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.
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ABBREVIATIONS

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<th>Abbreviation</th>
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<tr>
<td>CGC</td>
<td>Clinical Governance Committee (part of the Hospice’s governance framework)</td>
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<td>CQUIN</td>
<td>Commissioning for Quality and Innovation (payment)</td>
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<td>IPU</td>
<td>In Patient Unit</td>
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<tr>
<td>MHRA</td>
<td>Medicines and Healthcare Products Regulatory Agency</td>
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<td>NICE</td>
<td>National Institute for Clinical Excellence</td>
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<td>OOH</td>
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Part 1 – Statements

1.1 Statement from the Chairman of the Board of Trustees and Chief Executive

It may help to first explain what is meant by a Quality Account.

A Quality Account is a report about the quality of NHS services. This includes services that the NHS funds under grants and contracts. Whilst the Hospice is a Charity, 45% of our income is funded by NHS contracts; as such we are required to produce this report to demonstrate improvements to those services that we deliver as part of those contracts.

This is a requirement under the Health Act (2009) and the Health and Social Care Act (2012). This legislation also requires us to submit our report to the Secretary of State and publish it on the NHS Choices website by 30 June each year. The report follows a required format.

The purpose of this Quality Account is to give detailed examples of how quality of care, safety, effectiveness and patient experience is at the forefront of everything we do. It aims to demonstrate the attention to detail with a behind-the-scenes look at how the Hospice is run, the breadth of services we provide and the way in which we continually strive to improve what we do to make a greater difference to the lives of individuals living with terminal illness.

Further information about what we do and what we have achieved during the year can be found in our Annual Reports and on the Hospice website: [http://www.birminghamhospice.org.uk/reports-and-reviews](http://www.birminghamhospice.org.uk/reports-and-reviews) along with an overview of our future priorities in our [Hospice Strategy for 2016-2020 – Hospice care for all](http://www.birminghamhospice.org.uk/reports-and-reviews).

This sets out our five priorities for the next four years:

1. Providing a better experience at the end of life
2. Expanding our specialist centre of research and excellence
3. Locating our facilities so that we can reach more people
4. Being an employer and volunteering centre of choice

**Hospice care for all** is our aspiration to take the Hospice’s individualised approach everywhere, whether delivered by the Hospice or, through our education of other professionals, in all settings such as hospitals, care homes, general practice and prisons. It already works well where we have good partnership arrangements. We aim to strengthen partnerships in all these settings, working as a team, so that everyone has the best experience of living, leading up to and at the end of life.

The dignity, experience and confidence of our patients, their families and carers comes first. We are also striving to reach more people over the next four years as the demand for hospice care increases across our diverse communities.

We hope this Quality Account helps you to better understand how we are working to achieve our priorities for the benefit of our whole population to improve everyone’s experience at the end of life.

Vij Randeniya – Chairman
Tina Swani – Chief Executive
Our Board is made up of 12 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:

Executive Director changes during the year

We are pleased to congratulate Commercial Director, Claire Marshall on her appointment as Chief Executive of Compton Hospice at the end of March. She will be succeeded on 13 June 2016 by Susan Newcombe as Director of Income Generation & Marketing.

Following a period of secondment, Helen O’Halloran was appointed to the substantive post of Nursing Director. Helen had been Community Palliative Care Team Leader and Deputy Director of Nursing prior to her secondment and brings a wealth of experience and knowledge to this Executive level role. Helen O’Halloran is also our Registered Manager.

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 2015-16 - what we achieved last year

### Patient Safety

**Priority:**
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 these reasons 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 was this priority achieved?
We installed a MGPS liquid oxygen system by:

- Removing 10 no. existing cylinders and installing two new liquid oxygen tanks within the manifold room with a four cylinder back up
- Removing a tree from the front of the building and installed a concrete pad with removable bollards for 24 hour access. The fill point is located within the concrete pad and consists of valves, controls and connection point to refilling. Restricted access to controls / tamper proof
- Existing manifold room was fire proofed to reduce any risk of fire. Skylight was boarded with fire resisting materials, additional ventilation installed for cross ventilation, door set changed for wooden to steel and vented
- Existing medical gas pipework was utilised as this was fit for purpose
- Temporary cylinders were installed whilst installation took place to avoid a drop in oxygen to the ward.

Alarm systems were modified slightly to be in line with the new system.
How was progress monitored and reported?

- Regular progress reports to quarterly meetings of the Hospice’s Compliance Committee (Environment and Risk)
- Daily monitoring of gas usage and refill requirements by the Facilities Team.
- Where demand reached >16 litres p/m for a patient, ward staff advise facilities to confirm there is an increased high demand.

Going forward there will be daily monitoring of usage levels compared to the patient demand on the wards.
Clinical Effectiveness

Priority:
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 were keen to improve their experience of research within palliative care, as well as ensuring that the care we provide is the best evidence based care. We worked with the clinical research network (NIHR CRN) and were invited to be a study site for the national portfolio trial "A cluster randomised trial of alternative forms of hydration in cancer patients in the last days of life (feasibility study)". We were one site of 12 across England and Wales involved in recruiting 200 patients nearing the end of life to observe their symptoms as they deteriorated.

How was the priority achieved?
We worked with clinicians and research staff at the Royal Surrey Hospital who were coordinating the trial. We were randomised to standard intervention arm A, which involved giving usual medications for symptom control, oral hydration as patients were able and mouth care as patients approached the end of their life. The standard intervention arm B added in parenteral fluids to the care plan. Patients and their families were incredibly generous with their assent to being involved in the trial, and the Hospice managed to recruit 29 patients over the period when the trial was open. This made Birmingham St Mary’s Hospice the second highest recruiter nationwide. Nursing staff on the Inpatient Unit ward assisted in data collection, and were extremely conscientious and proactive in this. The research team liaised with the Royal Surrey Hospital team to ensure that data collected at the Hospice was accurately included in the overall data collected.

Data is still being analysed by the lead researchers, and we therefore have not yet had any feedback about results, but once this is available, we will be inviting the research team to present their findings to staff at the Hospice.

It is possible that in order to improve the power of the study, the data from the first 200 patients will be used within the definitive study, and if this is the case, there may be some times delay prior to receiving results.

We have submitted a formal expression of interest to the study team with respect to being involved in the definitive study as staff reported that the study was not unduly onerous, and patients and their families reported being pleased to be asked to be involved in the study.

