Our vision...
...is for a future where the best experience of living is available to everyone leading up to and at the end of life.

We continually strive to achieve this through the specialist and practical range of services we offer to individuals, families and carers; through education and partnerships; and through working with professionals and communities to share our expertise and learn from others.
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Part 1 – Statement

1.1 Statement from Tina Swani, Chief Executive

Birmingham St Mary’s Hospice is far more than a building or an organisation – we deliver a philosophy of care, dedicated to helping men and women, living with incurable illness, to make the very best of their lives.

Through specialist expertise, care, treatment and listening, we make it possible for many people to enjoy the years, months or days they have left; and when the time comes, have a good death. Loved ones and carers are fully supported during this difficult time and beyond.

Hospice care is also known as “specialist palliative care”. It is about settling the physical and psychological symptoms of a person’s illness and helping them to deal with any emotional distress and practical difficulties. Everything is done to enable each individual and their family to live life to the full.

Most of our care is given by our community team in our patients’ own home. Each year we support over 1,000 people at home, in our Day Hospice and on our Inpatient Unit. As our elderly population grows, with more people living alone, the demand for care at home is certain to increase. We will use our expertise to help more people remain safely and comfortably in their own home if that is what is best.

As a pioneer in palliative care, and through our education programmes we have trained and supported many NHS doctors, nurses and other health & social care professionals, to provide palliative care as part of their role. We work with other organisations to improve the co-ordination and quality of care people receive and raise awareness within local communities, so that as many people as possible can get timely help when they need it.

Birmingham St Mary’s Hospice is an independent charity and a big part of the local community since our launch in 1979. As such, we continue to work with our community and statutory services to develop services relevant to current and future needs. Over the latter end of 2014-15 the Hospice has started a service redesign programme to ensure we continue to respond to the changing needs of individuals within the context of ongoing financial austerity and significant changes within our population over the years ahead. Our Quality Account 2015-16 will set out some of the service changes which support the programme’s main principle of delivery of safe, compassionate care to patients, families and carers.
Our Board is made up of 11 Trustees drawn from a variety of professions and backgrounds. The Executive Team are responsible for the Hospice on a day to day basis and the Team is made up as follows:

This Quality Account illustrates, through specific examples, our commitment to continual improvement to service quality and through innovation.
Part 2 – Priorities for Improvements and Statements of Assurance

2.1 Priorities for improvement 2014-15 - what we achieved last year

Patient Safety - Organisation-wide monitoring and review system for mandatory training

Priority One:
Organisation-wide monitoring and review system for mandatory training

Standard:
• To have an effective and accessible monitoring and review system across all disciplines

How was this identified as a priority?
Following a Care Quality Commission inspection in 2014, the Hospice sought to improve the accessibility to accurate and up-to-date training records so that:
• Managers could track training and development within their teams
• To identify organisational compliance with Statutory and Mandatory training
• Centrally held records to support accurate recording of information

How was the priority achieved?
• Managers ensuring that staff consistently complete registration documentation for training sessions
• Implementation of a 3-monthly manual review of the training matrix in order to identify staff overdue for statutory and mandatory training
• An automated reminder system for statutory and mandatory training is currently in development

How was progress monitored and reported?
• Through the 3-monthly manual review referred to above
• Introduction of bi-annual reports to Departmental Managers/Team Leaders to highlight those staff in need of training or refresher courses
Clinical Effectiveness - Implementation of SystmONE electronic records for Hospice at Home

Priority Two: Implementation of SystmONE electronic records for Hospice at Home

Standard:
- In order to improve efficiency and safety and reduce duplication, the Hospice at Home clinical records database will be transferred onto SystmONE.

How was this identified as a priority?
The Hospice at Home service was launched as a pilot in January 2013. The existing clinical record system used in the Hospice is SystemOne but it was decided that as the Hospice at Home service was a pilot and permanent funding had not been secured, a separate data collection system would be developed to allow for accurate evaluation at the end of the pilot project. Alongside the database developed by the Hospice, there was a patient held document together with a paper record to enable clinicians to record their clinical activity with the patient. Responsibility for the patient held document lay with Birmingham Community Health Care Trust.

Following a successful pilot period, Hospice at Home became one of the core Hospice services. In order to address information governance requirements, reduce risks and avoid duplication, it was agreed that the clinical records be transferred onto SystmONE. Therefore, the overarching objective of this priority was the transition to SystmONE fit for the efficient and safe delivery of the service in the future and capable of enabling its expansion through evidencing robust data collection and reporting mechanisms.

How was the priority achieved?
A Project Management Group was set up and the members of this group wrote a ‘Project Initiation Document’ to map out the stages of development and potential risks. The Group met regularly to track progress and address issues as they arose.

How was progress monitored and reported?
Progress was monitored through the Project Management Group. The Chair of the Group was the Director of Nursing who had responsibility for ensuring that:
- There was appropriate stakeholder engagement, in particular appropriate clinical representation
- The project followed Hospice standards and existing established practice
- The Group met regularly in order to discharge its responsibilities
- That progress was reviewed by the Project Management Group every 4-6 weeks
- Progress was monitored through the project deliverables
- Any issues highlighted were appropriately escalated to the Executive Director Team
Patient Experience - Day Hospice review

Priority Three: Day Hospice Review

Standard:
To ensure the Day Hospice service is effective, evidence based and reflects the needs of our local community

How was this identified as a priority?
Due to increased numbers of referrals to Day Hospice with non-cancer diagnosis and National Council for Palliative Care (2013) reporting that there has been an increase in non-cancer patients accessing Specialist Palliative Services, consideration was needed as to whether Day Hospice should be accessed by different cohorts of patients on different days, based on diagnosis. Whilst the Lead Nurse and Director of Nursing found that this would not be a feasible way of offering a service, due to variety of diseases, they did see the need for a systematic review of other Day Hospice service models.

The review was identified as a priority as there had not been a review of the current service model for several years and it was necessary to assess if the existing model was cost effective, if there was an evidence base behind the service model, what patients understood about the service on offer and what service referrers might wish from a Day Hospice service.

The Lead Nurse had already identified the need for a more therapeutic model and had introduced 'group education/discussion' sessions for self-management of symptoms at home to the Day Hospice patient cohorts across the four days the service ran. The idea behind the sessions and how they were structured was presented at the first End of Life Partnership conference 'Small Changes, Big Differences' in October 2014.

How was the priority achieved?
- A project group carried out a systematic review over 12 months and presented their findings to the Hospice Executive Team and Clinical Leads in January 2015
- Other Day Hospice models were scoped for effectiveness and evidence base
- Day Hospice patients undertook a qualitative questionnaire of what services are provided and what services could be provided
- Day Hospice patients were encouraged to ask friends/relatives to complete questionnaire of service requirements from a carers perspective
- Day Hospice Lead Nurse attended Association of Palliative Day Service Leaders Conference in Sept 2015 and scoped views on other models of service across the country.
- Day Hospice Lead Nurse undertook a review of evidence base as far as able with documented reviews of Day Hospice service models via Athens
- Scoping of other Day Hospice Leads at locality group meetings, as use of model (social, therapeutic, mixed models) and of services on offer.

How was progress monitored and reported?
- The Project Group gathered and decided on a plan of how to obtain evidence from other Day Hospice services
- An internal communication plan was devised by the Project Group.
- The project group met monthly, then weekly as the review gathered momentum
- Progress was provided to the Director of Nursing at monthly one to one meetings
• Project Group’s written report was completed in October 2014 and circulated to Executive Directors.
• The Project Group presented the completed review to Executive Directors and Clinical Leads in January 2015
Part 2 – Priorities for Improvements and Statements of Assurance

2.2 Other Hospice Achievements 2014 – 2015

- **Food Hygiene**
  In March 2015 Birmingham City Council’s Environmental Health Officer conducted an unannounced inspection. The Catering Team achieved 5H rating, which represents excellent food hygiene standards in our food preparation areas. We have achieved this level consecutively over the last 5 years.

