Quality Account 2016-17

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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Cross City CCG

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<table>
<thead>
<tr>
<th>ABBREVIATIONS</th>
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<tbody>
<tr>
<td>CGC</td>
<td>Clinical Governance Committee (part of the Hospice’s governance framework)</td>
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<tr>
<td>CQUIN</td>
<td>Commissioning for Quality and Innovation (payment)</td>
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<tr>
<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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<tr>
<td>NICE</td>
<td>National Institute for Clinical Excellence</td>
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<tr>
<td>OOH</td>
<td>Out of Hours</td>
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<tr>
<td>RCA</td>
<td>Root Cause Analysis</td>
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<tr>
<td>SCCM</td>
<td>Senior Clinicians Communications Meeting</td>
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Part 1 – Statements

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

At Birmingham St Mary’s Hospice, individuals, their families, carers and loved ones come first. Their experience, confidence and dignity is our top priority. We are extremely proud of our staff, volunteers and supporters and grateful for their efforts in making such a difference for so many people.

This has been a year of change and success. Whilst we have ended the year in a very positive financial position, we cannot be complacent as we aim to increase our reach from 1,200 individuals a year to 2,500 by 2018/19 including the support we provide to their families, loved ones and carers.

‘Hospice Care for All’

We need to reach more people due to an increased demand for hospice care. This is due to growth of our elderly population; more people living longer with dementia, frailty and other conditions at the end of life; many young people surviving childhood with long-term, life-limiting conditions; and too many people dying in hospital when they would rather be at home.

In January 2016 we launched our new Hospice Strategy (2016-2020) “Hospice Care for All”. This outlines that hospice care should be a main-stream approach, in any setting, whether delivered by the Hospice or through our education of health and social care professionals in other organisations such as in prison, care homes, hospitals, general practice or out in the community. Our work continues to focus strongly on community development, resulting in greater awareness of hospice care across our diverse population; better access to people who are disadvantaged; and strengthening our own engagement with and development of locally led initiatives.

The Hospice has worked with partner agencies and our commissioners to develop Birmingham’s End of Life and Palliative Care Strategy. The NHS England Planning Guidance for 2016-2017 also set a directive for NHS commissioners and local authorities to work together to develop “Sustainability and Transformation Plans” by mid-2016. Whilst this aspires to make things better for people, it will also add to the complexities in the locality around us as changes are put in place. As such we aim to be proactive in our influence and support in the interests of men and women living with terminal illness and those that matter to them as this work progresses.

At the end of last year, when Sandwell & West Birmingham Clinical Commissioning Group put End of Life and Palliative Care out to tender, we formed an alliance with other partners and the Sandwell & West Birmingham Hospitals NHS Trust who took the lead provider role. We were pleased that the alliance was successful which means Birmingham St Mary’s Hospice will continue to deliver services to patients in those areas. However, whilst we are able to continue our delivery of high quality care, a disproportionate amount of clinical time and cost was diverted into this process.

Birmingham Cross City Clinical Commissioning Group and Birmingham South Central Clinical Commissioning Group are also considering a similar process. We recognise that competition works well for some services; we also recognise the benefits of collaboration. We are, therefore, working with neighbouring hospices to offer our commissioners an alternative, more collaborative solution to make better use of time and money than a costly tender approach.

The national strategy “Ambitions for End of Life Care: A National Framework for Local Action 2015-2020” emphasises the need for local organisations to work collaboratively to make it easier for people to get the help they need. This is reinforced by the words of an individual whom the hospice has helped:

“I can make the last stage of my life as good as possible because everyone works together confidently, honestly and consistently to help me and the people who are important to me.”
Responding to the growing demands on Hospice care

We have already put in place extensive plans to respond to growing demand for hospice care coupled with the continued economic constraints. These plans include collaborative working and some redesign of our services so that we can remain financially strong whilst reaching more people. Our case for change resulted in some additional funding from the NHS for this work and a significant major voluntary donation.

With this support we were able to launch our first phase of plans in February 2016; this includes services we implemented in the summer:

- A new volunteer run social day called the Welcome Group to address social isolation.
- Outpatient clinics so that people can have an appointment to see a nurse if they prefer this to a home visit.
- Our first two Satellite Clinic locations in GP surgeries/health centres supported by our own specialist nurses.
- The introduction of Home from Home beds on our Inpatient Unit.

These services provide more choice for patients, families, friends and carers. They respond to unmet need and bring hospice care closer to home, supported by skilled and caring volunteers. We continue to provide most of our care in our patients’ own homes, alongside our progressive in-patient and day services at the hospice.

In the words of a local GP:

“As a local GP in Birmingham I have worked with many patients who require palliative care and many of those patients ask if they can receive this care at home or in a more local setting.”

This Quality Account

A Quality Account is a report about the quality of services provided. They are an important way for services to report on quality and show improvements in the services they deliver to local communities. The quality of services is measured by looking at patient safety, the care that patients receive and feedback about the care provided.

Our approach to this requirement is to share three of our clinical priorities for the coming year as well as reporting on how we did with the priorities we published last year. We also like to give the reader information and highlights from the preceding year at the Hospice. Some of this is given in the form of data and statistical information, supported by graphs.

The Department of Health asks providers to submit their final Quality Account to the Secretary of State by uploading it to the NHS Choices website by 30 June each year. The requirement to do this is set out in the Health Act 2009.

Thank you to our supporters

The Hospice appreciates the hard work and generous support of all our supporters, staff and volunteers. We thank everyone for working with us through the increasing changes and complexity as our health and social care services strive to improve in challenging times. We hope you will continue to support us to reach more people through partnership, education, research and the delivery of impeccable care. We look forward to another year of working together to make a truly valuable difference.

Mr Vij Randeniya OBE Chairman

Ms Tina Swani MBA, MCIM Chief Executive
Our Board is made up of 12 Trustees drawn from a variety of professions and backgrounds.

Note: Julie Burgess, Jim Murray and Damian Walmsley resigned from the Board of Trustees during the year covered by this report.
The Executive Team are responsible for the Hospice on a day to day basis and working with the Board to develop the direction for the future. The Team is made up as follows:

Tina Swani
Chief Executive

Lynsey Breeze
Finance Director

Dr Debbie Talbot
Medical Director

Helen O'Halloran
Nursing Director

Susan Newcombe
Director of Income
Generation & Marketing

This Quality Account illustrates, through specific examples, our commitment to continual improvement to service quality and through innovation.
2.1 Priorities for improvement 2016-17 - what we achieved last year

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 was the priority achieved?
- Continuous recruitment campaign to maintain safe staffing levels in the absence of national guidance we have benchmarked ourselves against other hospices.
- Flexible arrangements with finance allow short term recruitment to vacancies to cover Maternity leave etc.
- Review of job descriptions to allow better career progression
- Targeted competency training, aligned to job description and appraisal objectives.
- Recruitment to a new post (Professional Development Nurse) to support nurse education and development.
• The new Home from Home service has matured and numbers have increased over a period of time. This has allowed the nursing staff to develop their assessment skills and increase their clinical confidence.
• Re-Introduction of joint nursing and medical rounds to increase multi-disciplinary approach to holistic care.

How was the progress monitored?
Progress was monitored by pressure ulcer incidence, slips and falls, incidence of infection and incident reporting, complaints and compliments which were all monitored through the Clinical Governance Committee. Activity was monitored through the SWB end of life return and service performance review group. Reporting as above.
How was this identified as a priority?
The Hospice Strategy 2016-2020 advocates Hospice Care for All, based on individual choice and need at the right time in the right location. The provision of a range of services in a wide number of settings brings Hospice care closer to people in the locality, and increases collaboration with other organisations to expand our reach to them.