How was progress monitored and recorded?
As this was a national portfolio research study, the research team had to maintain a site file with important information about the local conduct of the trial included. We underwent regular monitoring visits from the lead research team at Royal Surrey Hospital, and they checked all data collection at each visit.

We screened a total of 31 patients to achieve our recruitment of 29 patients, meaning that the acceptability of the study to patients and relatives was high. Patients reported that they were happy to assist in taking part in research which would make a difference to others.

The principal investigator at the Hospice, Dr Christina Radcliffe, was required to complete periodic questionnaires about the study.
Birmingham St Mary’s Hospice was also asked to take part in a focus group of staff who had been involved in data collection as part of the feasibility study. This took place at the Hospice.
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 the standard as part of the Commissioning for Quality and Innovation payment framework.

How was the priority achieved?
• The Bereavement service was evaluated thoroughly and a report produced to describe the current structure and delivery of bereavement care within the Hospice
• A series of audits were then conducted to measure the service against national standards. Patient and staff feedback was also collated. The results were then analysed and the service measured in key areas: These covered service planning, awareness and access, assessment, supervision and support, education and training, resources, monitoring and evaluation
• Progress was evaluated on a quarterly basis and any gaps in provision identified and addressed
• An action plan based on the results of the audit has been produced to guide the direction of ongoing service development
• Achievement of this priority has also enabled the Bereavement team to structure and implement an ongoing audit programme, to continue to evaluate the service and guide further developments.

How was progress monitored and reported?
Quarterly progress reports were submitted to Birmingham Cross City Clinical Commissioning Group with an update of audit results and service developments.

The final report included results of all the audits and service evaluation tools used during the year and a summary of actions taken and planned for the future.

We have received very complimentary letters from the Clinical Commissioning Group in respect of our work in this area.
Part 2 – Priorities for Improvements and Statements of Assurance

2.2 Other Hospice Achievements 2015 – 2016

- **Module on Spinal cord compression**
  In response to the implementation of NICE Guidance on Metastatic Spinal Cord Compression (2008), a module was developed which now forms part of the core training for clinical staff. The aim of the module is to ensure staff have an awareness of the NICE Guidance on Metastatic Spinal Cord Compression (2008) and adhere to its recommendations. On completion of the training staff will:
  - Be able to identify at risk patients
  - Have more awareness of information available
  - Be aware of when to give information to patients

- **New patient information leaflets**
  We are continually looking to improve the information leaflets provided to our patients. This year we have added three new leaflets to our library of resources:
  - Driving when on medication
  - Planning ahead
  - Research in the Hospice.

- **Presentation at national conferences**
  The Hospice had two poster presentations at the Hospice UK conference ‘The Art and Science of Hospice Care’ held in Liverpool in November 2015
  - Developing a Strategy for a Research Active Hospice: Process and Progress (Christina Radcliffe, Debbie Talbot and Alistair Hewison)
  - Reaching People: Engaging communities to support patients in End of Life: A Birmingham St Mary’s Hospice Lived Experience (Diana Murungu and Tina Swani)
  This was also the subject of a presentation at the International Public Health and End of Life Care Conference earlier in the year.

- **Secure offsite access**
  Remote access to our secure clinical system is now available for our Doctors who are on call, thus improving the safety and reliability of ‘out of hours’ advice given over the telephone.

- **Journal Club**
  Following the successful development of a Journal Club at the Hospice, two members of our team (Consultant in Palliative Care and Research Nurse) had a poster presentation at the regional research showcase regarding their experiences of setting up a journal club.

- **Published work**
  - *International Journal of Palliative Nursing* (December 2015)
    Use of a supportive care pathway for end-of-life care in an intensive care unit: a qualitative study - Christina Radcliffe, Consultant in Palliative Medicine and Alistair Hewison, Senior Lecturer at the University of Birmingham.
• **West Midlands Specialist Palliative Care Audit and Guidelines Group**
  Through our involvement in the above group and a recent audit, a working group will be set up within the region to improve management of methadone titration within hospices.

• **State of the Art of equipment**
  We have been fortunate to obtain funding from a number of trusts making it possible for us to purchase new presentation equipment for our Resource Centre. This will be used to deliver education sessions both to external delegates (GPs, district nurses, nursing homes) and internally to staff and volunteers.
Since April 2015 we have re-deployed our multi-faith team of spiritual care volunteers so that there is a member of the spiritual care team available to visit in the IPU/Day Hospice every weekday, whether the (part-time) Lead Chaplain is on-site or not. Timetables of the spiritual care team’s availability are held at the nurses’ station; in the notes room and at main reception.

At present, we have regular visits from volunteers who represent Buddhism, the Methodist and Baptist faiths and the Metropolitan Community Church. We continue to be able to call on the resources of the QE Chaplaincy Team who have chaplains representing Judaism, Hinduism, Sikhism, Islam and Buddhism, as well as Roman Catholic, Anglican and Free Church chaplains. The Roman Catholic chaplain from the QE visits the Hospice twice a week and an up-to-date weekly rota of available chaplains on-call at all times is kept at the nurses’ station.

We have opened the Spiritual Care Steering Group to representatives from every team in the hospice and now have a core group which meets three times annually.

To inform patients and families about spiritual care, notices are on display in the Butterfly Lounge and in the Peace Room advising patients about the availability of chaplains and volunteers.

We emphasise that pastoral/spiritual support is for everyone who requests it, without any requirement of faith or belief.

The Lead Chaplain has given presentations to volunteers, Day Hospice patients, District nurses, colleagues, medical students and a group of people exploring the idea of ordained ministry. These presentations aim to raise awareness of spiritual care in general and of particular issues, for example: Hospice Chaplaincy, Spiritual Distress; Nurturing the Spirit; African Pentecostal Patients at end of life. The lead chaplain has been invited to take part in the presentations on Equality and Diversity offered by the HR department.

In preparation for a spiritual care audit, the lead chaplain carried out research from other Hospices, to find out what features are included and which aspects of spiritual care need to be evaluated.
Two ministry students from The Queen's Foundation have served attachments in Hospice Chaplaincy here at Birmingham St Mary's Hospice. Both students contributed much to the Hospice by devising a presentation to delivery to Day Hospice patients and visiting patients on the inpatient Unit.

A local artist, Jake Lever, visited the Day Hospice to help patients contribute to an art installation called "Soul Boats" which hung in Birmingham Cathedral between November 2015 and March 2016; the chaplain assisted at his presentation and ran the second session with a different group.

