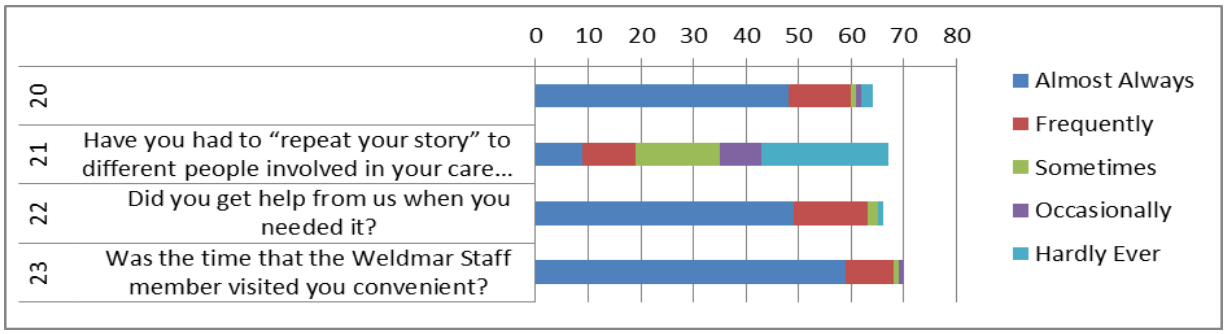
Questionnaire responses (April – September 2017)