- **Gold Standards Framework (GSF)**
  The Hospice has been accepted as a Regional Training Centre for the Gold Standards Framework. The GSF is a systematic approach to optimise the delivery of end of life care by improving the quality, organisation and pre-planning of care.

- **National Information Standard for End of Life Care Co-ordination**
  The Hospice’s Director of Nursing was appointed by the Royal College of Nursing (RCN) to represent the RCN on this Public Health England Clinical and Professional Assurance Group. This national standard specifies the core content to be held in Electronic Palliative Care Co-ordination Systems and support implementation of the National End of Life Care Strategy.

- **Invaluable new equipment**
  Our Lead Nurse on the Inpatient Unit was able to tick something off her wish list this year. In April 2014 the Hospice purchased a ‘Hoverjack’ which is a piece of equipment to help get fallen patients off the floor. This has benefitted patients by providing a far more comfortable means of transferring them and has made a huge impact on the amount of manual handling by staff working on the Inpatient Unit.

- **Survey results published**
  Two Hospice staff, Head of Nursing and a locum Consultant in Palliative Care, conducted a survey to establish the number of patients transferred to an acute hospital setting, the reason for transfer and the subsequent outcomes. They presented the results of the survey in the European Journal of Palliative Care 2014:21(5). Key points included:
    - Reasons for transfer included medical emergencies, requirement for intravenous therapy, ventilation assessment, interventional procedures, urgent radiotherapy and palliative surgery
    - Among 844 patients admitted to the Hospice during the study period, 36 (4.27%) were transferred to a hospital for investigation or treatment
    - Out of 36 patients transferred to hospital, 14 were eventually discharged home and 22 died within a mean of 24.6 days
    - When the benefits of active treatment are less certain, the appropriateness of hospital interventions in patients with advancing and incurable disease can be hard to determine
• **Space to Breathe**
  Last year we reported on our achievements in relation to the Space to Breathe project to support patients with chronic obstructive pulmonary disease.
  
  o **Master’s Degree for one of our Clinical Nurse Specialists**
    Sharon Hudson was the driving force behind the space to breathe project and her research focused on the palliative care needs of people with advanced chronic obstructive pulmonary disease (COPD). The course fees and cover for her substantive post were funded by the NHS National Institute for Health Research.
  
  o **Nursing Times Award 2014**
    In August we were shortlisted for two Nursing Times Awards, one for Respiratory Nursing and the other for Integrated Approaches to Care. Whilst we did not win, the nominations profiled the important work we have done in this area.

• **Specialist Advisor**
  The Hospice’s Director of Nursing has been appointed as an End of Life Care Specialist Advisor by the Care Quality Commission (CQC). This role provides specialist advice and input into the Commission’s regulatory inspection and investigation activity. This advice ensures that CQC’s judgements are informed by up to date and credible clinical and professional knowledge and experience.

• **Carers Support Needs Assessment Tool (CSNAT)**
  Family and Carers play an important role in enabling patients to be cared for at home. The Carers Support Needs Assessment Tool (CSNAT) was developed to help measure the support needs of Family and Carers engaged in providing this care. During January to June the Hospice’s Community Palliative Care Team were involved in one of the final phases of the CSNAT study. Members of the Team used the tool with carers and provided feedback to the researchers based on their experience of implementing it in practice. They provided information in respect of the challenges they faced and what might help or hinder its adoption by Clinical Teams.

• **National Institute for Health and Care Excellence (NICE): Care of the Dying Adult, Guideline Development Group**
  The Hospice’s Director of Nursing was appointed by NICE to this guideline development group. The Department of Health asked NICE to develop these guidelines. Until July 2014, care in the last days of life was delivered and coordinated in many places by the use of end of life care pathways such as the Liverpool Care Pathway (LCP) or its local derivatives. The LCP was intended to ensure that people thought to be in the last 2 or 3 days of life, regardless of their setting, died free of distressing symptoms and with dignity, by transferring the model of care as practised in hospices to other healthcare settings. However, there has been criticism about how some elements of the LCP have been implemented. These include issues about how patients were selected to be placed on the LCP; communication with patients and families; the appropriateness of withholding or withdrawing hydration, nutrition and some medication; injudicious. The NICE guidelines will go some way to providing an alternative to the LCP, so that health care professionals (doctors and nurses etc) can provide evidence based care to dying adults. These national guidelines are due for publication December 2015.
Part 2 – Priorities for Improvements and Statements of Assurance

2.3 Priorities for Improvements 2015 – 2016 – *what we will achieve next year*

**Patient Safety** - Provision of Oxygen to Hospice Patients

**Priority One:**
Provision of Oxygen to Hospice Patients

**Standard:**
To upgrade the system to address capacity issues and meet future requirements

**How was this identified as a priority?**
The limitations of the current system meant that the number of patients on oxygen and their usage had to be closely monitored and at times the admission of patients could be restricted if they had a requirement for oxygen. This was usually overcome by arranging for oxygen concentrators to be delivered in for the individual patient. However, these concentrators are quite noisy – both for the patient and also for others in the vicinity especially if used in a bay.

On occasion there have been several patients using concentrators, which is not conducive to good patient care.

For this reason we decided to upgraded the system to a bulk liquid oxygen system to address the following issues:
- Address health and safety issues for Facilities staff in respect of manual handling of heavy and bulky cylinders
- Remove the need to organise oxygen concentrators to support admission of patients
- Make the admission of patients a smoother process – reducing the anxiety for clinical staff over the ability of the oxygen system to support admissions
- Reduce deliveries of oxygen from up to 3 per week to 1 per week most weeks with the occasional extra delivery of portable cylinders (different part of BOC operation)
- Remove the need for Facilities staff to work outside their normal working hours
- Provided a system to meet current and future requirements

**How will the priority be achieved?**
The Facilities Manager will conduct a review in order to identify an appropriate system that:
- Addresses the issues identified above
- Can utilise the existing manifold room
- Will have little impact on other Hospice operational systems using the front yard
- Will not require planning permission because the Hospice is located in a conservation area

**How will progress be monitored and reported?**
- Facilities Manager and Lead Nurse meetings
- Business Case reviewed by Business Development Team and Executive Directors
- Regular progress reports to quarterly meetings of the Hospice’s Compliance Committee (Environment & Risk)
Clinical Effectiveness - Study of Hydration at the End of Life

Priority Three: Study of Hydration at the End of Life

Standard: The Hospice clinical teams will be able to use this information to help inform our practice and education of others

How was this identified as a priority?
Birmingham St Mary's Hospice recognises the importance of research within palliative and end of life care to provide evidence and therefore enable our clinical teams to provide the best possible care for our patients. As a result we have been working with the clinical research network to find opportunities to be involved in national and international research. We were selected in late 2014 as a site for a research study entitled "A cluster randomised trial of alternative forms of hydration in cancer patients in the last days of life (Feasibility study)". This research study is being co-ordinated by clinicians working with the University of Surrey (chief investigator Andrew Davies) and we are one of only 12 sites across the UK to be involved in recruiting patients for the trial.

How will the priority be achieved?
This research recognises that the provision of clinically assisted hydration (CAH) at the end of life is a contentious issue but that one of the reasons for this is the lack of evidence for either benefit or harm. The study aims to provide evidence for or against the hypothesis that CAH during the last days of life reduces the frequency of hyperactive delirium in cancer patients. This study is a feasibility study to ensure that recruitment and retention for the trial is possible, and to enable a review of the impact of trial procedures on clinical workload and resources. Assuming the feasibility study is possible, we will be invited to take part in the definitive research. The trial is a cluster randomised trial so each site involved in the research is randomised to one of two standard interventions and data is recorded and collated by the site for processing by the University of Surrey.

How will progress be monitored and reported?
The Hospice is required to feedback progress on this research to the University of Surrey on a regular basis. Monitoring visits will take place and the research is strictly supervised in line with research ethics. The research team from Surrey will be seeking feedback from the nursing and medical teams on the inpatient unit as to their experience of being involved with the study and this will form part of the reporting of the research.