The focus of our Spiritual Care team over the past year has been two-fold; to re-deploy our volunteers to regular times on the Inpatient Unit and to inform colleagues about spiritual care and its importance for patients and families. Large numbers of colleagues and volunteers have attended Spiritual Care training sessions, including sessions on Recognising Signs of Spiritual Distress in patients.

Our Peace Room can be used as a multi-faith environment or as non-religious space, with its provision for Wudu for Muslim patients, families and colleagues; its cupboards with artefacts for six major faith groups and its quiet, inviting atmosphere continues to be a haven for patients, families and colleagues. A selection of religious items has been added to the collection, as well as some books for the bookcase.

In order to ensure that we provide appropriate care for patients and families of all ethnicities and cultures, there is close liaison between our Equality and Diversity Group and the spiritual care team. Information is shared in respect of cultural and religious needs that have been identified.

An interactive workshop: Embracing Hospice Care Everywhere was held in February 2016. The Hospice invited community leaders from all over the Birmingham and Sandwell area to come and learn more about the Hospice and the services we provide. At the same time we were able to identify the cultural and religious needs of different faith groups, for example different faiths have their own interpretations of their spiritual journey.

We recognise that strong links between the hospice and a patient’s own community are vital as they promote and sustain the patient’s well-being. With this in mind we continue to seek the support of the communities at every opportunity especially in matters such as diet and faith requirements.

Our volunteers are offered training on the needs of patients from different faith traditions. The multi-faith chaplaincy at the Queen Elizabeth Hospital is available to answer specific questions relating to religious provision.
The patient profile at Birmingham St Mary's Hospice continues to change with a greater number of people living longer with more complex illnesses. This has resulted in an increasing number of patients with co-morbidities such as dementia.

The Hospice is part of the Dementia Action Alliance, a movement whose aim is to bring about a society-wide response to dementia. Through membership of the Alliance we are encouraged to take practical actions to enable people to live well with dementia and reduce the risk of costly crisis intervention.

**Training**

All Hospice staff now have the opportunity to attend awareness training sessions put on by Birmingham Community Healthcare NHS Trust. The following levels of training are available:
- Dementia basic awareness
- Dementia enhanced
- Dementia Advanced Intervention two-day course.

**Creating a dementia friendly ward**

In light of our changing patient profile we aim to create a home from home for patients in our care with dementia. We will be improving signage on the Inpatient Unit and conservatory space by creating an environment that is comforting, familiar and will reduce anxiety, isolation and confusion and improve social interaction.

NICE Guidelines for treatment of dementia recommend that priority should be given to ensure the maintenance of physical comfort and quality of life. Whilst this is a daily reality for the care we deliver across the services at the Hospice, we aspire for this to be a reality for dementia sufferers, as it is for other patients in our care.

We are therefore planning to refurbish and update the main conservatory area within the Inpatient Unit and an outline of the project brief is below:
- There will be a clear distinction between the dining and sitting room space – this will create a more home like environment with easy, open access between the two spaces and allow for more frail or disabled patients to move around independently
- Whilst the space is open plan, it also leads out onto the garden which will help reduce feelings of frustration and anger which can be caused by restriction and a feeling of being trapped. This will also provide easy access to nature and support patients with seasonal awareness
- Lighting will be improved as older people and those with dementia need higher light levels
- The flooring will be matt and neutral in style and in clear contrast to the colour of the walls. The noise absorbent surface will reduce unnecessary confusion and anxiety
- All furniture will be neutral in pattern and colour will distinguish between walls, windows, ceilings and floors
- The sitting room space has been designed with multiple seating options to encourage conversation
- The dining area, which will accommodate wheelchair access, will have seating which is bright and more café like in appearance to create a social space where board games can be played and meals served to a number of inpatients, thus providing an alternative to eating in their room
- There will be a TV and radio/CD player to encourage reminiscence, with a range of films and CDs from different eras. Individual patient needs will also be met by families and carers being encouraged to provide familiar items for extra comfort
- A ‘Wii console’ will provide further mental stimulation, perhaps for those patients who once had a sporting hobby
- Storage space will keep the conservatory area clutter-free to minimise distraction
We aim to improve signage throughout the Inpatient Unit to assist dementia sufferers with navigation and to feel more confident moving independently. We will include toilet signs, nurse on duty and signs denoting the name of the Hospice to assist with orientation. Signs will be hung where possible at a height of approximately 1.2m for easy viewing and will include both pictures and words.

Funding for this project has already partly been achieved and there are applications in progress for the balance.
2.3 Priorities for Improvements 2016 – 2017

**Patient Safety**

**Priority:**
Safe staffing levels

**Standard:**
To conduct a skill mix review to inform staffing levels going forward

**How was this identified as a priority?**
The safety of our patients is a priority for the Hospice and is embedded within the culture and governance of the organisation. In the absence of national guidance on what is considered safe staffing levels, traditionally our establishment has been benchmarked against other local hospices. However following the Francis, Keogh and Berwick Reports national guidelines on safe staffing and skill mix is a priority for all health and social care providers.

**How will the priority be achieved?**
The Hospice has recently had a very successful recruitment drive to ensure appropriately skilled nurses are available on the Inpatient Unit. A key objective within this recruitment drive is the retention of appropriately trained and supported staff.

Newly recruited staff will have a meaningful induction and have expertise available to them in order for them to become competent in their role through supervised practice.

Particular expertise is needed in medicines management, in the use of syringe drivers and administration of intravenous medication. Assessment skills such as for pressure ulcer incidence, risk of falling and management and infection prevention are also needed. Holistic expertise in
assessing and managing emotional and spiritual distress also form part of palliative care nursing expertise. A training needs analysis has ensured that the training needs of both existing and new staff are known.

By ensuring staff are skilled and competent we are able to improve patient safety. The next step will be to review the skill mix based on national guidance to ensure we meet the needs of our patients.

An example of this is our new model in our ‘Home from Home’ beds for Sandwell and West Birmingham Acute Trust.

More emphasis will be placed on the nursing team to lead the service and they will need to be supported to develop their skills and competence in specific areas moving forward.
How will progress be monitored and reported?
Patient’s safety can be measured by pressure ulcer incidence, slips and falls, incidence of infection and incident reporting, complaints and compliments. All of these measures should be benchmarked against dependency and staffing levels.