The introduction of satellite and nurse led clinics was identified as a priority to respond to rising demands on community services, and to utilise current resources more efficiently and effectively. Therefore, the Clinical Nurse Specialists have designed a different way of working to provide specialist care and bring the service closer to the communities served.

The Hospice community service response to this identified priority can be demonstrated through understanding the factors that have created an overall increase in the caseload in the period June 2016 to January 2017, from 254 to 304 patients, indicating a greater reach overall. This is likely to be due to multiple factors including:

- The movement of two Sandwell practices into Cross City CCG
- Greater engagement with referrers and community
- Increase in pressures in the health and social care system
- The initiation of the satellite clinic project

The response included the first phase of this new initiative, which involved:

- A pilot clinic at the Hospice, the evaluation of this was completed in April 2016, with Executive Director recommendation to proceed in three sites, with a further interim evaluation at six months.
- The clinic at Birmingham St Marys Hospice continued, and two further sites at Jiggins Lane GP Practice, Bartley Green and Sparkbrook Medical Centre, Sparkbrook began in June 2016, with formal commencement of clinics in September 2016.
- A Clinical Nurse Specialist was appointed as Lead to the Satellite Clinic Service in October 2016, with responsibility to develop and evaluate the service.
- A Community Engagement Officer was also appointed in July 2016 to develop and engage the local community to increase knowledge of palliative care and hospice services.
- Professional meetings with referring clinicians in primary and secondary care were held to inform them of the service, scope requirements and encourage referrals.
- A steering group was developed with representation from GP’s, users, clinical nurse specialists, a palliative medicine consultant and service development leads, to be accountable to the Board of Trustees for satellite service provision.

How was this priority achieved?
From June 2016 to January 2017, there have been 124 patient consultations delivered in a clinic setting for this 6 month period, which is 6% of total CNS (Clinical Nurse Specialist) activity. No additional new Clinical Nurse Specialist appointments have been made to deliver the clinics. The clinics have been incorporated into the ‘usual’ CNS caseload, creating efficiencies in working practices, allowing less travel time and mileage between patients, and therefore a greater number of patients seen in the time available.
The current clinic caseload is 22 patients. This is equivalent to a 5 day CNS caseload, but is being managed within 3 half day clinics plus administration time.

How was progress monitored and reported?
This was achieved through monitoring and reporting of clinical attendance and CNS activity during this time.

June 2016 – January 2017

<table>
<thead>
<tr>
<th></th>
<th>New patient attendance</th>
<th>Follow up attendances</th>
<th>Total attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sparkbrook</td>
<td>13</td>
<td>24</td>
<td>37</td>
</tr>
<tr>
<td>Jiggins Lane</td>
<td>16</td>
<td>15</td>
<td>31</td>
</tr>
<tr>
<td>Birmingham St Marys</td>
<td>23</td>
<td>33</td>
<td>56</td>
</tr>
</tbody>
</table>

Costs have been monitored:

<table>
<thead>
<tr>
<th></th>
<th>Year One</th>
<th>Year Two</th>
<th>Offset costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community engagement officer 1 year</td>
<td>£20,167</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinic lead CNS 2 years</td>
<td>£51,288</td>
<td>£51,288</td>
<td></td>
</tr>
<tr>
<td>Two laptops</td>
<td>£1,898</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dongle for use at Sparkbrook clinic from June - January</td>
<td>£120</td>
<td>£140</td>
<td></td>
</tr>
<tr>
<td>Clinic mileage for 3 CNS’ travelling to &amp; from clinic since June- January</td>
<td>£207 (Full year £310)</td>
<td>£310</td>
<td>Equivalent 12 month mileage costs for home visits £4, 212</td>
</tr>
<tr>
<td>Postage costs for initial clinic appointment letter</td>
<td>£35 (Full year £54)</td>
<td>£53</td>
<td></td>
</tr>
<tr>
<td><strong>Total costs</strong></td>
<td><strong>£73,716</strong></td>
<td><strong>£51,671</strong></td>
<td></td>
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The summary of findings from the evaluation during this period, and feedback during the recent Hospice Board reporting cycle, have highlighted a requirement for a formal review of the following information for a more in depth analysis and evaluation of the service:

1. We are awaiting review of data from Public Health England to demonstrate differences in the numbers of people we support compared to deaths in the general population. This will inform future service design.
2. The aim of the service was to see people earlier in their disease advancement. This is not evident in the review of people seen who continue to have complex needs. This may be related to the referral route and this will be addressed in recommendations.
3. Patient ‘views on care’ questionnaires indicate satisfaction with the service and improvement in quality of life, although these are limited numbers.
4. GP discussion and evaluation is positive with examples given of people ‘not ready’ for hospice being referred for local clinic and improved working relationships with the hospice.
5. CNS, user, community and GP scoping and evaluation indicates a need to widen the remit of the service to meet local need e.g. carer support, therapeutic and rehab interventions, social care advocacy, advice and support.
6. As we have a limited number of locations across a large footprint it is difficult for some to travel the distance from home to their allotted clinic e.g. those in Sandwell travelling to Bartley Green.
7. The clinic held at the Hospice has greatest activity, this may be related to opportunity to attend and become familiar with the Hospice or that the locality already has increased activity and therefore referrals are representative of this. This clinic has now been running for two years.
8. There are also savings in mileage costs when a CNS delivers a clinic session in a satellite clinic.

The satellite and clinic service is an important component of a total community service, and those patients who evaluated the service stated they were grateful for this being available as a choice. It remains a positive choice for those early in disease trajectory, and those who are more physically able to attend. However, there are also a large number of patients who are too unwell to attend a clinic setting and require ongoing Clinical Nurse Specialist input in their own homes.
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 was the priority achieved?
Patients and carers have been actively involved in many new ways
- Patients in Day Hospice were asked for their views on the new patient feedback form (now called ‘How are we doing questionnaire’)
- On-going progress of the new questionnaire across all clinical areas. IPU and community still in progress
- Better data collection and presentation on the new dashboard for the Board of patient/carer feedback
- New format will demonstrate improvements in patient/carer experience
- Patient from DH attended the Hospice’s annual AGM to give her views on the care and services she has received
- Patient representative is now attending the Satellite Steering Group meetings
- Attendance at conferences aimed at patient engagement and measuring patient outcome measures
- Networking with other Hospices and follow up meeting with Shakespeare Hospice planned May 2017
- Awareness of the need to involve patients and carers in the development of new services has increased. For example the new Support at Home steering group will also have a patient or carer representative.
- New projects are also required to use the Logic Model to help develop outcome measures so that social impact can be incorporated into the measures

How was progress monitored and reported?
- Progress was monitored through the Clinical Governance Committee with a quarterly verbal update of progress of the new ‘How are we doing questionnaire’
- A presentation to CGC is planned for the next meeting to give an overview of progress.
- Progress on setting up patient forum was highlighted at CGC
2.2 Other notable achievements 2016 – 2017

London launch of ‘Hospice Care for All’

Our strategy ‘Hospice Care for All’ which aims to expand the provision of end of life care in people’s homes or in community locations was backed by the Chief Executive of NHS England, Simon Stevens who applauded the hospice on the fantastic work achieved so far.

Speaking at the launch in Westminster, the Birmingham born NHS CEO said: “This will not only be of enormous benefit for the people of Birmingham and the wider West Midlands, it will also set a clear route map that other hospices across this country can take.”

In attendance at the launch was also Hospice UK Chairman, the Rt Hon Lord Michael Howard who supported the new strategy; “We are absolutely determined to extend the reach and to make hospice care available to everyone who can benefit from it.”

The launch was a significant opportunity for us to showcase our amazing work to a room full of high profile dignitaries. It was also an important opportunity to reinforce why ‘Hospice Care for All’ is needed.