We anticipate being informed of the results of the study soon after they are available, and will be able to use this information to help our practice and education of others. Being involved in research which answers questions for patient benefit is also hugely rewarding and motivating for our clinical team.
Patient Experience - Bereavement CQUIN

Priority Three: Bereavement (Commissioning for Quality and Innovation)

Standard: Bereavement Care Standards 2014 – defined quality criteria

How was this identified as a priority?
Bereavement care standards 2014 are endorsed by the National Bereavement Alliance and define a set of quality criteria for what clients, carers, staff and volunteers can expect from bereavement care services. The standards represent what professionals, patients and families have said they would like from bereavement services and improving experience is one of the five domains against which the NHS is held to account.

Birmingham Cross City Clinical Commissioning Group offered us the opportunity to prioritise this standard as part of the Commissioning for Quality and Innovation payment framework.

How will the priority be achieved?
- Report describing the current structure and delivery of bereavement care within the hospice.
- Audit of bereavement services against national standards
- Evaluate progress and identify any gaps in provision
- Formulate an action plan based on the results of the audit and assessment of any actions put into place

How will progress be monitored and reported?
Quarterly progress reports will be submitted to Birmingham Cross City Clinical Commissioning Group.
Part 2 – Priorities for Improvements and Statements of Assurance

2.4 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.

Review of services
During 2014-15 Birmingham St Mary’s Hospice supported commissioning priorities in Birmingham and Sandwell with regard to the provision of local specialist palliative care by providing the following services which were also part-funded through charitable funding:

- Inpatient Unit
- Community Palliative Care Team
- Day Hospice
- Hospice at Home
- Occupational therapy
- Physiotherapy
- Complementary therapies
- Family & Carer support services, including bereavement support and spiritual care

Participation in Clinical Audit
As a provider of specialist palliative care Birmingham St Mary’s Hospice was not eligible to participate in any of the national clinical audits or national confidential enquiries. This is because none of the 2014-15 audits or enquiries related to specialist palliative care.

Supporting vulnerable patients
Our services are developed to respond to the individual and diverse needs of our population and provided free of charge to patients and their families.

- Safeguarding
  The Trustees and Executive Team believe that the quality of the care depends on having a skilled and resourced workforce of paid and voluntary workers with access to appropriate training and development. We work with individuals and families at particularly vulnerable times in their lives and during the last 12 months we have developed a rigorous training programme for staff and hospice based volunteers to ensure they are appropriately supported to recognise safeguarding issues, discrimination, exploitation and intimidation. As part of this mandatory training we also provide PREVENT training to support staff in the identification of radicalisation.

- Translation
  To ensure that we are able to welcome and support those patients and families who do not have English as their first language, we have an agreement with a local interpretation service who are able to provide support on an ad hoc or regular basis. We have also had some of our key documents translated.

- Dementia
  Our referral criteria is needs based and not based purely on diagnosis and this means that we are able to take patients who, for example, are suffering from dementia. This is because our referrals do not take account of a patient’s underlying pathological diagnosis. The Lead Nurse on the Inpatient Unit is currently scoping specialised ‘diffusion and breakaway’ training for staff
in order to support both patients and staff appropriately in potentially difficult situations. The Hospice is also a member of the Dementia Alliance.

The feedback we receive from our patients and their carers demonstrates the unique package of care each of our patients receives.

**Staff Survey**

In the spring of 2014 we conducted a staff survey. The responses were extremely positive and indicated that 92% of respondents were proud to tell people they work for Birmingham St Mary’s Hospice, which is above benchmark statistics. In terms of the service provided by the Hospice, 88% of participants felt that Birmingham St Mary’s Hospice is delivering a high quality service to its clients, as set out in the current 4 Year Plan. Results from the staff survey were delivered by the Head of Human Resources in a training session for Team Leaders and Heads of Departments.

**Equality and Diversity Monitoring**

Equality and Diversity Monitoring is the process used to collect, store and analyse data about the age, gender, sexual orientation, disability, ethnicity, religion and beliefs of our workforce. This information is also referred to as being “protected characteristics” under the Equality Act 2010.

In early 2015 staff at the Hospice were asked to complete an ‘equality and diversity monitoring form’.

This information informs us where we have shortfalls in our workforce and how accessible we are as an employer. It is also summarised to help with internal performance reports and used to understand how the Hospice is performing overall in terms of equality.

The completed forms are stored on personal files so that we can continue to meet the individual needs of staff that may have, for example, a disability requiring adjustments to be made to their working environment or for when completing training.

Staff were made aware that as well as it being our focus to do all that we can so that people from all backgrounds have a fair opportunity to be represented in our workforce, we are required by law to ask for this information. Staff were also advised that they are not legally obliged to provide it and were given the opportunity to select the option ‘prefer not to say’.

**Research**

**Developing a Strategy for a Research Active Hospice-Process and Progress**

1. **Background**

If evidence-based care is to be provided for patients at the end of life, hospices must engage in research¹. A framework has been developed which provides guidance for three levels of research participation which hospices can use to become Research Active². The production of this guidance coincided with the Hospice securing funding to support the achievement of one of its core strategic aims to: “promote, encourage or assist research into the care and treatment of people suffering from [chronic or terminal] illnesses³.”

**Aims**

- To develop an inclusive and realistic research strategy for the hospice
- To increase research activity in the hospice
- To build a partnership approach involving key stakeholders

2. **Approach**

A palliative care consultant was designated as a ‘Research Champion’ and recruited to provide two protected research sessions a week (for two years). In addition a senior lecturer was supported by
the local University to work with the hospice to develop research. They devised a research strategy to guide the development of research activity in the hospice.

3. Outcomes
The strategy was endorsed by the Hospice Board of Trustees and several short term objectives were achieved including: re-establishing a journal club to promote scholarship and research; reviewing the research dissemination and promotion function; reviewing existing research to ensure it was reported widely; and integrating research into the business planning cycle. In the medium term, the aim is to integrate research activity with the University by supporting staff to undertake academic work, and strengthening the links with existing research teams and recruit a research nurse to join the team. The hospice has already become research active, with involvement in several portfolio clinical trials.

4. Conclusion
Through investment in research and the development of a research strategy considerable progress has been made. Work continues to increase research activity in the longer term.

References
3. Hospice 2012/13 annual report

The Hospice also participated in the following research studies during 2014-15. Findings from research are shown where known at the time of writing this Quality Account. Final reports on research are discussed at the Hospice’s Research Steering Group in terms of how these might apply to the work of the Hospice together with any recommendations made by researchers.

- **Josh Quadri, HR Learning & Development Lead, Birmingham St Mary’s Hospice**
  MSc study - a critical study evaluating the effectiveness of e-learning through the perspectives of employees at Birmingham St Mary’s Hospice

- **Liz Reed, Researcher, Princess Alice Hospice, Esher**
  European Certificate in Essential Palliative Care Research - “Can Palliative Care education intervention improve and sustain participants confidence and professional development in Palliative Care and how does this translate to patient outcomes”

**Preliminary findings from this research:**
- Have improved confidence in palliative care at 3 months post course which is sustained at 6 months
- Have a better appreciation of holistic care
- Incorporate evidence into their practice
- Aim to influenced the practice of others
- May considered a career in palliative care or be the palliative care resource for their clinical area

Anecdotally data suggests that interviewees have influenced their practice and that of others. These range from developing a palliative care strategy in an acute unit, a teaching programme in a care home or examples of general oncology practitioners changing their practice with increased knowledge and confidence in symptom control, communicating with families etc. we have defined it as ‘influencing care delivery’ as unless we were taking to patients we can’t determine patient outcomes.