All of the quality measures listed above will continue to be reported to the Clinical Governance Committee and Board of Trustees within the Hospice and some also externally to the Care Quality Commission and Clinical Commissioning Groups.
How was this identified as a priority?
In 2008, the Department of Health in the End of Life Care Strategy recommended the delivery of high quality services for patients needing palliative care, with access to rapid, specialist advice and clinical assessment. This was built upon by NHS England with the publication of 2014-16 Actions for End of Life Care and by the third sector partnership publication, Ambitions for Palliative and End of Life Care: A national framework for local action 2015-20. Locally, a further driver for change has been reduced Community Palliative Care Team (CPCT) staffing levels and increasing referrals, which has led to the need to identify new ways of working.

The wider development of outpatient clinics formed part of the service re-design projects put together into the Case for Change submitted by the Hospice to the Birmingham CCGs in January 2016. The Case for Change aims to reach more people who could benefit from access to palliative care. One of the key aims is to maximise the use of limited skilled clinical staff resources, which includes the development of a model of multi-disciplinary outpatient clinics. This evaluation of the nurse led clinics is the first phase of the development of this model.

How will the priority be achieved?
A Hospice priority documented in the hospice strategy 2016-2020 is to reach more people that need specialist palliative care. Developing a clinic service that can also be taken to satellite centres (GP surgeries, community centres) could also meet this aim. Initiating an outpatient clinic here allows the Hospice to develop this service to then take out into the wider community.
The objectives of the Clinical Nurse Specialist (CNS) Outpatient Clinics are to offer patients an in-depth, comprehensive, holistic assessment by a Clinical Nurse Specialist and where appropriate to facilitate early access to specialist palliative care. It is hoped this will also allow more patients to be seen by the Community Palliative Care Team (CPCT) by reducing CNS travelling time and also lower CPCT mileage expenditure.

The effectiveness of the clinic in terms of increasing the amount of patients seen in clinic can best be judged by comparing clinic and community caseloads. The one-day a week nurse led outpatient clinic with an average caseload of 12 patients, equates to the average caseload of a 3-day a week community CNS.

The reasons for this are a combination of savings in travel time, patients not being as complex/dependent and patient/carer expectations being time bounded by the appointment structure of the clinic.

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

Data, both qualitative and quantitative will be collected from the following sources:
- Patient/carer feedback from a questionnaire at the end of the appointment
- CNS feedback from a questionnaire completed at the end of each clinic to capture learning.

Data recorded manually from paper records and from SystmOne reports to Clinical Governance Committee and Executive Directors.
Patient Experience

Priority:
Patient/user engagement

Standard:
To review and update the way in which we engage with patients and carers

How was this identified as a priority?
Currently the Hospice offers all patients and their carers a questionnaires/feedback form to provide comment on their care. There is also a board in the inpatient unit for patients and families to write any comments about the care they have received. Whilst this offers opportunities to comment on the care received, there is little active engagement with this process and as the forms are anonymous it is difficult to draw meaningful information from them.

Our new Day Hospice Therapeutic Day is piloting a suite of outcome measures and this has highlighted the need to measure the outcomes of patient care in all our patient facing services. This will ensure a more robust process that also demonstrates the Hospice is actively committed to monitoring the quality of the patient services provided by the Hospice.

Over the last 12 months the Hospice has reviewed many of its clinical services and we need to ensure that patients and their carers have an opportunity to engage fully with us in this process and help us to re-design services that meet their needs. Until recently the Hospice had a Patients’ Forum which provided an opportunity for patients to actively participate and engage with the Hospice, and the senior Hospice staff have recognised the importance of re-establishing this as soon as possible.

How will the priority be achieved?
- Contemplate different methods of engaging with patients and carers - use feedback from Community Development Conference, Dying Well Charter Pathfinder, Dying Matters week and BrumYODO to inform this
- Following evaluation report of the new Day Hospice Therapeutic Programme roll out of the patient outcome measures across all clinical areas
- Consider service user involvement within the Hospice’s current governance structure
- Re-establishing an effective patient/user forum that meets their needs i.e. times, venues etc as it may be more appropriate to have patient forums in the community
- Liaise with colleagues in other hospices to gain an understanding of their work in this important area
- Develop methodology and outcome measures with support from Cogent Ventures and Social Impact analysis
- Enhance the effectiveness of Patient Satisfaction questionnaires currently in use
- Ensure that we have real-time systems in place to monitor patient/carer experience
- Demonstrate improvements in patient/carer experience
- Demonstrate a clear commitment to improve patient/carer engagement.

How will progress be monitored and reported?
- Quarterly progress reporting to the Executive Director Team and Clinical Governance Committee
- Recommendations and updates to the Board of Trustees.
Part 2 – Priorities for Improvements and Statements of Assurance

2.4 Statement of assurance from the Board

Review of services
In 2015-16 Birmingham St Mary’s Hospice supported commissioning priorities in Birmingham and Sandwell, providing specialist palliative care services. A brief outline of these services, which were also largely funded through charitable funding, is given below:

- **Inpatient Unit**
  A mixture of single rooms with en-suite facilities and small multi bedded bays. Medical and nursing assessment is carried out daily and there is access to medical advice 24 hours per day.

- **Community Palliative Care Team**
  This Team consists of Clinical Nurse Specialists, Doctors, Occupational Therapists and the Family and Carer Support staff who are experienced in palliative care and who provide support and advice to patients and carers in their own homes.

- **Day Hospice**
  The Day Hospice is open one day per week and up to 20 patients can attend on alternate weeks from around 10.00hrs to 15.00hrs. Patients attending Day Hospice on Thursdays are able to take part in a range of therapies including art and music as well as specialist palliative care interventions on site and Consultant outpatient appointments.

- **Hospice at Home**
  This service is provided to patients who are at the end stage of a terminal illness who have expressed their wish to die at home and who require additional support. Care is delivered by Registered Nurses and Health Care Assistants in the patient’s own home.

- **Physiotherapy and Occupational therapy**
  Physiotherapy and Occupational therapy services are provided by special agreements with University Hospital Birmingham NHS Foundation Trust. The Therapists specialise in palliative care support and are designated to work at the Hospice.

- **Complementary therapies**
  A range of complementary therapies are provided by volunteers managed and supervised by the Senior Physiotherapist through a Service Level Agreement with University Hospital Birmingham Foundation NHS Trust.