A key component of our recent service design is the development of our Satellite Clinics. Two, 24 month pilot Satellite Clinics have already been launched in Sparkbrook and Bartley Green in different locations such as GP/Health Centres offering easier access to their services closer to the communities where individuals live.

You can download our Hospice Strategy 2016-2020 ‘Hospice Care for All’ on our website: www.birminghamhospice.org.uk/our-values
BrumYODO

BrumYODO are a voluntary community of artists, health professionals, undertakers and many more, who have come together to encourage and enable conversations about death and dying in our Birmingham communities.

Birmingham St Mary’s Hospice are partners in this conversation and this year for Dying Matters Week 8th - 14th May 2017 BrumYODO will be hosting a festival at the MAC in Birmingham. The festival will have panel discussions, films, drama productions and workshops all creating ways in which we can talk openly about death in society.

Butterfly Lounge

The Butterfly Lounge was relaunched in August 2016 to include longer opening hours, new look and greater rotation of stock and some exciting additions to the menu. Our Head of Facilities is currently scoping the provision of meals for visitors which we hope to introduce in the next 12 months.
Roots and Wings Children’s Counselling Room

Renovation of the new “Roots and Wings” Children’s counselling room was completed, using bright vibrant colours the room has been transformed and is now located in a more suitable area within Day Hospice. This was officially opened on Friday 18th November and coincided with Children’s Grief Awareness week. The room provides interactive space for children to express and explore their thoughts and feeling and was funded by Mazars Charitable Trust.

The room includes a beautiful mural and sculpture created by Danielle Swann and Martin Ward, as well as toys and games which have been generously donated.

Caring for patients suffering with dementia

Our patients and their families come first and our aim is to achieve an improved experience and support a wider range of patients, by providing a peaceful shared space.

Our existing conservatory required refurbishment and therefore following grant funding, a project was undertaken to improve these facilities, creating a homely environment for all of our patients, especially those living with dementia.

The refurbishment includes new furniture, chairs and settees with built in pressure relieving cushions and a sideboard, these items look similar to conventional home furniture thus achieving a relaxed atmosphere. Vinyl flooring has been chosen for its acoustic properties to reduce noise and confusion for people with dementia. The whole of the conservatory has been redecorated and the old cord operated roof blinds were replaced with modern anti heat/glare roof film providing a much safer and spacious feel to the conservatory.
Signage throughout the IPU has also been upgraded, using clear fonts and colours in accordance with Disability Discrimination Act (DDA) and dementia good practice.

**Dementia training through Birmingham Community Healthcare Trust**
To support staff working with patients suffering from dementia, staff were offered the opportunity to attend Dementia Awareness training provided by Birmingham Community Healthcare Trust. The Trust offered training at three levels - basic, enhanced and advanced. A large proportion of our staff frontline staff undertook the two day advanced course.

**Integrated Community Support**

In September we appointed an Integrated Community Team Leader to provide strategic leadership, delivering and developing services to support patients in their own home. They are responsible for the management of community nursing services across our community services which include Day Hospice, Hospice at Home, Community Clinical Nurse Specialists and CNS-led satellite clinics.

Across our community services we are seeing and supporting around 290 people with life limiting conditions and their families and carers the purpose of this new role is to ensure this care is seamless with the person and their family and carer at the centre.

The community service has seen an increase in referrals of approximately 15% in this last year which brings challenges; this new role has allowed us to think differently, bringing our teams together to work in more effective ways.
To further support this strategy, the Hospice recruited a Triage Nurse, who works alongside the multidisciplinary team to ensure a seamless core referral and discharge process across all clinical services at the Hospice.

The role ensures a robust referral route and aligns existing services with an integrated model of partnership working both within the organisation and with external health and social care providers.

**Equality and Diversity / Dignity and Respect**

Birmingham St Mary’s Hospice offers a range of services in a wide number of settings. We welcome patients from all faiths and backgrounds across Birmingham and Sandwell.

We are committed to providing high quality services that are open, culturally aware and equally available to all. Where needed, interpretation and signing services are available and we encourage patients and their families to make use of an interpreter to make it easier to tell us what they need and how we can help.

We have embarked on an ambitious and innovative programme of service redesign to enable us to reach more individuals and their families, carers and loved ones than ever before. A video has been produced which showcases how we are giving individuals more choice and making our care and expertise more accessible across Birmingham and Sandwell. [https://www.youtube.com/watch?v=EmLp0HAJfEM](https://www.youtube.com/watch?v=EmLp0HAJfEM)

In July our Community Engagement Officer was recruited in recognition of and to ensure that communities under-represented in patient referrals, have awareness of the Hospice and its services and expel any myths about the hospice. This role has been created alongside our newly launched satellite clinic services which are also placed in these same areas of under-utilisation.
Day Hospice

Birmingham St Mary's Hospice expanded its Day Hospice Therapeutic Programme, a clinically led, 12 week educational programme focusing on living well with a life limiting illness. This now includes a Transfusion Clinic open on Wednesdays providing blood/platelet transfusions or bisphosphonate infusions, an Outpatient clinic and The Welcome Group.

The Welcome Group was launched on the 29 June 2016. It is a weekly volunteer led service which provides social and peer support for people who have a life limiting or terminal illness. The non-clinical service is run by an experienced team of volunteers and can accommodate up-to 20 individuals per session.
Staff survey

In 2016 the Hospice conducted a staff survey for the whole organization and an extract from the results regarding discrimination and harassment is given below:

Response rate

151 people responded to the survey out of a possible total of 218, a response rate of 69%.

Results

The report uses 3 key measures:
- **Positive** percentage (%) figures: are calculated as % Strongly Agree + % Agree for positively phrased questions and % Strongly Disagree + % Disagree for negatively phrased questions
- **Neutral** percentage (%) figures: are calculated as % Neither Agree nor Disagree
- **Negative** percentage (%) figures: are calculated as % Strongly Disagree + % Disagree for positively phrased questions and % Strongly Agree + % Agree for negatively phrased questions

Results are presented as whole numbers for ease of reading. Therefore in some instances, results may not total 100%.

Results were benchmarked against 14 similar organisations.

The hospice’s employee engagement index was measured at 81%, an increase of 5% since the 2014 survey and well above the benchmark medium of 68%. The hospice was awarded the Agenda Consulting Employee Engagement Award 2016 for demonstrating high levels of employee engagement.

Other highlights included:
- 99% of respondents are clear as to how their role contributes to hospice objectives
- 95% of respondents are familiar with the organisation policies and procedures which affect them
- 95% of respondents are clear about the hospice’s values
- 95% of respondents report their line manager is open to new ideas and suggestions
- 93% of respondents would know how to report any wrong-doing if they saw it

Demographic reports have been distributed to each Executive Director for action planning and communication with teams.

Anonymity

It is Agenda Consulting’s practice not to allow the reporting on groups of fewer than 7 people to preserve anonymity. However, their data will still contribute to the scores for the organisation overall.

Traffic Light Scoring

Scores for the 2016 survey results are given a traffic light rating, based on the following:
- 70% or more of respondents Positive and less than 20% of respondents Negative
- Between 50 - 70% of respondents Positive and less than 20% of respondents Negative
- Less than 50% of respondents Positive or 20% - 30% of respondents Negative
- 30% or more of respondents Negative
Discrimination

43. In the last 12 months have you personally experienced discrimination in your role at the Hospice from a manager/team leader or other colleagues?

- How many occasions have you personally experienced discrimination in your role at the Hospice in the last 12 months from a manager/team leader?
- How many occasions have you personally experienced discrimination in your role at the Hospice in the last 12 months from other colleagues?

As fewer than 7 people responded 'Yes' to Q43 indicating that they have experienced discrimination, there is no data to show for the two follow-up questions.