- **Dr Cara Bailey, Senior Lecturer, University of Birmingham**
  EcoEnd Life: Economic Evaluation of End of Life
• **Dr Andrew Davies, Clinical Director Palliative Care, Royal Surrey County Hospital**  
A Cluster Randomised Trial of Alternative Forms of Hydration in Cancer Patients in the last few days of life (feasibility study)

• **Manjula Patel, Student University of Warwick**  
PhD study - Compassionate Communities

• **Marie Fallon, Professor, Institute of Genetics and Molecular Medicine, Edinburgh Cancer Research UK Centre**  
Two Versus Three Study - An international, multicentre, open randomised parallel group trial comparing a two-step approach for cancer pain relief with the standard three step approach of the WHO analgesic ladder in patients with cancer pain requiring step 2 analgesia

• **Cathy Knowles, Student, University of Bristol**  
MSc study - How are measures used to manage the performance of English and Welsh hospices?

• **Victoria Welch, Student, University of Birmingham**  
MSc study - An investigation into how hospice based palliative care is able to adapt to meet the needs of patients with a pre-existing diagnosis of mental illness.

The analysis revealed four main discourses at work: mental health issues as unnameable or unknowable, the ‘whole person’ team approach, adaptation actions and the concept of the hidden hospice.

Research analysis reveals that the workers engage in constructing a positive whole person discourse, as opposed to a disease discourse. The hidden hospice discourse performs a powerful function, as it is recognised as a problem by workers and work is being undertaken to address the issue. The participants know that something is amiss. They work hard to adapt to the needs of servicers users, but they are also isolated and unrecognised as carers of those who have mental health issues, which renders the service invisible. A dialogue needs to take place to build on the work already being done, so that services link and address issues together.

This study raises certain implications for future policy and practice. There is a need to establish a dialogue between services, as this hospice has begun to do. This finding also has wider implications for the lack of partnership between mental health care and physical healthcare across the spectrum, and for the wellbeing of service users.

**Hydration Research**

The Hospice has been selected as one of only twelve sites in the UK to work with the Clinical Research Network and participate in a research study entitled “A cluster randomised trial of alternative forms of hydration in cancer patients in the last days of life (Feasibility Study)”. This research recognises that the provision of clinically assisted hydration (CAH) at end of life is a contentious issue but that one of the reasons for this is lack of evidence of either benefit or harm. The study aims to provide evidence for or against the hypothesis that CAH during the last days of life reduces the frequency of hyperactive delirium in cancer patients.

We will be required to feedback progress on this research to the University of Surrey on a regular basis. Monitoring visits will take place and the research is strictly supervised in line with research ethics. The research team from Surrey will be seeking feedback from the nursing and medical teams on the inpatient unit as to their experience of being involved with the study and this will form part of the reporting of the research.

We anticipate being informed of the results of the study soon after they are available, and will be able to use this information to help our practice and educate others.
Guideline development and review
The following National Institute for Health and Care Excellence (NICE) guidelines, guidance and standards, applicable to the Hospice clinical practice, have been reviewed:

April 2014
• NICE Public Health Guidance 49: Behaviour Change: Individual Approaches
• NICE Quality Standard 38: Acute Upper Gastrointestinal Bleeding
• NICE Clinical Guideline 171: Urinary Incontinence in Women

May 2014
• NICE Quality Standard 50: Mental Wellbeing of Older People in Care Homes

July 2014
• NICE Clinical Guideline 161: Falls: assessment and prevention of falls in older people
• NICE Clinical Guideline 176: Head Injury

September 2014
• NICE Clinical Guideline 81: Advanced Breast Cancer Update

November 2014
• NICE Quality Standard 61: Infection Prevention and Control

December 2014
• NICE Clinical Guideline 140: Evidence Update Opioids in Palliative Care
• NICE Clinical Guideline 182: Early identification and management of chronic kidney disease in adults in primary and secondary care

January 2015
• NICE Clinical Guidance 183: Drug allergy: Diagnosis and management of drug allergy in adults, children and young people
• NICE Public Health Guidance 54: Exercise Referral Schemes to Promote Physical Activity
• NICE Medical Technology Guidance 20: Parafricta Bootees and Undergarments to reduce skin breakdown in people with or at risk of pressure ulcers

February 2015
• NICE Clinical Guidance 186: Multiple sclerosis: management of multiple sclerosis in primary and secondary care
• NICE Quality Standard 76: Acute Kidney Injury

March 2015
• NICE Clinical Guidance 75: The Management of Malignant Spinal Cord Compression
• NICE Technical Appraisal Guidance 327: Dabigatran etexilate for the treatment of deep vein thrombosis and/or pulmonary embolism
Use of Commissioning for Quality and Innovation (CQUIN) payment framework 2014–2015

A proportion of Birmingham St Mary’s Hospice income in 2014-15 was conditional on achieving quality improvement and innovation goals agreed between the Hospice, and the following Clinical Commissioning Groups: Birmingham Cross City, Birmingham South Central, Sandwell and West Birmingham. This was achieved through the Commissioning for Quality and Innovation payment framework and related to:

- Ensuring that we had real-time systems in place to monitor patient/carer experience
- Demonstration of improvements in patient/carer experience
- Demonstrating a clear commitment from the Board to improve patient/carer experience

The aim of this was to ensure patient/carer satisfaction and to measure the outcome of patient care whilst continuously monitoring the quality of the services provided through the use of questionnaires.

More detail on the methodology and outcomes from these questionnaires is given later in this Quality Account.

Whilst the Clinical Commissioning Groups have not decided to roll this CQUIN over to 2015-16, the Hospice has decided to continue with monthly patient satisfaction questionnaires to gather feedback from its core services to inform future practice.

Details of the initiative for 2015-16 are given below:

Description of CQUIN
- The focus is on the bereavement support for patients, carers and family members pre- and post-bereavement
- The purpose is to identify and describe services and processes and to audit those services against national standards and evaluate progress and identify gaps in provision.

Aim
- To work towards the defined set of quality criteria in the Bereavement Care Standards 2014 which are endorsed by the National Bereavement Alliance. These standards set the criteria for what clients, carers, staff and volunteers can expect from bereavement care services.
- We will report quarterly to the Clinical Commissioning Groups and include this information in our Quality Account next year.
Statement from the Care Quality Commission

Birmingham St Mary’s Hospice is registered with the Care Quality Commission to carry out the following regulated activities:

- Diagnostic and screening procedures
- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder or injury
- Personal care
- Nursing care

The following conditions of registration apply to all regulated activities listed above:

- **The Registered Provider must ensure that the regulated activities are managed by an individual who is registered as a manager in respect of the activity, as carried on at or from the location St Mary’s Hospice Limited**
- **These regulated activities may only be carried out at or from the following location:** 176 Raddlebarn Road, Selly Park, Birmingham B29 7DA

The following additional conditions apply:

- **This hospital is registered to provide treatment and care under the following service user categories only:** Hospice for adults H(A).
  - **Reason for condition:** To ensure that only treatment and services within the scope of the providers’ knowledge, skills and experience are offered.
- **A maximum of 25 patients may be accommodated overnight.**
  - **Reason for condition:** To ensure that only treatment and services within the scope of the providers’ knowledge, skills and experience are offered.
- **A maximum of 20 persons only may receive services provided on a day-case basis.**
  - **Reason for condition:** To ensure that only treatment and services within the scope of the providers’ knowledge, skills and experience are offered.
- **Notification in writing must be provided to the Care Quality Commission at least one month prior to providing any treatment or service not detailed in your Statement of Purpose**
  - **Reason for condition:** To ensure that only treatment and services that are safe to be undertaken in the premises and within the scope of the providers’ statement of purpose are offered.

The Care Quality Commission has not taken any enforcement action us during 2014-15 nor have we been required to participate in any special reviews or investigations by the Care Quality Commission during this period.