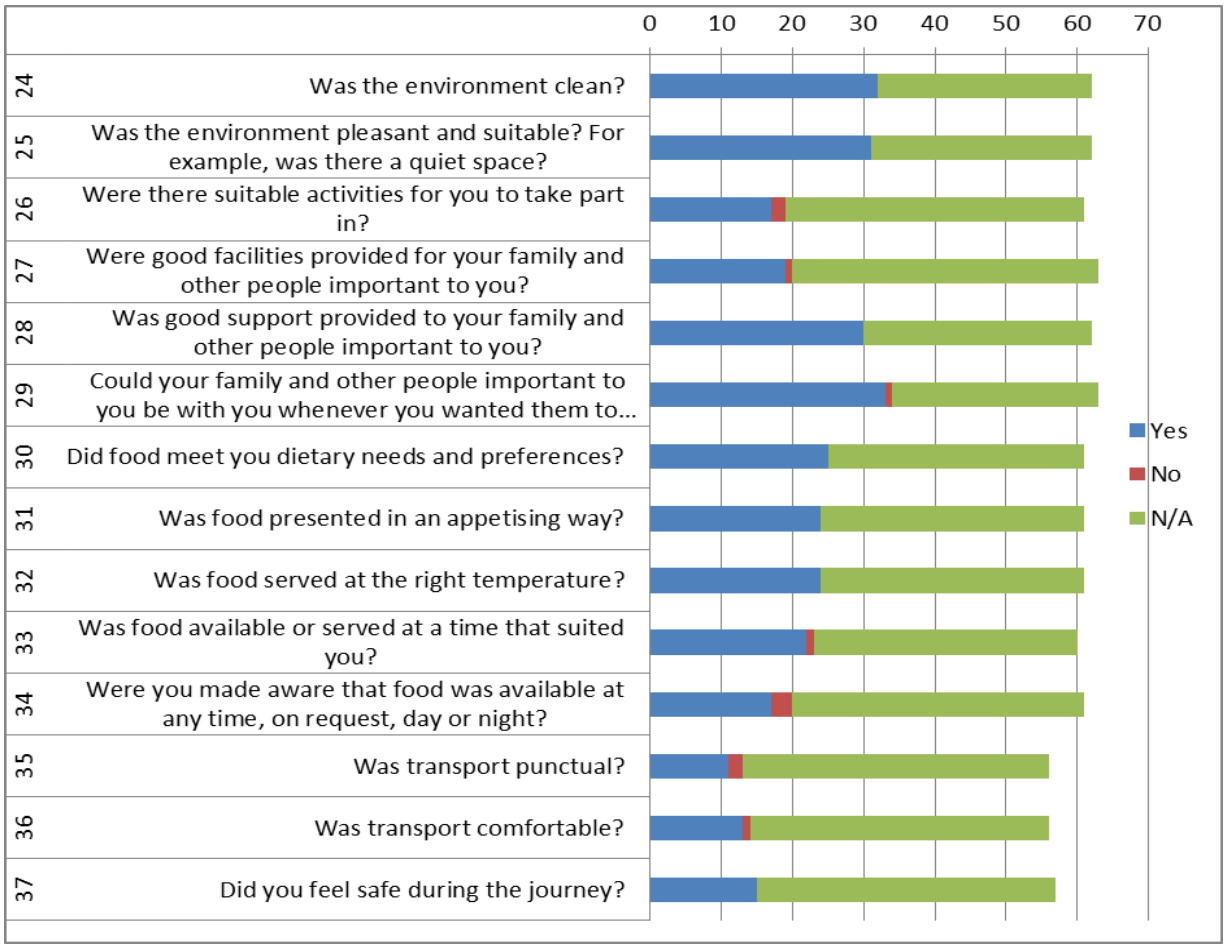




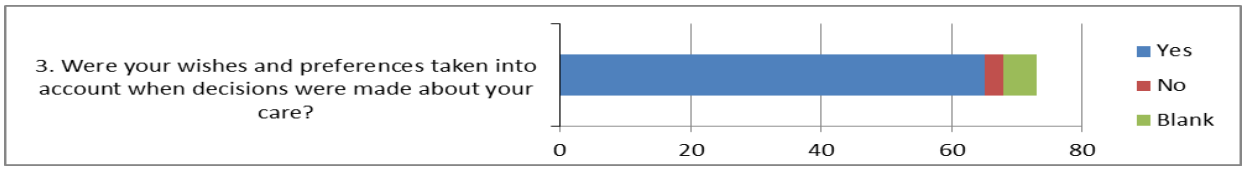

0 10 20 30 40 50 60 70 80
16 Did Weldmar staff always make sure that you had privacy?
17 Were you treated with respect and dignity?
Almost Always
Frequently
Sometimes
Occasionally
Hardly Ever

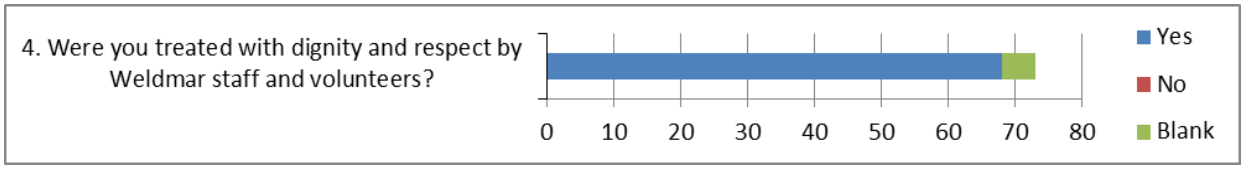

18 Did you feel confident that there were enough Weldmar staff to help if needed?
0 10 20 30 40 50 60 70
Yes
No
Don't Know

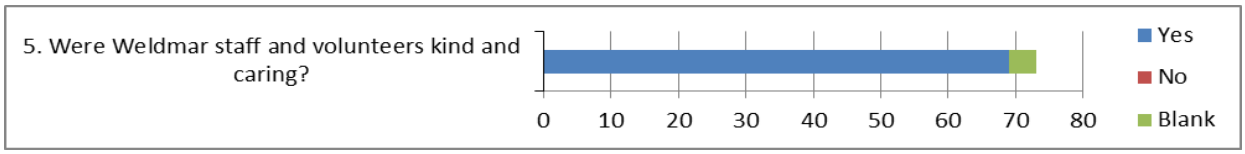

0 10 20 30 40 50 60 70 80
20
21 Have you had to "repeat your story" to different people involved in your care...
22 Did you get help from us when you needed it?
23 Was the time that the Weldmar Staff member visited you convenient?
Almost Always
Frequently
Sometimes
Occasionally
Hardly Ever