38. Have you ever experienced harassment, bullying or abuse from a colleague (paid staff or volunteer), patient, their relative, or carer, or a member of the public in your role at the Hospice in the last 12 months?

- 13.2% Yes
- 86.8% No
Please note: the following questions were asked only of those who answered 'yes' to Q38

39. How many occasions have you experienced harassment, bullying or abuse from patients / service users, their relatives, carers or other members of the public in your role at the Hospice in the last 12 months?

40. How many occasions have you experienced harassment, bullying or abuse from managers in your role at the Hospice in the last 12 months?

41. How many occasions have you experienced harassment, bullying or abuse from a direct report in your role at the Hospice in the last 12 months?

42. How many occasions have you experienced harassment, bullying or abuse from other colleagues (paid staff or volunteers) in your role at the Hospice in the last 12 months?
2.3 Priorities for Improvements 2017 – 2018

Patient Safety

Priority:
Improve practice in respect of drug incidents

Standard:
Reduce the severity of incidents reported, and the frequency

How was this identified as a priority?
The hospice has a clear policy in place for reporting of medicines related incidents, errors and near misses. This supports proactive reporting of incidents and errors by all staff members in order to gain understanding of any patterns associated with incidents, to work together as a team to prevent a recurrence of incidents in the future, or to downgrade the severity of any incidents in terms of impact on patients. We acknowledge as an organisation that incidents will occur, but that reporting and monitoring can improve safety and promote learning.

Medication incidents and errors are reported to the Hospice governance team who collate information about all incidents and provide reports of detail as well as absolute numbers and comparison to previous years to the Medicines Management Committee and Clinical Governance Committee within the Hospice.

During 2016 it emerged that the number of medications incidents had increased compared to previous years. The senior medical and nursing team involved in medicines management met to review incidents and create an action plan surrounding this. A growing awareness developed that some decisions about whether to report incidents had been made at a local level historically and some incidents were therefore never reported. The increase in reporting followed encouragement and training from senior members of the team so that our report figures are now a true reflection of our incidence of error. This allows better monitoring of the changes we are making and their impact on the error rate.

There was recognition that whilst the absolute number of incidents had increased, the severity of most incidents was low, and the impact on patients as a result was low. Frequently errors were related to documentation rather than administration of a medication, and errors were routinely picked up by good staff vigilance, reducing risks to patients. However, in an ideal world, the risk to patients would be ameliorated completely. With an aim of reducing risk, during 2016, professional accountability sessions were held for staff and a medicines administration subgroup met to discuss incidents and errors. Ongoing monitoring of incidents continued to take place.

Analysis of incidents throughout 2016 took place, and improvements in practice were suggested as a result.

How will the priority be achieved?
Changes to practice have already commenced. There is a clear and consistent message from the senior team that reporting of incidents is to be encouraged as we cannot learn from incidents and errors without staff feeling empowered to report them.
A quiet and protected prescribing area has been set up within the notes room to reduce prescribing errors. Do not disturb tabards are in use for nursing staff. Patient allocation has ensured that nurses are responsible for their patient’s drug administration rather than there being a general drug round undertaken by one person to all patients. It is anticipated that this change will encourage more accountability from staff in regards to medicines management.

In the next year, a review of the medications incident categories will take place with an aim to make reporting easier. The practice development nurse will be an important part of changing culture and practice on the ward by being involved in education and support for nursing staff. Pharmacist input will be sought with respect to changes required to the medication chart to make prescribing and administration safer prior to being able to introduce electronic prescribing as a safer method of prescribing within the hospice.

Scoping of the methods of electronic prescribing will take place and a business case will be submitted to support developing electronic prescribing within the organisation.

**How will progress be monitored and reported?**
By the monitoring of ongoing number and severity of incidents and errors with a strong narrative as to the cause and impact of the error. The reporting line will be (in order) to line managers, Medicines Management Committee, Clinical Governance Committee, Executive Team and Board of Trustees.

Minutes of Medicines Management Committee meetings will be available for scrutiny of ongoing actions as a result of medicines incidents and errors.

Electronic prescribing will be scoped and there will be a paper produced for scrutiny by the Executive Team and Board of Trustees.

Overall the aim is to reduce the severity of incidents reported, and the frequency, whilst also being reassured by the practice development and ward management team that incidents are not going unreported as a result of lack of understanding of the necessity or fear of a blame culture.
Clinical Effectiveness

Priority:
Going from Good to Outstanding

Standard:
Initiatives towards a potential outstanding rating in future Care Quality Commission inspections

How was this identified as a priority?
Birmingham St Mary’s Hospice achieved an overall good rating for its services from the Care Quality Commission unannounced inspection visit that took place on 28th July 2016. Following on from the inspection, there have been projects and new initiatives introduced to further improve the services provided towards potentially achieving an outstanding rating in the future.

This approach has also been in response to the recommendations in the ‘Palliative and End of Life Care: A national framework for local action 2015-2020’ report by the National Palliative and End of Life Care Partnership. A programme of change and transformation of services has been ongoing to aim towards the six ambitions for palliative and end of life care as advocated in the ‘Ambitions for End of Life Care’ guidance whereby:

- Each person is seen as an individual
- Each person gets fair access to care
- Maximising comfort and well being
- Care is coordinated
- All staff are prepared to care
- Each community is prepared to help

Our strategic vision is to improve end of life care through our Hospice strategy 2016-2020: Hospice Care for All; to assure that the dignity, experience and confidence of our patients, families and carers come first. The Hospice provides a range of care in a wide number of settings.

Our values include delivering quality care, improving access for all, sharing our expertise, working collaboratively and changing attitudes to end of life care. How we deliver and monitor our priorities has the potential to enhance and further improve person centred palliative and end of life care by reaching out to more people through effective and responsive partnership working.

How will this priority be potentially achieved?
- In Patient Unit
The In Patient Unit has successfully recruited into all posts and has introduced nurse led initiatives, with plans for the introduction of Non-Medical Prescribing resources within the unit. This has the potential to improve the nursing workforce skills and ability to move forward with more nurse-led admissions. Link nurse roles have also been initiated within the unit to share skills on specific clinical topics.

Throughout the past 12 months extensive support and education has been delivered within the unit regarding practice and professional accountability. This has in turn improved governance reporting. A new post to support this approach is currently being recruited to as a Professional Development Nurse. This role will be pivotal in assuring high standards of care are maintained, alongside staff development and support within the Hospice In Patient Unit, and across the broader educational resource available.

Staff support is a high priority during this change process, and to explore their thoughts and feelings through more effective reflection and learning.
• **Education**
Professionals providing palliative and end of life care need to feel they are supported in educational initiatives in order to share knowledge and skills across a much broader remit within health and social care services. A recent review of the Hospice’s education and training provision has demonstrated the need to build much better links between education, training and service improvement.

A new role will be created to explore opportunities for partnership with local providers to attempt to ensure the essential clinical, research and further education skills are more widely delivered by the Hospice, extending our reach.

• **Integrated Community Team**
The Hospice services have responded to our mission and ambition to ensure the best care is available across our community for the patients known to the Hospice. Equitable access to high quality care and support needs to be available across Birmingham whenever and wherever individuals need it. This approach will require more effective partnership working within the area between local hospices, health and social care providers.

Our vision mirrors the Integrated Palliative and End of Life Care Commissioning Strategy 2014/15 to 2017/18. The Hospice already provides an on call service 24 hours a day, 7 days a week utilising the skills of the In Patient Unit nursing team with the on call Medical and Clinical Nurse Specialist service. This service is a telephone advisory and support service to patients, families, carers and health care professionals.

More effective signposting to appropriate community or acute hospital based services has the potential to reduce duplication in service provision and potentially reduce hospital admissions for end of life patients. Easier referral processes to the Hospice will enhance the responsiveness of this service to local need.