Our last inspection by the Care Quality Commission was in January 2014 when we were inspected on the following standards as part of a routine inspection. The inspector found that we met all 5 standards:

- **Care and welfare of people who use services**
- **Staffing**
- **Supporting workers**
- **Statement of Purpose**
- **Assessing and monitoring the quality of service provision**

An extract from the Commission’s report was included in our Quality Account for 2013-14 but is also repeated below. Copies of the full inspection report are available on the Commission’s website: [www.cqc.org.uk](http://www.cqc.org.uk)
Why we carried out this inspection
This was a routine inspection to check that essential standards of quality and safety referred to above were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection
We looked at the personal care or treatment records of people who use the service, carried out a visit on 31 January 2014, checked how people were cared for at each stage of their treatment and care and talked with carers and/or family members. We talked with staff.

What people told us and what we found
We inspected the service that was provided in people's own homes, the Hospice at Home Service. At the time of our visit there were five people receiving this service but over one hundred and fifty people had used it over the past 12 months.

We found that people's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. Nurses and nursing assistants from the service worked with District Nurses from the NHS Community Healthcare Trust to provide end of life care for people in the their own homes.

There were sufficient numbers of staff on duty to meet people's needs. The service was staffed by Registered Nurses and nursing assistants who were supported by a manager and an administrator. The service also had flexible staffing arrangements to meet demands and people's changing needs. Staff were properly trained, supervised and appraised. They received support to deal with the challenging nature of their work providing end of life care in people's homes.

Information about the safety and quality of service that people received was gathered and scrutinised and used to improve the service. This included gathering the views of people who used the service and of other stakeholders in the service such as district nursing teams.

A family member of a person who used the service told us “My [relative] likes them, they are very thorough and very caring … I don’t know what we would do without them, they have been great.”

Data Quality
Birmingham St Mary's Hospice did not submit records during 2014-15 to the Secondary Users Service.

Information Governance Toolkit
Information Governance is the way in which we handle all organisational information, particularly personal and sensitive information about patients and employees. It allows organisations and individuals to ensure that personal information is dealt with confidentially, legally, securely, efficiently, effectively and ethically.

Birmingham St Mary's Hospice Information Governance Assessment Report overall score for 2014-15 was 66%, maintaining a satisfactory score and graded green.
Clinical coding error rate
Clinical coding is ‘the translation of medical terminology as written by the clinician to describe a patient’s complaint, problem, diagnosis, treatment or reason for seeking medical attention, into a coded format’ which is national and internationally recognised. We were not subject to the payment by results clinical coding audit during 2014-15 by the Audit Commission. This is because we receive payment under a mix of block contracts and payment on a cost per case basis when delivered, not through a tariff system. Therefore clinical coding is not relevant to this Hospice.

Our Clinical Information Officer collects and collates data extracted from SystmONE, our electronic patient record system, and a data integrity sub-group reviews this data quarterly.
Part 3 – Review of quality of Performance

3.1 Clinical Data

Birmingham St Mary’s Hospice uses ‘SystmONE’, an electronic patient records system which all patients are entered onto. We have, therefore, chosen to present data extracted from that system for the year 1 April 2014 to 31 March 2015 for the following services:

In Patient Unit (IPU)
- There were 409 admissions to our IPU – this includes those patients that may have been admitted more than once

Community Palliative Care Team (CPCT)
- 838 new referrals were received for this service
- 8,805 patient contacts were made during the year
- There were between 250-300 patients per month on the Team’s caseload during the year
Day Hospice
- Attendance in our Day Hospice was 1,809
- Patients were unable to attend Day Hospice for a variety of reasons on 899 occasions (see the breakdown on the next page)
Reasons for non-attendance – Day Hospice

<table>
<thead>
<tr>
<th>Reason</th>
<th>Total for 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient appointment</td>
<td>88</td>
</tr>
<tr>
<td>In hospital</td>
<td>169</td>
</tr>
<tr>
<td>In Hospice Inpatient Unit</td>
<td>127</td>
</tr>
<tr>
<td>Unwell</td>
<td>343</td>
</tr>
<tr>
<td>On holiday/away</td>
<td>47</td>
</tr>
<tr>
<td>Other (Visitors – family/district nurse/friends/workmen/delivery)</td>
<td>110</td>
</tr>
<tr>
<td>Reason unknown</td>
<td>14</td>
</tr>
<tr>
<td>Cancelled by service</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>899</strong></td>
</tr>
</tbody>
</table>
Part 3 – Review of quality of Performance

3.2 Quality Markers

- Patient Slip, Trips and Falls
- Pressure Ulcers
- Infection Prevention and Control
- Medicines Management
- Complaints and Compliments

Patient Slips, Trips and Falls
Patient slips, trips and falls are monitored and reported internally using our incident reporting process. Serious incidents are reported to the Care Quality Commission under the statutory notifications framework.

In 2014/15 there has been a decrease in the number of patient slips, trips and falls, with 91 incidents reported. No serious injuries were sustained during this reporting period and therefore no formal reports have been made to either the Care Quality Commission or Clinical Commissioning Groups.

![Slips, Trips and Falls 2014 - 2015](image.png)

We will undertake a root cause analysis when any of the following occur:
- A fall results in hospital assessment or admission
- A patient suffers loss of consciousness
- A patient has abnormal neurological observations
- A patient has repeatedly fallen i.e. more than 3 times on current admission
- A patient has died as a result of a fall or within 24 hours of a fall

During 2014-15 two RCA’s were completed. These related to two patients who, due to their complex care needs and frailty, fell on more than three occasions. Care is planned with patients individually to support their independence where appropriate, whilst at the same time trying to ensure their safety. We regularly monitor the falls data, which we use for education purpose and staff awareness sessions.
Pressure Ulcers
During 2014/15 there has been a significant decrease in the number of patients admitted to the hospice with Pressure Ulcers. Only 67 patients were admitted with Pressure Ulcers compared to 97 during 2013/14. This has resulted in a reduction in the percentage of patients admitted from home by 16% (51 in 2014/15 compared to 61 in 2013/14) and from hospital by 55% (16 in 2014/15 compared to 36 in 2013/14).

A Root Cause Analysis (RCA) is undertaken for all patients whose Pressure Ulcer progresses to a grade three or above whilst in our care. Statutory notifications are made to the Care Quality Commission and incident rates are also provided to the Clinical Commissioning Group.

In our Quality Account last year we reported a change in Root Cause Analysis investigations. With effect from 1 April 2014 we only conducted an RCA for those patients where grade 3 or above pressure damage was acquired at the Hospice. This change in process has resulted in a significant decrease in the number of RCAs completed for pressure damage, with only 4 RCAs completed this year.

![Graph showing changes in admissions and pressure ulcers](image-url)
In order to support staff in enhanced detection and prevention of the damage caused by pressure ulcers, we are starting a pilot of the SSKIN tool in June 2015. This will support heightened checking of patients’ skin and improved documentation. SSKIN is a five step model for pressure ulcer prevention:

- **Surface**: make sure your patients have the right support
- **Skin inspection**: early inspection means early detection. Show patients & carers what to look for
- **Keep your patients moving**
- **Incontinence/moisture**: your patients need to be clean and dry
- **Nutrition/hydration**: help patients have the right diet and plenty of fluids

In addition, one of our staff nurses has enrolled on a degree module in ‘pressure ulcer management’ and will share this learning with her colleagues on the Inpatient Unit.

**Infection Prevention and Control**

Our Infection Prevention and Control Resource Nurse works one day per week. In addition we have an agreement with an external consultant to provide 6 days each year to provide support and mentorship to the Resource Nurse and expert advice to the hospice. The Director of Infection and Prevention and Control is the Hospice’s Director of Nursing.

**Outbreaks**

There were no outbreaks during 1 April 2014 and 31 March 2015.

**Surveillance of MRSA and Clostridium Difficile**

The total number of patients known to have MRSA/C-Diff on the In Patient Unit between 1 April 2014 and 31 March 2015 are:

<table>
<thead>
<tr>
<th>Micro Organism</th>
<th>Total number of patients known to be colonised:</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA</td>
<td>0</td>
</tr>
<tr>
<td>Clostridium Difficile</td>
<td>1</td>
</tr>
</tbody>
</table>

**Medicines Management**

All drug related incidents and near misses are reported to the Hospice’s Medicines Management Committee as part of the governance framework. The Committee, which is chaired by one of the Consultants in Palliative Care, meets every three months and the Trust’s Pharmacist (see below) also attends the meetings.