- **Family and Carer support services**
  The Family & Carer Support Team provides specialist counselling, spiritual and psychosocial support to patients, carers and family members, including children whose parent is ill.

- **Bereavement Support Services**
  At the Hospice, we consider bereavement support to be an essential part of quality palliative care. The Bereavement Support Service consists of highly skilled volunteers who have been trained in supporting people in grief; they are managed by a full time Senior Social Worker and receive one to one supervision from external counsellors paid for by the Hospice.
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 2015-16 audits or enquiries related to specialist palliative care.

Safeguarding
This year we have continued to review our programme of mandatory training. We provide a level 1 session on adult safeguarding and PREVENT training which is delivered by an external expert from Birmingham Community Healthcare Trust. In addition to this we also provide level 2 and 3 training for appropriate staff. We have developed a bespoke session covering child protection and this is delivered by members of our Family and Carer Support Team.

The Hospice is one of the third sector organisations that has signed up to the Memorandum of Understanding from the Birmingham Safeguarding Adults Board (BSAB). This means that we can attend the partnership meetings and meet other organisations working towards the safeguarding agenda in Birmingham. We also have access to an online forum where, as members, we can communicate freely on matters of safeguarding and engage on the BSAB workstreams to complete pieces of work.

This year we have reviewed and updated the policies covering both adult safeguarding, taking into account local changes, and these have been made available to staff and volunteers across the organisation, including those working in our retail operation.
Current evidence suggests that improvements in healthcare performance can be achieved by the engagement of individuals and healthcare organisations in research. The aim was therefore that by working towards becoming a research active hospice, the service quality of the hospice would be further improved.

The starting point for research in the hospice was mixed. Some staff had a good awareness of research and had been supported to undertake higher degrees, however, research questions tended to be driven by professionals external to the hospice, with the hospice providing access to patients or staff, rather than leading research. The research strategy and the allocation of time and responsibility for research in the job plans of key professionals were key actions designed to address this situation.

Funding was granted by the Connie & Albert Taylor Trust to support development of research in Birmingham St Mary’s Hospice in 2014 and they have funded two sessions of consultant time since January 2015.

In addition Alistair Hewison, Senior Lecturer at Birmingham University, also gave one session of time to aid in development of a research strategy for the hospice.

More recently, funding was obtained from the National Institute for Health Research Clinical Research Network (NIHR CRN) to support a research nurse, and the nurse commenced in post in November 2015.
The overall goal is to develop the hospice into a level 3 research active hospice by 2017: 

Level 3: Generating and leading research
Develops and undertakes hospice initiated research
Building capacity for research and educating staff
Links with academic institutions
Hospice research consortia

Level 2: Engagement in research generated by others
Staff confidence and skills growing
More engagement in research
Offering research to more patients and carers

Level 1: research awareness in all professional staff
Staff as critical consumers of research
Evidence based practice
Education and training
Access to journals and search strategies

Below are the studies in which the Hospice was active during 2015:

The Hydration Study (more detail is given on page 8)
This is a national cluster randomised trial investigating the use of alternative forms of hydration in cancer patients in the last days of life (feasibility). It is funded by the Research for Patient Benefit Programme (National Health Service) and organised by the University of Surrey.

To date, of the 27 people invited to participate in the study, 25 patients have been recruited, far exceeding the projected recruitment figure of 15 patients in a year. Following a recent monitoring visit from the University of Surrey, ward staff were thanked and commended on their data collection.

The hydration study remains open.

Two versus Three (TVT) Study
This is an international, multicentre, open randomised trial comparing a two-step approach for cancer pain relief with the standard three-step approach of the World Health Organisation (WHO) analgesic ladder in patients with cancer pain. The UK study is sponsored by NHS Lothian and the University of Edinburgh.
Although the TVT study has been discussed with 2 patients, no patients have been recruited as yet at Birmingham St Mary's Hospice. Recruitment internationally has been far lower hoped for (400 predicted international recruitment, 71 actually recruited internationally) possibly due to strict inclusion and exclusion criteria associated with this study.

The TVT trial remains open.

**Economics of End of Life Care (valuing care study)**

This was a four year study which studied the economics of supportive end of life care. Fourteen Birmingham St Mary's Hospice patients were offered the opportunity to be involved in a part of this study, with 11 of those being recruited to the study. This project was funded by the European Research Council and was led by the University of Birmingham.

Patients at Birmingham St Mary's Hospice were asked to test a questionnaire which explored what they perceived to be the most important aspects of care. This, along with information from other organisations, has provided researchers with a more inclusive set of criteria that can be used to measure the economic evaluation of interventions at the end of life.

Patients who participated, and interested other parties, will be given the option to receive a copy of the end of project briefing. This study is now closed.
Here are some of the training initiatives and improvements to delivery of training that have happened over the last 12 months:

**Education programme and bespoke training**
The Hospice delivered 20 course and study days during 2015-16, totalling 33 days. Alongside this we provided:
- Study days for Birmingham Community Health Care Trust on Loss and Grief
- Residential Home training study days funded via Cross City CCG
- SAGE & THYME® Workshops funded via Health Education West Midlands
- Study days/half study days funded via Macmillan
- Study day for the Royal Orthopaedic Hospital
- Gold Standard Framework programme hosted

*SAGE & THYME® is a mnemonic which guides healthcare professionals/care workers into and out of a conversation with someone who is distressed or concerned.

| Setting: | If you notice concern – create some privacy – sit down |
| Ask: | “Can I ask what you are concerned about?” |
| Gather: | Gather all of the concerns – not just the first few |
| Empathy: | Respond sensitively – “You have a lot on your mind” |
| & Talk: | “Who do you have to talk to or to help you?” |
| Help: | “How do they help?” |
| You: | “What do YOU think would help?” |
| Me: | “Is there something you would like ME to do?” |
| End: | Summarise and close – “Can we leave it there?” |

Sage & Thyme is a well-established and recognised communication tool and a number of Hospice staff have been accredited to deliver it. It provides structure to psychological support by encouraging the health worker to hold back with advice and prompting the concerned person to consider their own solutions. It is suitable for use with patients, carers, students, colleagues and children – anyone who is distressed or concerned – inside and outside of health and social care.