The provision of a collaborative Hospice at Home service across the city as a collective resource within the community has the capability of maintaining care and support at home, if that is the patients preferred place of care and death. This service will require improved partnership working with local GPS, District Nursing Teams and acute hospital services.

Hospice at Home and the Community Palliative Care Team services have responded to a marked rise in referrals to all services. The Community Palliative Care Team have utilised their current specialist resources and adapted their working patterns to this increasing demand for services by introducing nurse led outpatient and satellite clinics in local areas. The aim is to open 2 further satellite clinics within the next 6 months.

The Day Hospice 12 week programme has been positively evaluated, and plans are being made to move forward with a second day based on demand for the service, alongside the provision of transfusion clinics and the Welcome Group. Innovations in practice within the Day Hospice unit include pre assessment clinics, with an enhanced focus on people with non-malignant disease, to further individualise care provision.

The Day Hospice facility may also be opened at weekends to support people and their families through transitional care from children’s to adult services. This initiative is dependent on funding and effective partnerships between the services involved in this transition, such as education providers and local hospices. The intention is to extend our reach, and provide a resource that is more local to service users in the city.

**How will progress be monitored and reported?**
Progress will be monitored via feedback from service users in satisfaction and quality of life surveys. A supportive partnership with a local hospice that has successfully implemented patient forums is
intended to be a model for future good practice in service user and staff engagement as another form of feedback to St Mary’s.

Compliments, complaints and suggestions on specific projects involving service improvements will continue to be reviewed, and learning reflected and acted upon. Assurance will be provided through formal evaluation of changes to clinical services in the form of quality impact assessments for each initiative.

Leading and supporting the workforce through transformation and change requires effective planning and staff communication. Utilising an effective change management model will enhance a workforce driven approach to change towards a higher quality and more responsive palliative and end of life care service.
How was this identified as a priority?
The Hospice offers many different services both in the community and at the Hospice, which are provided by many different professional groups. Referral into Hospice services can be complicated, in that different criteria exist for different services, there are different forms for different services and there are various routes used such as paper, email or fax.

Furthermore these services are described as set out in our Hospice website, which can be difficult to navigate. Although members of the public can email the Hospice on an ‘info@’ email address, patients do not have access to their professional from the Hospice and the website does not allow interaction or feedback from existing patients or carers such as Patient Opinion, Healthwatch,

Feedback from other organisations and patient feedback forms reinforces this issue. A small working group was set up to identify how we could improve this process and experience

How will the priority be achieved?
• The aim is to have all referrals for clinical services to come into one secure email account which is accessible by a number of appropriate clinical and administrative staff and to provide a referral system into the Hospice that:
  - Is easily accessible
  - Encourages rather than discourages referrals
  - Supports and is compatible with existing electronic clinical records systems outside the Hospice
  - Is safe and secure and complies with information governance requirements
  - Supports existing referral routes/documents that are relevant but replaces outdated/unsafe processes such as fax referrals
• The aim is to have a website that is
  - Interactive
  - User friendly
  - Allows existing or previous patients and carers to give feedback on services and care
  - Allows general enquiries to be treated appropriately and in a timely manner
  - Allows existing patients to make contact about a specific issue, concern (clinical or non-clinical) through a safe medium that maintains confidentiality and receives a rapid response from an appropriate member of the team

How will progress be monitored and reported?
• Progress reporting to the Executive Team and Clinical Governance Committee using the service design template as part of our Programme Management suite of documents.
Part 2 – Priorities for Improvements and Statements of Assurance

2.4 Statement of assurance from the Board

Review of services
In 2016-17 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.

- **Satellite clinics**
  Satellite clinics, based in GP practices, have been opened in order to reach more people across Birmingham and Sandwell. The Clinics are by appointment and run by Clinical Nurse Specialists from the Community Palliative Care Team.

- **Day Hospice**
  We expanded the Day Hospice Therapeutic Programme, a clinically led, 12 week educational programme focusing on living well with a life limiting illness which takes place every Thursday. On Wednesdays we now have a transfusion clinic providing blood/platelet transfusions or bisphosphonate infusions, an Outpatient clinic and The Welcome Group. The Welcome Group is a weekly volunteer led service which provides social and peer support for patients who have a life limiting or terminal illness. This non-clinical service is run by an experienced team of volunteers and can accommodate up-to 20 patients per session.

- **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.
Becoming ‘Research Active’ to realise the values of the Hospice

In November 2016 the Board of Trustees approved the Research and Scholarship Strategy 2017-20 written by Dr Christina Radcliffe, Ruth Roberts (Birmingham St Mary’s Hospice) and Dr Alistair Hewison (Department of Nursing, University of Birmingham). The strategy outlines the following anticipated progress during 2017:

Rebrand and build on the established journal club
- Rebrand to make journal club attendance more attractive to staff and relevant to all hospice teams.
- To make journal club more accessible to all, distribute summaries of journal club discussions
- Support staff in the further development of critical appraisal skills by encouraging more staff to attend and present papers at journal club
- Broaden the remit of the journal club by including non-clinical papers and inviting relevant hospice staff and teams to attend
- Promote future collaboration among team members by seeking research ideas and questions through journal club
- Develop teaching sessions from questions raised in journal club to educate staff and demonstrate the value and impact of journal club

An annual programme of dates will be prepared and disseminated to all staff. Branding and message will be discussed with income generation and marketing team.

Build on web presence and develop a research social media profile
- To raise the profile and visibility of the research undertaken in the Hospice
- To maximise the potential for disseminating research findings both within the hospice and to the wider community
- To increase opportunities for establishing research links
- To publicise the status of the Hospice as Research Active to serve as a quality indicator

This will involve ensuring the research team has a ‘web’ presence on the Hospice site, University platforms and other key sites (e.g. Research Gate and Google Scholar). It will also be necessary to assign responsibility for social media activity (e.g. twitter/Facebook activity) and agree principles for process and content. The overall outcome would be to have bi-monthly research news or updates on the Birmingham St Mary’s Hospice blog or social media.

Maintain a research and scholarship database
- To have an accurate and locally managed record of all current and past research projects maintained
- To have an accurate record of outputs
- To provide a ‘live’ source of information for reports (internal and external) and publicity materials.

This will require administrative support and expertise to ensure it is functional and compatible with other systems. The overall aim will be to have an accurate and live database of both ongoing research projects and future possible opportunities available on the public drive. Ongoing research will be reported at each quarterly research steering group.
Establish a group of “research champions” in the hospice

- To have champions who celebrate research achievements and promote the integration of research into day to day practice
- To make more staff aware of the amount and nature of research currently underway in the hospice
- To help embed research ownership at a clinical level
- To generate topics to research which are relevant to clinicians providing patient care
- To extend the research brief beyond clinical teams, and encourage non clinical personnel to engage with the research agenda

Introduction of named research champions to the Day Hospice, Hospice at Home, Inpatient Unit, Community Palliative Care Team and Family and Carer Support Team. Key non clinical team members to be invited to attend Research Steering Group meetings to aid assessment of research studies, identify key fundraising and income generation opportunities and develop awareness of research activity. The research team will explore with HR the possible addition of research time to contracts of other key personnel.
**Education: What we have done this year to educate our staff and other healthcare professionals**

**Clinical Education Lead appointed Honorary lecturer**
In December 2016 our Clinical Education Lead was appointed Honorary Lecturer in the Institute of Clinical Sciences within the College of Medical and Dental Sciences at the University of Birmingham.

During the course of the last year the Education Team at the Hospice have delivered a huge amount of education and training both to our own staff and external healthcare professionals. Below is a brief overview of what has been accomplished.