The Director of Nursing is Accountable Officer for Controlled Drugs for the Hospice. This is a statutory role identified in the Controlled Drugs (Supervision of Management and Use) Regulations 2013. The primary responsibility of the role is to secure safe management and use of controlled drugs. The Hospice is one of the partner organisations of the Birmingham, Solihull and Sandwell Local Intelligence Network for Controlled Drugs Governance. This Network meets quarterly and partner organisations have all signed an information sharing agreement in order to confidentially divulge information in respect of the use, handling, prescribing or management of controlled drugs. During the last 12 months the Hospice has raised zero concerns with the Network.

We have an agreement with University Hospitals Birmingham NHS Foundation Trust for a clinical pharmacy service. This includes provision of the following:

- supply of stock drugs, review storage quantities, expiry dates and storage conditions
- a pharmacist to visit the Hospice 3 days per week
- a pharmacy technician to visit daily
- monitoring of prescription charts and comprehensive medication reconciliation
and reactive advice on medications to patients, doctors and nurses
operating a dispensing for discharge service

During the last 12 months there were 79 medicines related incidents and 37% of these were external incidents identified by Hospice staff, i.e. errors made by others and discovered by a member of our clinical staff.

Complaints and Compliments
A summary of the complaints received between 1 April 2014 and 31 March 2015:

<table>
<thead>
<tr>
<th>Total No. of Complaints:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nursing:</strong></td>
<td></td>
</tr>
<tr>
<td>In Patient Unit</td>
<td>1</td>
</tr>
<tr>
<td>Day Hospice</td>
<td>0</td>
</tr>
<tr>
<td>Community Palliative Care Team</td>
<td>0</td>
</tr>
<tr>
<td>Hospice at Home</td>
<td>0</td>
</tr>
<tr>
<td><strong>Medical</strong></td>
<td>0</td>
</tr>
<tr>
<td><strong>Family and Carer Support Team</strong></td>
<td>0</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td>2</td>
</tr>
</tbody>
</table>

 Developing a Learning Culture
 A record of learning is being developed from each formal complaint to ensure that the organisation is continually improving from individuals' experiences. The organisation views complaints as providing invaluable feedback about the services it provides.

 Compliments and “Thank You's”
 The Hospice receives numerous thank you cards and letters which are normally received by individual departments. Compliments and thank you cards and letters are retained after they have been displayed in individual departments. Particular phrases and expressions of gratitude are used in Hospice material, with the permission of the author.

 Encouraging Feedback
 Staff and Ward Volunteers encourage and support patients to give feedback. Compliments/complaints slips are available in the Butterfly Lounge and referenced in the patient information booklets

 Compliments, cards and letters of gratitude are passed to the individual departments for sharing with staff. The information is retained for a total of twelve months and particular phrases and expressions of gratitude are used in Hospice material, with the permission of the author.
**Part 3 – Review of Quality of Performance**

### 3.3 Clinical Audit

A structured programme of clinical audit activity is agreed annually by all relevant departments and approved by the Research and Clinical Audit Steering Group. The programme includes national and local clinical audit priorities and is based on key quality and risk issues. Other drivers for clinical audit may include the Care Quality Commission essential standards such as policy and procedure compliance and responding to Central Alert System Alerts.

Auditors are identified to lead on individual projects by Senior Clinicians/Senior Managers.

The requirements for the management of audits at the Hospice are to ensure:
- It is for the benefit of the patient, staff and the general public
- It is of high quality
- Complies with legal requirements & meets ethical standards
- It is conducted in line with best practice guidance

The main purpose of Clinical Audit is to deliver improved outcomes for patients and where standards are not adhered to, then an action plan is produced which is regularly reviewed. During 2014/15 a total of 50 audits were conducted, of which 35 were clinical and 15 were medication audits.

<table>
<thead>
<tr>
<th>Audit</th>
<th>Medicines Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 audits were completed</td>
<td><strong>What we were good at:</strong></td>
</tr>
<tr>
<td></td>
<td>All Controlled Drugs are accurately up to date and reflect patterns of use</td>
</tr>
<tr>
<td></td>
<td>All Controlled Drug administrations are given within the specified time frame</td>
</tr>
<tr>
<td></td>
<td>All nurses pass the Patient Group Directions assessment</td>
</tr>
<tr>
<td></td>
<td>Drug stock levels are topped up weekly by Pharmacy Technician. Suggestions of improvements made during yearly review have been implemented</td>
</tr>
<tr>
<td></td>
<td>Oxygen prescribing administration documented for delivery route, delivery device and target saturations</td>
</tr>
<tr>
<td></td>
<td>Warfarin prescriptions are recorded correctly on the In-patient medication chart. Where changes are made to Warfarin dose or follow-up is required in the Community – plans are put in place</td>
</tr>
<tr>
<td></td>
<td>Accurately transcribing Electronic Verbal Orders onto the drug chart</td>
</tr>
<tr>
<td></td>
<td>Accountable Officer for Controlled Drugs compliant against relevant legislation, regulations, guidelines and policies.</td>
</tr>
<tr>
<td></td>
<td>Discharge prescriptions dispensed within turnaround times</td>
</tr>
<tr>
<td></td>
<td>Steroid dose appropriate for the indication</td>
</tr>
</tbody>
</table>

**What we are working to improve:**
- Improvements for signing of Oxygen administration with every drug round
- Medicines reconciliation education
- Recording signatures and codes for administration of Oxygen and recording discontinuation of drugs on drug charts
- Steroid plan to be included in discharge letter
<table>
<thead>
<tr>
<th>Audit</th>
<th>Involvement and Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 audits were completed</td>
<td><strong>What we were good at:</strong></td>
</tr>
<tr>
<td></td>
<td>• Documenting information shared to patients about risks and benefits of Acupuncture and Paracetesis treatments and documenting patient consent.</td>
</tr>
<tr>
<td></td>
<td>• Documenting a decision regarding resuscitation status of patients on the In-patient Unit</td>
</tr>
<tr>
<td></td>
<td>• Documenting Hospice at Home patient resuscitation decisions on admission to the service if it is their choice</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Audit</th>
<th>Safeguarding and Safety</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 audits were completed</td>
<td><strong>What we were good at:</strong></td>
</tr>
<tr>
<td></td>
<td>• Patient mattresses meet the require hospice Infection Prevention and Control standards</td>
</tr>
<tr>
<td></td>
<td>• Mobility equipment used on the In-Patient Unit and in Day Hospice are correctly labelled with patient’s information</td>
</tr>
<tr>
<td></td>
<td>• Cleanliness of our commodes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Audit</th>
<th>Personalised Care and Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 audits were completed</td>
<td><strong>What we were good at:</strong></td>
</tr>
<tr>
<td></td>
<td>• Clearly documenting types of diabetes, patients pre-admission management as well as evidencing review of management and adjustments during admission</td>
</tr>
<tr>
<td></td>
<td>• Recording and monitoring all incidence of pressure ulcer development and progression</td>
</tr>
<tr>
<td></td>
<td>• Maintaining our Hoist Slings, Slide Sheets and Pat Slides to a good condition</td>
</tr>
<tr>
<td></td>
<td>• Communicating in a sensitive way and offering immediate and on-going bereavement, emotional and spiritual support to people closely affected by a death including children</td>
</tr>
<tr>
<td></td>
<td>• Offering interpretation services to patients whose first language is not English, including people who are deaf and hard of hearing</td>
</tr>
<tr>
<td></td>
<td>• Offering patients the opportunity to sit in a suitable position in a chair during mealtimes, where they can do so independently and providing the necessary adapted equipment.</td>
</tr>
</tbody>
</table>