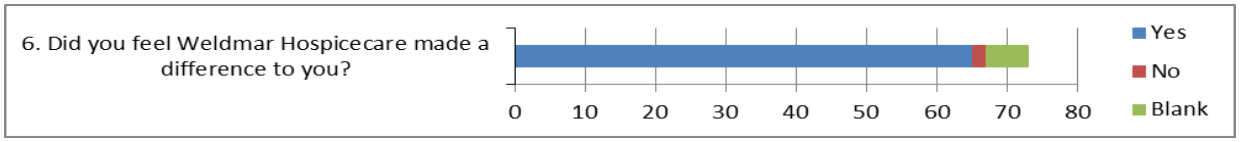

0 10 20 30 40 50 60 70
24 Was the environment clean?
25 Was the environment pleasant and suitable? For example, was there a quiet space?
26 Were there suitable activities for you to take part in?
27 Were good facilities provided for your family and other people important to you?
28 Was good support provided to your family and other people important to you?
29 Could your family and other people important to you be with you whenever you wanted them to...
30 Did food meet you dietary needs and preferences?
31 Was food presented in an appetising way?
32 Was food served at the right temperature?
33 Was food available or served at a time that suited you?
34 Were you made aware that food was available at any time, on request, day or night?
35 Was transport punctual?
36 Was transport comfortable?
37 Did you feel safe during the journey?
Yes
No
N/A

Questionnaire responses (October 2017 - March 2018)









3.3.2 Reflections

From 1.4.17 to 31.3.18 we received 64 completed Reflections Leaflets. Some leaflets had comments relating to more than one area of service as indicated below

- 10 x IPU
- 8 x Day Services
- 9 x Bereavement Support
- 5 x Catering
- 5 x Arts Therapy
- 7 x Children's Support
- 5 x MND Nurse/Service
- 9 x Community Nursing Team
- 5 x Hotel Services
- 7 x Complementary Therapy
- 6 x Chaplaincy
- 1 x Social Work
- 1 x Doctors
- 1 x Volunteers

Carers enjoy a day out on the Swanage Railway complete with a delicious afternoon tea

The forms were completed by the following:

- 29 x Patients
- 21 x Bereaved Relatives
- 13 x Carers/Relatives
- 1 x Other (School)

All of the comments received were shared with individual members of staff (where named) and /or departments immediately upon receipt to ensure any remedial responses were followed up on. Comments were also shared with Health Watch Dorset when consent had been given enabling us to do this.

The majority of comments received were overwhelmingly praiseworthy, with only a small number requiring us to consider if we need to change or improve certain aspects of our service/practice.

All Clinical Reflections are now included on the Weldmar Intranet Page for all staff to view.

3.3.3 Compliments

We are pleased to report that we receive a great deal of positive feedback from our patients and their families and carers, and below we have highlighted a selection of the comments from patients and their relatives across all services:

The care I received was wonderful and all the staff were very caring and considerate.

Because you have listened to my needs and acted upon them very efficiently. Most helpful and caring patient care I have been given and most important knowing someone is at the end of the phone if my family and I need them, so important to know we are not alone.

Lots of experience. You are listened to. Very helpful.

Outstanding social workers, great listeners, practical advice, no patronising!

Great support from nurses with answers to any worrying queries. Good support for carers as well.

It felt as if Weldmar first took over our hands and guided us and supported us through this final phase of life. Thank you.

Super service. Very professional nice and friendly.

We were moving into a very stressful 'unknown' and you gave us confidence that help and kindness were there for us to support us in this journey.

My husband was taken care of by the wonderful staff there, can't praise the Hospice enough.

It is nice to know you have back up and support and telephone numbers to call.

Tremendous attention to detail on the part of all the nurses, staff and volunteers.

Surprised by the assessment nurse who was very helpful and cheerful, plenty of help offered and she maintained contact.

Direct one to one contact – answers to questions resulted in further medication which has helped greatly.

The service you provide in time of need is second to none. Thank you.

Very helpful and always on hand if needed. Treated as a person not a patient.

Kindness and understanding – care giving reassurance.

Because they are dedicated and so reliable – excellent attention.

You have met all the commitments made in a timely manner.

3.3.4 Complaints

There were eight complaints during the year (as compared to nine in 2016/17). One of the complainants felt it necessary to take the complaint to the Chairman, but none to the Health Ombudsman. We use the feedback from complaints and other comments/feedback to help us continue to improve our services. A summary of the complaints made and our response is detailed below.