**Delivery on Education Project Work for Health Education West Midlands**
The Hospice was commissioned by Health Education West Midlands to provide ten, three day courses and twelve workshops on Advance Care Planning for Health and Social Care professionals. Some outcomes from this training were:
- 75% of respondents to a post course survey reported that this programme had changed how they do Advance Care Planning.
- Participants had more awareness around the need to discuss; communication skills; other resources; the importance of advance care planning.
- Over half of respondents (56.25%) reported making minor changes to practice, while 18.75% reported making significant changes to practice following the three day programme.
Some comments from participants:
"I will start to apply all I have learnt to my role and discuss with colleagues how we will complete an Advance care Planning"
"I will explore in more details what patient's wishes are and their understanding"
"I will review my current practice and look at how I can make improvements"
"I will be able to apply the strategies on good communication when I do Advance Care Planning with our residents and their families"
"I will be more confident to instigate a conversation regarding ACP".

Education Visits to the Hospice
The Hospice welcomes education visits and this year we hosted:
• A group of 6th form students from Edgbaston Girls School who were interested in careers in healthcare. They attended a session which discussed Hospice services and the different roles within the Hospice environment
• A French student nurse attended an education session to gain more understanding of the British healthcare system and more specifically what services British Hospices provide.

University Student Nurse Audit
During this time period the Hospice accommodated twelve student nurses from the University of Birmingham and Birmingham City University who were undertaking their nurse training. As part of this process the Hospice is audited by the universities to ensure the quality of placements provided.

Nursing and Midwifery Student Nurse Placement Inspection
During March 2016 the Nursing and Midwifery Council inspected the University of Birmingham as part of their remit to check on the provision of student nurse training and the placements they complete. As part of this three inspectors came to the Hospice to meet the Education Team, a student nurse on placement, student nurse mentors and some patients. We are pleased to say that there were no action points for the Hospice following the inspectors visit.

Medical Students – University of Birmingham Medical School
• 4th Year Medical Students

• Module Lead for Palliative Care
One of our Consultants has taken on the Module Lead for Palliative Care for 4th year medical students from the University of Birmingham. This provides an excellent formal between the University of Birmingham and the Hospice.

• Oncology module
The Hospice delivers teaching sessions to 4th year medical students from the University of Birmingham Medical School. At the start of their oncology module up to 200 students come to the Hospice for a full day session and these sessions are held 4 times a year. This is followed at the end of the module with another session, in smaller groups of up to 17 students. The sessions have standard timetables, devised by the Hospice, covering elements of palliative care such as pain control, the patients’ journey, religious and spiritual considerations, loss and grief. Students are also given a tour of the Hospice facilities. This year we hosted 405 medical students.

• Hospice Experience Day
Medical Students are also able to take part in an ‘experience day’. We accept two students at a time who are given the opportunity to go on home visits with clinical nurse specialists from the Community Team and then spend time observing on the Inpatient Unit.
Shadowing opportunities
We are pleased to be able to offer the opportunity for doctors from other specialties to shadow Hospice doctors and consultants working on our Inpatient Unit.

Teaching at Universities
The Hospice teaching and clinical team have been involved with several teaching sessions at local Universities. The content for these sessions included, how to manage symptoms, what we mean by “care”, what palliative care is. International students are able to participate via video link.

Interviewing applicants for pre-registration student training
For the first time this year the Hospice has been involved in the interview process for applicants for student nurse training at the University of Birmingham.

Updated fire training resource
An additional statutory fire training resource was developed which allows staff to choose between attending a face to face session or complete an online version.
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 2015
- NICE Quality Standard – 74 Head Injury
- NICE Quality Standard – 76 Acute Kidney
- NICE Clinical Guideline – 131 Colorectal Cancer
- NICE Quality Standard – 77 Urinary Incontinence In Women
- NICE Clinical Guideline Gastro-Oesophageal Reflux Disease: Recognition, Diagnosis and Management

May 2015
- NICE Guideline Psychosis and Schizophrenia in Adults
- NICE Quality Standard – 79 Idiopathic Pulmonary Fibrosis
- NICE Quality Standard – 78 Sarcoma

July 2015
- NICE Quality Standard – 54 Physical Activity: Encouraging Activity in all people in contact with the NHS
- NICE Quality Standard – 82 Falls in Older People: Assessment after a fall and preventing further falls
- NICE Quality Standard – 82 Smoking: Reducing Tobacco Use
- NICE Clinical Guideline Alcohol – preventing harmful alcohol use in the community
- NICE Clinical Guideline – NG5 Medicines Optimisation: The safe and effective use of medicines to enable the best possible outcomes

September 2015
- NICE Clinical Guidance - 6 Excess winter deaths and morbidity and the health risks associated with cold homes
- NICE Quality Standard - 84 Falls in older people: assessment after a fall and preventing further falls

November 2015
- NICE Clinical Guideline – 13 Workplace policy and management practices to improve the Health and Wellbeing of employees
- NICE Technical Appraisal Guidance - 341 Apixaban for the treatment and secondary prevention of deep vein thrombosis and/or pulmonary embolism
- NICE Quality Standard – 88 Personality Disorders – Borderline and Antisocial
- NICE Guideline – 8 Anaemia management in people with chronic kidney disease
- NICE Quality Standard – 91 Prostate Cancer

January 2016
- NICE Quality Standard – 89 Pressure Ulcers
- NICE Quality Standard – 90 Urinary tract infections in adults
- NICE Guidelines – 15 Antimicrobial Stewardship

March 2016
Use of CQUIN payment framework 2015 – 2016
A proportion of Birmingham St Mary’s Hospice income in 2015-16 was conditional on achieving quality improvement and innovation goals agreed between the Hospice, and Birmingham Cross City and Birmingham South Central Clinical Commissioning Groups. This was achieved through the Commissioning for Quality and Innovation payment framework and focused on the bereavement support for patients, carers and family member’s pre- and post-bereavement.

More detail on the CQUIN and our work in this area is given on page 10 of this Quality Account.