**What we are working to improve:**

• On-going Nursing and Doctor education on Diabetes management
• Provide childhood bereavement booklets for all patients and recording in the relationship section details of children under 18 years of age
• Improved recording of a patients first language and communication skills
• Educating both patients and staff how to achieve the optimal position to aid feeding and the role of Occupational Therapy in relation to feeding
• Metastatic Spinal Cord compression education on the identification of risks to patients, awareness of available information and knowledge of when to give information
<table>
<thead>
<tr>
<th>Audit</th>
<th>Quality of Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>21 audits were completed</td>
<td><strong>What we were good at:</strong></td>
</tr>
<tr>
<td></td>
<td>• Completing manual handling assessments, wound assessment charts, care plans, bowel assessments, observations, VTE Prophylaxis and ACP templates on admission</td>
</tr>
<tr>
<td></td>
<td>• Patients referred to our Day Hospice service are contacted within 5 working days of the referral being received. Patients also have their first visit arranged within 2 weeks</td>
</tr>
<tr>
<td></td>
<td>• Recording when a member of the Community Palliative Care Team plans to next make contact with a patient, so other clinicians and administrators can easily identify this information</td>
</tr>
<tr>
<td></td>
<td>• Patients receive their first visit by a Hospice at Home Registered Nurse within the specified time requested by the referrer</td>
</tr>
<tr>
<td></td>
<td>• Patient trips, slips and falls are managed and documented according to Hospice policy</td>
</tr>
<tr>
<td></td>
<td>• Appropriate referrals are admitted to the In-Patient Unit within 2 days</td>
</tr>
<tr>
<td></td>
<td>• Reporting accurately members in attendance at the Community Palliative Care Multi-disciplinary Team meetings. As well as documenting the physical, psychological, social and spiritual needs of patients</td>
</tr>
<tr>
<td></td>
<td>• All blood transfusions administered on the In-patient Unit and in Day Hospice are recorded through the integrated care pathway by appropriate staff. Observations are always completed and recorded, as well as the patient’s registration number</td>
</tr>
<tr>
<td></td>
<td><strong>What we are working to improve:</strong></td>
</tr>
<tr>
<td></td>
<td>• Updating assessment tools when patients return from an acute setting and on every shift (early, late and night)</td>
</tr>
<tr>
<td></td>
<td>• Reporting additional information including; care package and funding thereof and also who administers medication in the nursing discharge letters</td>
</tr>
<tr>
<td></td>
<td>• Information is correctly provided to Equipment supplier at the point of order, as well as advising them that the order is required within a timely manner. Therapy staff to remain up-to-date with equipment stock levels in store</td>
</tr>
<tr>
<td></td>
<td>• Integrated Care Pathway documentation to be reviewed to identify gaps</td>
</tr>
<tr>
<td></td>
<td>• To ensure the recording of Venifon information is always documented for blood transfusions using the integrated care pathway</td>
</tr>
<tr>
<td></td>
<td>• Gold Form redesign to capture more relevant information and integrate into SystmOne</td>
</tr>
</tbody>
</table>
Audit Presentations 2014

Audit presentations are held on a quarterly basis and are available for all members of staff. They provide an opportunity to discuss outcomes and learning from the audits undertaken at the Hospice. The following 16 presentations took place during 2014 and were attended by various disciplines:

<table>
<thead>
<tr>
<th>Date of Presentations</th>
<th>Presentation Titles</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2014</td>
<td>Falls Audit</td>
</tr>
<tr>
<td></td>
<td>Integrated Notes</td>
</tr>
<tr>
<td></td>
<td>Consent for Invasive Procedures</td>
</tr>
<tr>
<td></td>
<td>CPCT advice on appropriate dose of immediate release Opioid for breakthrough pain</td>
</tr>
<tr>
<td>July 2014</td>
<td>Medicines Reconciliation Policy</td>
</tr>
<tr>
<td></td>
<td>Malignant Spinal Cord Compression Guidance and Information</td>
</tr>
<tr>
<td></td>
<td>IPU Waiting Times</td>
</tr>
<tr>
<td></td>
<td>Referrals by the IPU to Childhood Bereavement</td>
</tr>
<tr>
<td>October 2014</td>
<td>Discharge Letters</td>
</tr>
<tr>
<td></td>
<td>Bereavement Practice</td>
</tr>
<tr>
<td></td>
<td>The Quality of the Gold Form information to the Bereavement Service</td>
</tr>
<tr>
<td></td>
<td>Advance Care Planning</td>
</tr>
<tr>
<td>January 2014</td>
<td>Documentation of Resuscitation Status</td>
</tr>
<tr>
<td></td>
<td>Interpreters Audit</td>
</tr>
<tr>
<td></td>
<td>GSF Meetings</td>
</tr>
<tr>
<td></td>
<td>Hospice at Home DNAR</td>
</tr>
</tbody>
</table>

Surveys and Reviews in 2014

The following survey and reviews took place in 2014:

<table>
<thead>
<tr>
<th>Date</th>
<th>Title</th>
<th>Reported to</th>
<th>CQC Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>January through to December 2014 (Monthly)</td>
<td>CQUIN</td>
<td>Commissioner CQC</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>In-Patient Unit</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Discharged patients from the In-Patient Unit</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Day Hospice</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospice at Home</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialist Community Palliative Care Team</td>
<td></td>
<td></td>
</tr>
<tr>
<td>March 2014</td>
<td>Out of Hours</td>
<td>Hospice</td>
<td>1</td>
</tr>
</tbody>
</table>
Part 3 – Review of quality of Performance

3.4 Feedback from patients and families on services

Patients’ Forum

Whilst Patient Forum meetings took place for the first quarter of the year during April to June, we decided it was time for a review. We postponed future meetings whilst a review of Patients Forum and the wider issue of patient engagement was undertaken. During this period the patient satisfaction questionnaires was our principal source of feedback from patients and their carers. To do this we circulate a series of questionnaires to both patients and/or carers at specified timescales during their association with us; the method we use for collecting information is outlined below:

CQUIN
In-Patient Services
• A questionnaire was given to patients or their carer on the fourth day following admission
Discharged Patients from In-Patient Unit
• A questionnaire was initially given to all patients or their carer on the day of discharge
Day Hospice
• A questionnaire was initially given to all patients attending Day Hospice and thereafter on a patient’s fourth visit
Community Services
• A questionnaire was given to the patient/carer after the third community visit. This was provided in a pre-paid, addressed envelope for them to return to the Hospice
Hospice at Home
• A questionnaire was given to the patient/carer during the first visit with a pre-paid return envelope.

Number of questionnaires returned by department during 2014-15
You can’t improve on excellence.

All the service, care and treatment I received whilst an inpatient was excellent.

Extremely grateful and think you are a wonderful organisation.

<table>
<thead>
<tr>
<th>IN-PATIENT UNIT Question</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree nor disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The first three days of my stay have been satisfactory</td>
<td>87</td>
<td>27</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>I understand the reasons for my admission and what the hospice is trying to achieve for me</td>
<td>84</td>
<td>30</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>I have found the staff approachable</td>
<td>95</td>
<td>13</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>I have been given the opportunity to discuss my care and treatment</td>
<td>86</td>
<td>24</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>I have been able to express any concerns or issues that I’ve had</td>
<td>78</td>
<td>32</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>The In-Patient Unit staff are doing everything I would expect them to do</td>
<td>91</td>
<td>24</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>If I have a complaint about the care I was receiving I would know what to do</td>
<td>50</td>
<td>45</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>The service I have received could be improved in some way</td>
<td>43</td>
<td>14</td>
<td>12</td>
<td>38</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PATIENTS DISCHARGED FROM THE IN-PATIENT UNIT Question</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree nor disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I was satisfied with the care and treatments I received</td>
<td>86</td>
<td>15</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I always felt that I knew what was going on</td>
<td>73</td>
<td>22</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>The service I received could be improved in some way</td>
<td>31</td>
<td>13</td>
<td>19</td>
<td>36</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SPECIALIST COMMUNITY TEAM Question</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree nor disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have found the staff approachable</td>
<td>84</td>
<td>20</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>I have been given the opportunity to discuss my care and treatments</td>
<td>87</td>
<td>30</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>I have been able to express any issues or concerns I had</td>
<td>73</td>
<td>28</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>The Community Team is doing everything I would expect them to do</td>
<td>79</td>
<td>21</td>
<td>3</td>
<td>0</td>
</tr>
</tbody>
</table>
The hospice is somewhere for me to go for company and makes me happy