Complaints	**Apr**	**May**	**Jun**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Number of complaints received	1	0	1	0	1	0	0	3	0	1	1	0
% of complaints acknowledged within 3 operational days	100%	n/a	100%	n/a	100%	n/a	n/a	100%	n/a	100%	100%	n/a
% of complaints responded to within agreed timescales (20 working days)	100%	n/a	100%	n/a	100%	n/a	n/a	100%	n/a	100%	100 %	n/a
Number of complaints referred to the Ombudsman	0	0	0	0	0	0	0	0	0	0	0	0
Date when last complaints summary published on website	Nov-16	Nov-16	Nov-16	Nov -16	Nov-16	Nov-16	Oct-17	Oct-17	Oct-17	Oct-17	Oct-17	Oct-17

Details of lessons learnt and actions taken

	Issue	**Investigation & Action**
1	Communication and call bell system – Inpatient Unit (IPU): Inpatient complaint about their treatment when they requested assistance. The patient felt they were left for too long in an undignified position. The patient asked that the nurse not be involved in their care again.	The nurse did not hear the call bell asking her to return. The CEO apologised for distress to the patient and explained the nurse's interpretation of the situation and conveyed the nurse's apologies for any misunderstanding. The call bell system is being reviewed to make sure it is heard throughout the IPU. The patient was assured they would not receive care from that nurse again as requested.
2	Repeating history: Patient dying before arranged admission: Complaint made to Dorset County Hospital (DCH) about multi agency care and citing unhappiness with Weldmar's involvement on patient's discharge home due to: length of time it took for Weldmar nurse to visit, having to repeat the patient's history to the Weldmar nurse, feeling let down about the availability of a bed at Joseph Weld Hospice (JWH). The patient died following discharge from DCH and before admission to JWH.	Weldmar Medical Director replied to the DCH Complaints Officer to say patient unknown to Weldmar until referred on the day of hospital discharge with no referral form or discharge summary hence the need to repeat history. Weldmar liaising with Hospital Palliative Care Consultant to improve transfer of information for patients unknown to Weldmar. The referrer did not state urgent, and a Weldmar nurse visited on the third and fourth working day following discharge, so was within the standard of five working days. Admission was arranged for the subsequent day after liaison with the hospice doctor and GP. It was not anticipated the patient would die that evening.

3	Communication – IPU: Complaint received via website 'contact us'. Complainant very happy with care of deceased parent but unhappy with communication with her and felt she was spoken to rudely by some nursing staff. Condolence letters were sent to her sibling.	Patient gave permission for both children to be given information however, as complainant's sibling was present at JWH they were more included, but staff did pass similar information to complainant by phone or in person. It was not intentional on the part of the staff to make complainant feel excluded and they are very sorry about this. CEO wrote to complainant to explain and to say training of staff is being reviewed to ensure all family members are equally included, and that the Weldmar documentation is clear about emergency contact, main carer and next of kin.
4	Safeguarding: Complaint received by telephone to CEO from carer of patient (a family member) that without complainant's knowledge a Weldmar Community Nurse(WCN) put in a safeguarding concern that the complainant was refusing access to the patient and therefore the receiving of medical care. Complainant also upset that the WCN did not attend the safeguarding hearing.	CEO replied by letter to acknowledge the safeguarding alert was very distressing for the complainant; however the WCN has a professional duty to raise concerns. As the WCN had referred to the safeguarding team there was no need for her to attend the meeting. The palliative care social worker visited the family following the complaint and ongoing support for the family will be from another WCN. Investigation also said the safeguarding team should not have told the complainant the name of the WCN who raised the safeguarding concern.
5	Communication - IPU: Verbal complaint by family member of patient re donation not acknowledged, insensitivity by nurse discharging patient, patient moved from side room to bay without informing family who found an empty bed, and complainant had to 'argue' to get patient into the hospice.	A thank you letter regarding the donation was sent within the timeframe of 10 days of receipt. The discharging nurse explained the discharge and funding process several times with several family members. The patient was happy with the offer of a care home and had the capacity to make this decision. On the two occasions the patient was admitted this occurred as soon as a bed was available. It was agreed that ongoing communication skills training and support would be offered to all staff holding a discharge role. Bed moves will be communicated to JWH reception so they can inform visitors. Head of Nursing spoke by phone with the complainant at their request rather than a face to face meeting or letter.
6	Communication – Day Services: Complaint via email from family member of patient upset that the patient, who, after being on the waiting list, enjoyed a session at day services, then was told they could not attend again until a suitable commode was obtained. This did not happen and left patient and their partner dispirited. Due to the lack of respite from day services the patient ended up having respite in a care home.	CEO apologised to the complainant that they did not get the support they should have had from Weldmar. Complainant informed that capacity has increased in day services, so should reduce waiting time. The patient's needs are being assessed by a WCN whilst having respite in a care home and the day services lead and an Occupational Therapist will assess the patient on returning home for day services. Complainant replied to CEO that they felt hopeful that they would not be 'abandoned'.