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 Care Quality Commission has not taken any enforcement action us during 2015-16 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

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 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 2015-16 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 2015-16 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 2015-16 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 2015 to 31 March 2016 for the following services:

In Patient Unit (IPU)
- There were 271 admissions to our IPU – this includes those patients that may have been admitted more than once

[Graph showing Inpatient Unit Admissions 2015 / 16]

Community Palliative Care Team (CPCT)
- 833 new referrals were received for this service
- 8,917 patient contacts were made during the year
- There were between 250-300 patients per month on the Team’s caseload during the year

[Graph showing Community Palliative Care Team New Referrals 2015 / 16]
Day Hospice
- Attendance in our Day Hospice was 530
- Patients were unable to attend Day Hospice for a variety of reasons on 231 occasions (see the breakdown on the next page)
Reasons for non-attendance – Day Hospice

<table>
<thead>
<tr>
<th>Reason</th>
<th>Total for 2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient appointment</td>
<td>25</td>
</tr>
<tr>
<td>In hospital</td>
<td>38</td>
</tr>
<tr>
<td>In Hospice Inpatient Unit</td>
<td>29</td>
</tr>
<tr>
<td>Unwell</td>
<td>109</td>
</tr>
<tr>
<td>On holiday/away</td>
<td>6</td>
</tr>
<tr>
<td>Other (visitors – family/district burs/deck/emen/delivery)</td>
<td>24</td>
</tr>
<tr>
<td>Reason unknown</td>
<td>0</td>
</tr>
<tr>
<td>Cancelled by service</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>231</strong></td>
</tr>
</tbody>
</table>

Hospice at Home

- 213 referrals were accepted by this service.
- 1,726 visits to patients were made during the year. The majority of which were made by two nurses.

![Hospice at Home Accepted Referrals 2015 / 16](image1)

![Hospice at Home - Visits 2015 / 16](image2)
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.

Patients 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 2015/16 there has been a significant decrease in the number of patient slips, trips and falls, with 55 incidents reported, compared to 91 reported in 2014/15. You will see from the graph below that no serious injuries were sustained, during this reporting period and therefore no formal reports were made to either the Care Quality Commission or Clinical Commissioning Groups.

![Slips, Trips and Falls 2015 - 2016](image)

Root Cause Analysis (RCA)
A Root Cause Analysis is a systematic investigation technique that looks beyond the individuals concerned and seeks to understand the underlying causes and environmental context in which the incident happened. It is basically a collection of tools to help structure an investigation and analysis of events designed to get to the root of a problem.

There are a number of instances when we would routinely conduct an RCA and some of these are listed below, although this list is not exhaustive:

- If patient has repeatedly fallen more than 3 times on current admission
- If patient suffers loss of consciousness
- When a fall results in hospital assessment of admission
If a patient has abnormal neurological observations
If a patient were to die as the result of a fall or within 24 hours of a fall.

Two RCA’s were completed during 2015/16 an both related to patients who, due to their complex care needs and frailty fell on more than three occasions. Care plans are prepared for individual patients to ensure their safety as well as supporting patient independence where appropriate at the same time.

Slip, trips and fall data is regularly monitored and used for education purposes and safe awareness sessions.

**Pressure Ulcers**
During 2015/16 there continues to be a decrease in the number of patients admitted to the hospice with Pressure Ulcers. 60 patients were admitted in 2015/16 with Pressure Ulcers compared to 67 during 2014/15. The number of patients admitted from home with a Pressure Ulcer has reduced by 19.5% (41 in 2015/16 compared to 51 in 2014/15). Patients admitted from hospital with a Pressure Ulcer has increased by 18.5% (19 in 2015/16 compared to 16 in 2014/15).

A Root Cause Analysis 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. Four RCAs in respect of grade 3 pressure ulcers were conducted during this 12 month period.
In order to support staff in enhanced detection and prevention of the damage caused by pressure ulcers, we use the SSKIN tool. This supports 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 and 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 is our link nurse to tissue viability too.

**Infection Prevention and Control**
The Hospice has an Infection, Prevention and Control Resource Nurse who works one day per week. In addition to this; an additional agreement has been agreed with an external Infection Prevention consultant who offers a further 6 days support to the Hospice by providing expert advice as well as supporting and mentoring our Resource Nurse.

**Outbreaks**
There have been no outbreaks during 1 April 2015 and 31 March 2016.

**Surveillance of MRSA and Clostridium Difficile**
The total numbers of patients known to have MRSA/C-Diff on the In Patient Unit between 1 April 2015 and 31 March 2016 are:

<table>
<thead>
<tr>
<th>Micro-organism</th>
<th>Total number of patient known to be colonised</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA</td>
<td>0</td>
</tr>
<tr>
<td>Clostridium Difficile</td>
<td>0</td>
</tr>
</tbody>
</table>
Medicines Management
The Hospice's Medicines Management Committee meetings every three months and is chaired by one of the Consultants in Palliative Care. The Trust's Pharmacist (see below) is also in attendance at these meetings. All drug related incidents and near misses are reported to the Medicines Management Committee as part of the governance framework.

Our Nursing Director is the 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.

Birmingham St Marys Hospice is one of the partner organisations of the Birmingham, Solihull and Sandwell Local Intelligence Network for Controlled Drugs Governance. All partner organisations have signed an information sharing agreement in order to confidentially divulge information in respect of the use, handling, prescribing and management of Controlled Drugs. The network meets on a quarterly basis and during the last 12 months the Hospice has raised 1 concern with the network.

The hospice has an agreement with the 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
- Reactive advice on medications to patients, doctors and nurses
- Operating a dispensing for discharge service.

During the last 12 months there were 51 medicines related incidents and 12 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 2015 and 31 March 2016:

<table>
<thead>
<tr>
<th>Total No. of complaints</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing</td>
<td></td>
</tr>
<tr>
<td>- Inpatient Unit</td>
<td>2</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>1 (formal feedback dealt with via complaints process)</td>
</tr>
<tr>
<td>Medical</td>
<td>0</td>
</tr>
<tr>
<td>Family and Carer Support Team</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
</tr>
</tbody>
</table>

Compliments and “Thank You's”
The Hospice received 154 thank you cards and letters during the year which are normally received by individual departments. Compliments, thank you cards and letters are retained for a period of time after they have been displayed in individual departments. Particular phrases and expressions of gratitude are anonymised and used in Hospice material.
75/75 reviews left on Facebook were given a 5* rating. The hospice also received a 2* rating with the following positive comment attached:

“St Mary's is a fantastic place especially if your terminally sick like I am you can talk to them and they understand greatly I love St Mary's they are angels in disguise”

Details of the reviews can be found on our Facebook page on the following link: https://www.facebook.com/birminghamstmaryshospice/reviews/

**Encouraging Feedback**

Staff and Ward Volunteers encourage and support patients and their families to give feedback. A magnetic display board is available in the Butterfly Lounge where visitors and patients can share their experiences.