<table>
<thead>
<tr>
<th>DAY HOSPICE Question</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree nor disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>My recent visits have been satisfactory</td>
<td>17</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I understand the reasons for attending Day Hospice</td>
<td>12</td>
<td>6</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>I understand what the hospice is trying to achieve for me</td>
<td>14</td>
<td>3</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>The service I received could be improved in some way</td>
<td>12</td>
<td>2</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HOSPICE AT HOME Question</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree nor disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have found the staff approachable</td>
<td>27</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I have been given the opportunity to discuss my care or treatments</td>
<td>27</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I have been given the opportunity to express any issues or concerns I have</td>
<td>27</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hospice at Home has helped me to stay at home</td>
<td>27</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hospice at Home have supported my family/carers</td>
<td>27</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Over the few days we had the use of the service; we found it exemplary and feel it would be hard to suggest any improvement
Part 3 – Review of quality of Performance

3.5 Benchmarking Activity

We are currently participating in the following benchmarking exercises:

**West Midlands Hospice Nurse Managers Group**
With regard to the safety dimension of quality, the West Midlands region is collating data on a monthly basis in the following areas:

- Percentage occupancy
- Pressure ulcers
- Slips, trips and falls
- Infection control
- Deaths and discharges

The West Midlands Hospice Nurse Managers Group scrutinise the data on a quarterly basis. Following reflective discussion, the WMNM are in agreement that there is consistency between the hospices in the West Midlands region.

Through this process of continuous quality monitoring, the group would quickly identify any significant differences between hospices and act to identify the underlying cause(s).

**Help the Hospices Inpatient Unit Quality Metrics (National Project)**
Last year we took part in the pilot programme with Hospice UK. We have decided to continue with this national benchmarking project for a further 12 months. This project looks at the following three patient safety indications in hospice Inpatient Units:

- Falls (5 levels of harm: none, low, moderate, severe, death)
- Pressure ulcers (avoidable and unavoidable)
- Medication incidents (levels 0-6)

This national project is still in the developmental stages and the national group administering the project have stated the data is not yet robust enough to use for benchmarking purposes.
Part 3 – Review of quality of Performance

3.6 Statement on Birmingham St Mary’s Hospice Quality Account for 2014/15

Statement of Assurance from Birmingham CrossCity CCG May 2015 – annotated by the Hospice

As coordinating commissioner Birmingham CrossCity CCG has welcomed the opportunity to provide this statement for the St Mary’s Hospice Quality Account for 2014/15. The review of this Quality Account has been undertaken in accordance with the Department of Health guidance and Monitor’s requirements. The statement of assurance has been developed in consultation with neighbouring CCGs, the Birmingham, Solihull and Black Country Area Team and the Birmingham CrossCity CCG Patient Council.

Ensuring high quality care for all is a fundamental component of improving patient outcomes and experiences, and therefore Birmingham CrossCity CCG is committed to working with providers such as St Mary’s Hospice to drive forward best practice in respect to clinical quality, patient safety and patient experience. Hence during 2014/15 we have continued to work closely with the Hospice’s clinicians and managers, monitoring the delivery of care through reviewing the quality and performance through the quarterly Clinical Quality Review Group meetings, addressing any issues around the quality and safety of patient care with the Hospice, as and when they have occurred.

It is clear that whilst writing the Quality Account that efforts have been made to make this a user-friendly easy read document that was easy to navigate and understand. It was also obvious that the Hospice has worked hard during 2014/2015 to improve standards and quality of care.

It was positive to learn that the Hospice has been accepted as a Regional Training Centre for the Gold Standards Framework, as this clearly demonstrates how the Hospice is committed to promoting best practice and staff development.

We were pleased that the Hospice has established systems to support vulnerable patients. There was a clear focus on safeguarding, PREVENT and the provision of translation and access to interpreting services for people whose first language is not English. It was also positive to learn of the work undertaken to support people who are deaf and patients with dementia.

We welcomed the description of the robust processes in place for ensuring that patient slips, trips and falls are monitored and reported internally. We noted that the Hospice indicated that there has been a decrease in the number of patient slips, trips and falls reported in 2014/2015, and no falls resulting in serious incidents. It was also good to hear that the Hospice has invested in the purchase a ‘Hoverjack’ which helps fallen patients off the floor safely.

It was positive that the Hospice has achieved a 5H rating for Food Hygiene, which indicates that the service when inspected was found to have ‘very good’ hygiene standards.

It was useful that the Quality Account included a section which covered clinical audit which identified areas of practice that people were good at where further improvements were required.

Whilst reviewing the Quality Account it was noted that there were some issues which were either not covered, or adequately explored. For example whilst the document mentions research participation, it does not identify whether any examples of local learning from such research that has positively impacted onto patient care. However the CCG accepts that this is a very minor issue that could be easily addressed within the final published version of the Quality Account.

Response: Preliminary research information has been included where known – see p17-19
In a similar manner the current draft of the Quality Account lists NICE guidance that is relevant to the service, however does not provide any details of any local developments concerning this guidance that has positively impacted onto patient care.

Response: Comment noted for inclusion in the QA for 2015-16

During 2014/2015 there were 4 Root Cause Analysis reports completed for pressure ulcer damage that occurred within the in-patient services of the Hospice. We noted that the figures of Grade 1 and Grade 2 pressure ulcers that occurred within in-patient care within 2013/14 and 2014/15 have remained relatively consistent and it would be useful to know within the final published version of the Quality Account whether the Hospice has any plans to address this issue.

Response: Information in respect of a toolkit pilot has been added – see p30

Within the ‘Priorities for Improvements’ section of the Quality Account the performance against the 2014/15 priorities are very well described, however there was no data offered to support the statements made.

Response: Comment noted for inclusion in the QA for 2015-16

Currently the Quality Account refers to the experience of staff and patients, however consideration to how equality and diversity featured within these systems would have been useful such as the capture of protective characteristics and how this information may be used. The CCG therefore suggests that reference could have been made, within the final published version of the Quality Account, to whether such issues as complaints, serious incidents and staff survey results are routinely monitored by protected characteristics - age, sex, race, disability, sexual orientation, gender reassignment, religion and belief or any other personal characteristic

Response: Collection and collation of staff information has been included – see p17

It was noted that the current draft of the Quality Account does not provide very much detail on medicines management e.g. medication errors. The CCG therefore suggests that additional information and data is added into the final published edition of the Quality Account in respect to:

- medicines-related incidents
- drug administration
- missing or late doses
- any other issues relating to medicines safety

Response: Information about our arrangements in respect of medicines management has been included – see p30-31

In summary, we welcomed the opportunity to comment on the Hospice’s Quality Account which overall provided a balanced and accurate summary of the work of the organisation. The Quality Account provides description of a number of positive developments and innovative improvements made during the year, although in some areas the document lacked the necessary detail.

The Quality Account does however demonstrate the Hospice’s commitment to making year on year improvement to patient experience and clinical quality, and we shall continue to work in partnership with St Mary’s Hospice to deliver the quality agenda in 2015/2016.

Barbara King
Accountable Officer
Birmingham CrossCity Clinical Commissioning Group
3.7 Feedback and Comments

If you would like to provide feedback on the report or make suggestions for content for future reports, please contact:

Helene Trebinska  
Governance Manager  
Birmingham St Mary's Hospice  
Tel: 0212 472 1191  
Email: helene.trebinska@birminghamhospice.org.uk
Birmingham St Mary’s Hospice

Quality Account 2014–2015