**Hosted Nursing students on placement**
- We have hosted 7 students from Birmingham City University on placements ranging from 4 – 14 weeks. Within this group we had to confirm that 2 students met NMC standards for registration.
- We also hosted 3 students from the University of Birmingham, one of which required confirmation in respect of NMC standards.
- In addition we host day visits for students, an activity that is not coordinated by a university.
- We held 12 two hour sessions for student nurses. The sessions include a presentation on Hospice services, a tour of the facilities and a case study delivered by either a Clinical Nurse Specialist in the Community Palliative Care Team or a member of the nursing team from Day Hospice.

**Study days**
- In 2016 we reached the 10th anniversary of providing the European Certificate in Essential Palliative Care programme.
- 30 full days comprising of courses or study days, plus 7 half day workshops. Many of these sessions were also accessed by our own staff.

**Bespoke delivery of SAGE & THYME®**
- We were asked to deliver SAGE & THYME workshops to 4th year Pharmacy students from Aston University. This has not been delivered to this student group before and we will be writing a joint article with the University to highlight this development.
- The workshops evaluated very well and we have been asked to repeat this in 2017.

**Pilot of Interdisciplinary placements**
- Aston University wanted us to pilot interdisciplinary placements with 10 of their pharmacy students. This involved them attending for a placement at the same time as a student from another discipline, which provided learning not only about the Hospice but also about other student roles.
- The pilot was a success and we have been asked to host further placements as part of a new Service Level Agreement with Aston University.

**Journal Clubs**
We held 12 journal clubs attended by various members of the Hospice teams. Each session receives a presentation on an article which is undertaken by different staff each month. During this year two articles have led to further teaching sessions on:
- Delirium
- Hydration in End of Life Care

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1 SAGE AND THYME is a mnemonic which guides healthcare professionals/care workers into and out of a conversation with someone who is distressed or concerned.
Bespoke training for Macmillan
We were asked to deliver 3 bespoke events for Macmillan as part of a training programme for Practice Nurses, GPs and volunteers. The content included exploring
- End of Life Care
- Symptom management
- Communication skills
- SAGE & THYME ®

Sessions delivered to Universities and Colleges
- Chinese Introduction to British Health Care – University of Birmingham
- The concept of caring – MSC programme University of Birmingham
- International Student End of Life Care Discussion - University of Birmingham
- The Philosophy of End of Life Care- University of Birmingham
- The Role of community services within End of Life Care - University of Birmingham
- Loss & Grief in End of Life Care- Newman College
- The role of the Palliative Care Hospice Social Worker – Birmingham City University

Gold Standards Framework Regional Centre
Following our recognition as a Gold Standards Framework Regional Centre, we ran our first GSF Care Home programme. Ten Care Homes started the programme, each sending two members of staff.

Nursing Associate role
Birmingham Community Healthcare Trust are part of the second round of pilot sites for the new Nursing Associate role. We were members of the working group that submitted an application to Health Education England and are now planning to have some Nursing Associate trainees on placement at the Hospice.

Hosted visits: Local girl’s school, Chinese Health care Managers and French student nurses
As part of raising awareness of Hospice care and our role in healthcare, we hosted visits from:
- School leavers from Edgbaston High School for Girls who were interested in a career in Health Care.
- Student Nurses from France undertaking an international visit to the Midlands
- Health Care Managers from China undertaking a University of Birmingham programme

Developed and delivered professional accountability session
We developed a new training session this year centred around professional accountability. The sessions last one hour and were delivered to nursing staff working on our Inpatient Unit.

Hosted and organised 2x GP Primary Care events funded by Heath Education West Midlands
The Hospice was involved with hosting, coordinating and presenting on two half day training events for GP’s. The events were supported by Health Education West Midlands and 140 GP’s attended the training.
Clinical update workshops for Birmingham Community Healthcare Trust
The Community Palliative Care Team were involved in a Birmingham Community Healthcare Trust Clinical Update day. The Hospice team provided two half day workshop sessions on symptom management at the end of life.

Delivered Palliative Care study day for non-clinical hospice staff
Following identification of a learning need for our non-clinical staff, a study day was developed and delivered looking at:
- the philosophy of End of Life Care
- communication skills
- symptom management
- caring for someone at the end of life.

Hosted European Certificate in Palliative Dementia Care exam
The Hospice provided local exam support for a candidate undertaking the European Certificate in Palliative Dementia Care. This enabled the candidate to undertake the course exam in Birmingham instead of Surrey or Northern Ireland.

Work experience placement
Our HR Team have introduced a policy covering work experience placements and this supported us hosting a student from Dudley College studying Health Care. The student attended a one day placement within the Day Hospice Welcome Group. This is the first Nursing work experience placement the Hospice has facilitated and we hope there will be many more.

Hosted OACC Workshop for Hospice UK
The Hospice was pleased to host a ‘train the trainer’ session for Hospice UK on Outcome Assessment and Complexity Collaborative (OACC) workshop. As well as hosting, we were able to send 5 members of Hospice staff to the workshop.
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:

May 2016
- TA367: Vortioxentine for treating major depressive episodes
- Nice Guideline – 24: Blood Transfusion
- Nice Guideline - 22: Older People with Social Care needs and multiple long term conditions

June 2016
- Nice Guideline – 31: Care of dying adults in the last days of life
- Quality Standard QS108: Multiple Sclerosis
- Association of Palliative Medicine: Withdrawal of ventilatory support at the request of an adult patient with Neuro-muscular disease

July 2016
- Nice Guideline - ESNM69: Prevention of chemotherapy induced nausea and vomiting in adults: Netupitant/palonosetron
- Quality Standard - QS110: Pneumonia in adults
- Nice Guideline - 46: Controlled drugs: Safe Use and Management
- Quality Standard – QS111: Obesity in Adults
- Quality Standard – QS120: Medicines Optimisation
- Quality Standard – QS29: VTE Update

August 2016
- Quality Standard – QS113: Healthcare Associated Infections
- Quality Standard – QS116: Domestic Violence and Abuse
- Nice Guideline - 42: Motor Neurone Disease: assessment and management
- Nice Guideline - 43: Transitional Care
- Quality Standard – QS2: Stokes in Adults
- CG90: Depression in Adults
- ESMPB2: Chronic Wounds
- Quality Standard - QS123: Home Care for Older People

November 2016
- Nice Guideline - 36: Cancer of the upper aero digestive tract: assessment and management in people aged 16 and over
- Quality Standard - 103: Acute Heart Failure
- Nice Guideline - 28: Type 2 diabetes in adults: management
- Nice Guideline - 3: Tuberculosis
- Nice Guideline - 51: Sepsis: recognition, diagnosis and early management
- Quality Standard – QS12: Breast Cancer

December 2016
- Nice Guideline - 53: Transition between inpatient mental health care settings and community or care home settings
- Nice Guideline - 54: Mental Health Problems in people with learning disabilities; prevention, assessment and management

January 2017
- Nice Guideline - 56: Multimorbidity: clinical assessment and management
Use of CQUIN payment framework 2016 – 2017

A proportion of Birmingham St Mary’s Hospice income in 2016-17 was conditional on achieving quality improvement and innovation goals agreed between the Hospice and Birmingham Cross City and Birmingham South Central Clinical Commissioning Groups (the CCGs). This was achieved through the Commissioning for Quality and Innovation payment framework and focused on two areas:

- **Advance Care Plan**
  - Ensure that individuals’ preferences and choices, when they wish to express them, are documented in an Advance Care Plan (ACP) and this is communicated to appropriate professionals
  - Following work on this CQUIN during the contract year April 2016-March 2017 the following recommendations and improvements were identified:
    - To undertake an annual audit of ACP to include the newly developed read codes
    - To continue to raise awareness of the importance of quality data recording through education and training and through the clinical mandatory training programme
    - To audit the number of patients referred to the Hospice with an ACP in 6 months to determine if this is a relevant piece of data for the hospice
    - To roll out the new letter template across all clinical areas and audit the quality of these letters in 12 months.