Compliments/complaints slips are available in the Butterfly Lounge and are referenced in the patient information booklets. The Hospice also welcomes feedback via its social media networks.
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 and 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 1st April 2015 and 31st March 2016 a total of 40 audits were conducted, of which 24 were clinical and 16 were medication audits.

**Medicines Management**

What we were good at:
- Completing Drug Charts for all Patient Group Directives (PGD) and PGD Nurse assessment compliance
- Transcribing instructions from Electronic Verbal Orders onto Drug Charts accurately
- Storing medication in patients lockers appropriately
- Accountable Officer for Controlled Drugs compliant against all areas including legislation, regulation and policies
- Monitoring Drug Stock levels
- Managing the demand for Medical Gas supplies between the In Patient Unit and Facilities departments
- Documenting changes to patients medication on discharge letters to the GP.

What we are working to improve:
- Updating patients journals when a Patient Group Directive (PGD) has been administered
- Documentation of distribution of steroid card and review of dose
- Signage and storage improvement for Medical Gas cylinders
- Understanding the difference between POD and CD destruction cupboard.
Caring and Safe

What we were good at:
- Obtaining verbal consent for Acupuncture and documenting
- Completing audit forms for all incidence and progression of pressure ulcers
- Carrying out Falls Risk Assessments on admission
- Ensuring patient equipment is delivered/fitted within 7 working days
- Clearly documenting diabetes information
- Documenting conversations with family members reflecting prognosis and deteriorating condition
- Recording resuscitation status during admission of patients and making the information easily accessible to hospice professionals in an urgent situation.

What we are working to improve:
- Change of method for consent for Paracentesis
- To achieve 100% ward staff attendance on pressure ulcer prevention training
- Updating post fall observations
- Use of diabetes templates and algorithms and formal review of diabetes plan
- Patient or family members to be given the name of the senior doctor in charge of the patient care
- To review DNACPR (IPU) information leaflet and to ensure prompt is in discharge letter to ensure medical staff communicate DNACPR decisions to GP.

Audit Presentations 2015/16

Audit presentations are held on a regular basis and are available for all members of staff to attend. They provide an opportunity to discuss outcomes and learning from the audits undertaken at the Hospice. The following 11 presentations took place during 2015 and were attended by various disciplines:

<table>
<thead>
<tr>
<th>Date of Presentations</th>
<th>Presentation Titles</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 2015</td>
<td>Delirium Documentation and Management</td>
</tr>
<tr>
<td></td>
<td>Diabetes Management</td>
</tr>
<tr>
<td></td>
<td>Audit of Community Palliative Care Team Chemotherapy Reminders</td>
</tr>
<tr>
<td></td>
<td>Incident of Pressure Ulcer Development for patients admitted to IPU</td>
</tr>
<tr>
<td>October 2015</td>
<td>DNAR (CPCT) documentation record on SystmOne</td>
</tr>
<tr>
<td></td>
<td>Documentation Audit</td>
</tr>
<tr>
<td></td>
<td>Documentation of Capacity Assessments on IPU</td>
</tr>
<tr>
<td>January 2016</td>
<td>Audit of Slip, Trip and Falls</td>
</tr>
<tr>
<td></td>
<td>Hospice at Home Waiting/Response Time Audit</td>
</tr>
<tr>
<td></td>
<td>Phase of illness and recording of CPCT</td>
</tr>
<tr>
<td></td>
<td>Therapy Nutritional Care Round</td>
</tr>
</tbody>
</table>
Part 3 – Review of quality of Performance

3.4 Feedback from patients and families on services
We will be reviewing the way we collect feedback and engage with patients and carers during the next 12 months – please see page 18

In-Patient Services
- A questionnaire was given to patients or their carer on the fourth day following admission

<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>If my friends or family needed similar care or treatment I would recommend your service to them</td>
<td>46</td>
<td>5</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>The first three days of my stay have been satisfactory</td>
<td>43</td>
<td>8</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>I understand the reasons for my admission and what the hospice is trying to achieve for me</td>
<td>45</td>
<td>7</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I have found the staff approachable</td>
<td>45</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I have been given the opportunity to discuss my care and treatment</td>
<td>43</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I have been able to express any concerns or issues that I've had</td>
<td>41</td>
<td>10</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>The In-Patient Unit staff are doing everything I would expect them to do</td>
<td>40</td>
<td>9</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>If I have a complaint about the care I was receiving I would know what to do</td>
<td>35</td>
<td>11</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>The service I have received could be improved</td>
<td>29</td>
<td>8</td>
<td>4</td>
<td>0</td>
</tr>
</tbody>
</table>

Discharged Patients from In-Patient Unit
- A questionnaire was initially given to all patients or their carer on the day of discharge

<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>If my friends or family needed similar care or treatment I would recommend your service to them</td>
<td>24</td>
<td>5</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>I was satisfied with the care and treatments I received</td>
<td>22</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I always felt that I knew what was going on</td>
<td>22</td>
<td>7</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>The service I received could be improved in some way</td>
<td>12</td>
<td>6</td>
<td>5</td>
<td>0</td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>SPECIALIST COMMUNITY SERVICES Question</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree nor disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>If my friends or family needed similar care or treatment I would recommend your service to them</td>
<td>42</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I have found the staff approachable</td>
<td>39</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>I have been given the opportunity to discuss my care or treatments</td>
<td>37</td>
<td>5</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>38</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>The Community Team is doing everything I would expect them to do</td>
<td>39</td>
<td>3</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

Hospice at Home
- A questionnaire was given to the patient/carer during the first visit with a pre-paid return envelope.

<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>If my friends or family needed similar care or treatment I would recommend your service to them</td>
<td>16</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I have found the staff approachable</td>
<td>20</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>19</td>
<td>1</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>20</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hospice at Home has helped me to stay at home</td>
<td>19</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hospice at Home have supported my family/carers</td>
<td>19</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>The Hospice at Home Team is doing everything I would expect them to do</td>
<td>14</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Day Hospice
Patients are able to complete one of the Comments, Complaints and Compliment cards located in the Day Hospice. The Kings College IPOS evaluation form is given to patients at the start, middle and end of their programme. This evaluates patient symptoms, quality of life and includes a carers questionnaire.
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 quarterly 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. 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 Statements on Birmingham St Mary’s Hospice Quality Account for 2015/16

To follow
Part 3 – Review of quality of Performance

3.7 Feedback and Comments

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

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Governance Manager
Birmingham St Mary’s Hospice
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Email: helene.trebinska@birminghamhospice.org.uk