7	Bereavement support: Complaint via email from daughter of former Weldmar patient who died in a care home following a stay in JWH. Complainant upset that her mother has not had a phone call from Weldmar nor any support following her father's death which has been a difficult time for her mother and resulted in weight loss 'due to stress and grief'.	As complainant left only a phone number, CEO phoned to acknowledge complaint and apologise for any distress. Bereavement lead contacted complainant and her mother to see if she needed bereavement support. The investigation revealed following patient's death a WCN visited his wife (complainant's mother) to offer condolences and bereavement support. Wife said she felt well supported by friends and family. A bereavement pack was sent to the patient's wife 6-7 weeks after her husband's death, which is the usual timescale. There was no further contact from the patient or family.
8	Understanding the role of WCNs: Communication: Reporting: Access to services in rural areas: Complaint from a family member via email following receipt of a letter inviting complainant and partner to Time To Remember service. Complainant stated patient died in a Nursing Home (NH). Prior to this, help at home was requested and patient was visited by a WCN. Complainant stated they heard no more from WCN and objected to being included as being in receipt of care from Weldmar in their invite when a District Nurse (DN) arranged the NH. Requested explanation of 1 why no care provided for patient 2 how statistics are compiled 3 how geographical mismatch of care is handled/prioritised	Investigation found WCN contacted patient and son the day the referral was reviewed in Triage. WCN then visited patient at home four days later. She made several calls over several days liaising with DN and GP and Continuing Health Care (CHC). WCN also gave advice re patient to other Health Care Professionals (HCPs) on four other occasions. She spoke with NH who reported patient as settling in well and no visit was required. The following month WCN visited patient in NH with further calls to HCPs and patient discussed at two Weldmar Multi-Disciplinary Team (MDT) meetings. CEO replied to explain above and that the WCNs have a coordinating role that can be invisible to the family but does impact on the quality of care provided. Also explained to complainant that Weldmar is aware CHC has difficulties brokering for care agencies in rural areas, and is something Weldmar lobbies about whenever possible. Explained the reporting includes the number of visits and telephone calls made to patients and other HCPs involved in the care of our patients and is detailed in the Weldmar Quality Account on our Website. CEO also stated that in future, WCNs will be asked to leave a card in a patient's room in NH so families are aware of the visit.

Summary

Four complaints came from the IPU, two from the community, one relating to day services and the other bereavement support. Poor or inadequate communication is often at the root of the problem, and as detailed above action has been taken, and where appropriate changes made. Complex service provision by a variety of agencies, in which Weldmar is only one part, is another theme. We must continue to develop our skills in helping patients and their families/carers to navigate and understand these relationships, and ensure we are as clear as we can be where our own commitments and responsibilities start and end. We continually strive to improve communication skills throughout the organisation, to 'grow our own' staff, as we look to the future of increasing workloads and a decreasing number of people in the care profession.

Annex 1: Supporting Statement

NHS Dorset CCG

Dorset Clinical Commissioning Group sees Weldmar Hospicecare as a key partner in the delivery of end of life and respite care for patients from Dorset.

During 2017/18 Weldmar Hospicecare continued to provide the highest levels of care and support to our service users and their families, working hard to improve their already excellent levels of service by prioritising patient safety, clinical effectiveness, and enhancing patients' and their families' experience.

Weldmar Hospicecare have an open and welcoming culture which has provided assurance to the CCG that the service they provide meets or exceeds the standards required, and feedback indicates that their support is much appreciated by their patients and families.

Looking forward to 2018/19, Dorset CCG is delighted to have the opportunity to continue working closely with the Hospice as a key partner in helping us to continually improve our services, by providing high quality respite and end of life care to patients and their families.