- **Health and wellbeing**
  - The introduction of health and wellbeing initiatives covering physical activity
  - Providers should develop a plan and ensure the implementation against this plan
  - At the end of the contract year (March 2017) we shared a detailed Physical Activity Plan with the CCGs which included completed work in respect of the following ‘headline’ specific tasks:
    - Engaging staff representatives in identifying, promoting and organising physical activity initiatives
    - Researching different physical activity options and benchmarking against other Hospices, NHS and corporate partners
    - Identify, pilot and implement physical activities which can either be built into working hours or provided on site at the Hospice – as a result the following were implemented
      - Lunchtime walks
      - Yoga class
      - Taster sessions from local instructors
    - Research physical activity available in the local community
      - Hospice discounts offered
    - Engage managers to actively promote physical activity

**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 2016-17 audits or enquiries related to specialist palliative care.

**Data Quality**

Birmingham St Mary’s Hospice did not submit records during 2016-17 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 2016-17 was 66%, maintaining a satisfactory score.
The focus moving forward for the Head of IT and his team will be ensuring compliance with the new General Data Protection Regulations (GDPR) which will apply in the UK from 25 May 2018.

**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 2016-17 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 Service Performance Review Group made up of clinical service leads, analyses this data on a monthly basis.
Duty of Candour
We have updated our Accident /Incident reporting policy and the associated incident reporting form. The policy includes the following wording around Duty of Candour. Discussion on this change took place at our Clinical Governance Committee where service leads were tasked with cascading the information to their teams. All new staff across the organisation have to read this policy and confirm their knowledge and understanding.

Policy extract:
The hospice has a statutory responsibility to inform patients (or their representative) about any serious incident (i.e. one causing death, serious harm or moderate harm), and what further inquiries or actions will be carried out. The hospice must also provide an apology to the patient (or representative) that is reiterated in writing. The discussion with the patient (or representative) should be documented in the clinical notes and the Incident Form completed stating that the patient/relative has been informed.

Keeping the patient central to the incident response is good practice in following all patient related incidents.

As such the patient (or their representative) must be offered:
- Information and apology as soon as practicable and reiterated in writing.
- Information regarding the investigation process and timescales, how they can contribute should they wish to
- Point of contact for ongoing communication throughout process
Care Quality Commission ratings poster

St Mary's Hospice Limited

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Are services

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CQC Overall summary
This inspection took place on 28 July 2016 and was unannounced. Further phone contact was made with people using the hospice’s community services, whose views we were unable to capture on the day of the inspection, on 2 August 2016.

St Mary’s Hospice provides palliative and end of life care, advice and clinical support for adults with life limiting illness and their families. The hospice provides care to people from a multidisciplinary team of nurses, doctors, counsellors and other professionals including therapists. The hospice has a 16 bed inpatient unit that accepts admissions for end of life and palliative care, symptom control and respite care. At the time of our inspection there were 14 people receiving care and treatment in the inpatient unit. The day hospice service offered a range of care and treatment to people diagnosed with life limiting conditions. This included specialist clinical advice, educational courses and complimentary therapy sessions. The hospice community services supported people in their own homes through a hospice at home team and/or a clinical nurse specialist team. The hospice also provided patient transport services.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are ‘registered persons’. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.’

Staff were trained and knew how to recognise the signs of abuse and how to raise an alert if they had any concerns. The provider ensured that there were sufficient numbers of staff on duty at all times to meet people’s needs effectively. Staffing levels were reviewed and adjusted according to people’s changing needs. There were flexible working arrangements within the hospice to provide additional staff as was required. The recruitment process operated by the provider was effective in ensuring staff employed were suitable and safe to work with people who were cared for by the service. Assessments of potential risks were clear and included the measures to take to reduce the risks identified to make sure people were protected from harm. Accidents and incidents were effectively reported, analysed and shared to ensure that action was taken to minimise the risks of recurrence. Medicines were prescribed, recorded, administered and disposed of in safe and appropriate ways.

People were well supported by staff that were well trained. The provider supplied a range of learning opportunities for staff to enhance their knowledge and levels of skills. New staff were well equipped to undertake their role through effective induction. Staff received an annual appraisal and an appropriate level of supervision, with open access to the support they needed from peers and management. When complex situations occurred reflective learning sessions or debriefs were organised. People’s consent was sought by staff before any support was provided. Records in relation to Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) were completed to a high standard, with the person’s knowledge, participation and agreement where possible. People were well supported to access the nutrition and hydration they needed and of their choice. The variety of health care professionals employed enabled people’s health and wellbeing to be responded to in a timely manner when their health needs changed.

People were supported by staff that were kind and caring. The hospice had a relaxed and homely feel with a sociable atmosphere but still had plenty of space for people to access quiet reflective time. People and their families had access to services which provided support and counselling with regards to their emotional, spiritual and religious needs. The hospice had a chaplaincy team and provided a rest room for people of all faiths, where a range of bibles were also accessible. People were communicated with effectively and provided with the information they needed. Staff involved people in all aspects of their care provision and ensured that family were also kept well informed. Staff supported people to access personal care respectfully and with the utmost discretion. Provision of education and equipment were just some of the ways that staff supported people to maintain their independence.
People received care and support that was tailored to their individual needs and improved their quality of life. People were involved in making decisions about their current and future care and planning their end of life care. A range of complementary therapies were available to help and support people's relaxation and general wellbeing. This had a strong emphasis on personalised care and that had a positive effect on people. Initial assessments had been undertaken to identify people's support needs and which team within the hospice was best placed to provide the support people needed at that time. The provider supported people to be more independent in planning their care and how and where they wanted it to be delivered. They were keen to reduce the stigma and break down the taboos about hospice care. We saw that communication was effective both in inpatient and community services so that access to the most appropriate care was made available when people's needs changed. People told us they felt confident and well informed about how to raise a complaint or any concerns.

Stakeholders were complimentary about the leadership and approachable nature of management. Staff displayed excellent team working and promoted clear communication throughout the service with an inclusive approach to care. Staff enjoyed their work and felt involved and valued by the provider. The provider promoted and encouraged an open and transparent but challenging culture. The provider actively sought to engage and access people to utilise the service through community groups and faith centres. The provider encouraged the involvement in the development of the service from staff at all levels. There was a comprehensive program of in-house regular audits of aspects of the service such as medicines, infection control, the environment, incidents and complaints. The hospice worked in partnership with other organisations that assisted them in the monitoring and development of the hospice service. The provider sought external reviews of its management performance and structure. The service was proactive in ensuring that stakeholders' feedback was regularly sought and used to develop the service.

Whilst there were no areas identified as being inadequate and we were not given any areas for improvement, one of our priorities for next year is to work towards achieving 'outstanding' for a future CQC inspection.
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 2016 to 31 March 2017 for the following services:

In Patient Unit (IPU)
- There were 339 admissions to our IPU – this includes those patients that may have been admitted more than once

![Inpatient Unit Admissions 2016 / 17](chart)

Community Palliative Care Team (CPCT)
- 941 new referrals were received for this service
- 13,083 patient contacts and 3,986 MDT & professional contacts were made during the year
- There were between 250-300 patients per month on the Team’s caseload during the year

![Community Palliative Care Team New Referrals 2016 / 17](chart)
Day Hospice

- Overall attendance in our Day Hospice was 912
- Patients were unable to attend Day Hospice for a variety of reasons on 256 occasions (see the breakdown on the next page)
Reasons for non-attendance – Day Hospice

<table>
<thead>
<tr>
<th>Reason</th>
<th>Total for 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient appointment</td>
<td>50</td>
</tr>
<tr>
<td>In hospital</td>
<td>47</td>
</tr>
<tr>
<td>In Hospice Inpatient Unit</td>
<td>14</td>
</tr>
<tr>
<td>Unwell</td>
<td>79</td>
</tr>
<tr>
<td>On holiday/away</td>
<td>10</td>
</tr>
<tr>
<td>Other (Visitors – family/district nurse/friends/workmen/delivery)</td>
<td>33</td>
</tr>
<tr>
<td>Reason unknown</td>
<td>6</td>
</tr>
<tr>
<td>Cancelled by service</td>
<td>17</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>256</strong></td>
</tr>
</tbody>
</table>

Hospice at Home

- 224 referrals were accepted by this service.
- 2,178 visits to patients were made during the year. The majority of which were made by two nurses.
Hospice at Home - Visits 2016 / 17

Number of Visits

Month
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 2016/17 there has been a small decrease in the number of patient slips, trips and falls, with 50 incidents reported, compared to 54 reported in 2015/16. 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.

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.
Three RCA’s were completed during 2016/17. 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 2016/17 there has been an increase in the number of patients admitted to the hospice with Pressure Ulcers or Deep Tissue Injury (DTI). 79 patients were admitted in 2016/17 with Pressure Ulcers/DTI compared to 60 during 2015/16.

There has been a minimal increase in the number of patients admitted from home with a Pressure Ulcer/DTI with 44 patients admitted in 2016/17 compared to 41 in 2015/16. Patients admitted from hospital with a Pressure Ulcer/DTI have almost doubled with 35 admissions in 2016/17 compared to 19 in 2015/16.

In order to ensure appropriate and safe reporting of pressure sores and deep tissue injuries (DTI) with regards to the monitoring of grades and trends, our In-Patient Unit are now reporting all pressure ulcers and DTI for assurance purposes. Whilst grades 3 and 4 pressure ulcers were previously reported, the Hospice now has a clearer view of all grades and are able to identify further deterioration in skin condition, as well as identify whether they were avoidable or unavoidable.

The information monitors the overall situation for the patients involved, and offers learning and development opportunities to ensure nursing practice is safe and individualised. A Registered Nurse on the In-Patient Unit is the nominated Link Nurse for Tissue Viability and ensures nursing staff have access to up to date training, and provides effective assessment skills and advice to the IPU team. They also have contacts within the community and acute settings and feedback any concerns surrounding patients on admission or discharge with pressure ulcers or DTI.

In further support staff in enhanced detection and prevention of the damage caused by pressure ulcers, the SSKIN tool is used. 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.

For patients whose Pressure Ulcer progresses to a grade three or above whilst in our care a Root Cause Analysis is undertaken. Statutory notifications are made to the Care Quality Commission and incident rates are also provided to the Clinical Commissioning Group. There have not been any RCAs completed in respect of grade 3 pressure ulcers during this 12 month period.

**Infection Prevention and Control**
The Hospice has an Infection, Prevention and Control Resource Nurse who works one day per week.

**Outbreaks**
The Hospice had four suspected Norovirus outbreaks between 1 April 2016 and 31 March 2017 and these were reported to Public Health England and closely managed and monitored by the Director of Infection Prevention and Control, the Nursing Director and the Infection, Prevention and Control Resource Nurse. During these periods we closed the Inpatient Unit to new admissions and update meetings were held daily, attended by representatives from all departments across the organisation. Visitors to the Inpatient Unit were informed on entry to the building and advisory signage displayed at key points. Feedback from Public Health England was that these four instances were dealt with appropriately.

**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 2016 and 31 March 2017 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>2</td>
</tr>
<tr>
<td>Clostridium Difficile</td>
<td>2</td>
</tr>
<tr>
<td>MSSA</td>
<td>1</td>
</tr>
</tbody>
</table>

**Medicines Management**
The Hospice’s Medicines Management Committee meets every quarter and is chaired by a Consultant in Palliative Medicine. The Pharmacist from our local Trust (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. She has appointed a deputy to act in this role during periods when she is away from the Hospice.
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 0 concerns 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 have been 179 medicines related incidents and 5 of these were external incidents identified by Hospice staff, i.e. errors made by others and discovered by a member of our clinical staff.

Please refer to 2.3; improve practice in respect of drug incidents, for clarification on how incidents will be reduced and monitored over the next twelve months.
Complaints and Compliments
A summary of the complaints received between 1 April 2016 and 31 March 2017:

<table>
<thead>
<tr>
<th>Total No. of Complaints</th>
<th>17</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nursing:</strong></td>
<td></td>
</tr>
<tr>
<td>• Clinical Education</td>
<td>0</td>
</tr>
<tr>
<td>• Community Palliative Care Team (CPCT)</td>
<td>1²</td>
</tr>
<tr>
<td>• Day Hospice</td>
<td>0</td>
</tr>
<tr>
<td>• Hospice at Home</td>
<td>0</td>
</tr>
<tr>
<td>• In Patient Unit (IPU)</td>
<td>4³</td>
</tr>
<tr>
<td><strong>Medical:</strong></td>
<td></td>
</tr>
<tr>
<td>• Family and Carer Support Team (FACST)</td>
<td>1⁴</td>
</tr>
<tr>
<td>• Medical</td>
<td>2⁵</td>
</tr>
<tr>
<td>• Occupational Therapy</td>
<td>0</td>
</tr>
<tr>
<td>• Physiotherapy</td>
<td>0</td>
</tr>
<tr>
<td><strong>Income Generation and Marketing:</strong></td>
<td></td>
</tr>
<tr>
<td>• Community</td>
<td>0</td>
</tr>
<tr>
<td>• Corporate</td>
<td>0</td>
</tr>
<tr>
<td>• Events</td>
<td>0</td>
</tr>
<tr>
<td>• PR and Marketing</td>
<td>0</td>
</tr>
<tr>
<td>• Trading</td>
<td>0</td>
</tr>
<tr>
<td>• Trusts and Grants</td>
<td>13</td>
</tr>
<tr>
<td><strong>Support Services:</strong></td>
<td></td>
</tr>
<tr>
<td>• Administration and Governance</td>
<td>0</td>
</tr>
<tr>
<td>• Facilities - includes Housekeeping, Maintenance, Reception</td>
<td>1⁶</td>
</tr>
<tr>
<td>• Finance</td>
<td>0</td>
</tr>
<tr>
<td>• HR</td>
<td>0</td>
</tr>
<tr>
<td>• IT</td>
<td>0</td>
</tr>
</tbody>
</table>

Care Quality Commission feedback on hospice complaint handling:
The Head of HR/Support Services was interviewed by the Care Quality Commission (CQC) during the inspection on 28th July 2016. In their final report, the CQC determined that:

> The complaints procedure was accessible for people to refer to and leaflets were also made available to people. There were arrangements for recording, acknowledging, investigating and responding to complaints and any actions taken or changes made as a result. Records showed outcomes from complaints were clearly documented and were communicated to staff. The provider was keen to improve the service people received by learning from complaints and routinely used complaints as a learning exercise. For example, a complaint which identified issues with the referral process resulted in the recruitment of a triage nurse dedicated to supporting effective partnership working and streamlining the process of referral into the hospice. Another complaint had resulted in training being developed specifically for reception staff. Complaints received and outcomes of subsequent investigations undertaken were shared at regular clinical governance meetings and board meetings. This meant that the provider effectively listened, responded to and learnt from people’s concerns and complaints.

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² The complaint relates to multiple departments within the Hospice, specifically, CPCT, FACST, Facilities, IPU and Medical
³ Two complaints relate solely to the IPU, one complaint relates to the IPU and the Medical team, one complaint relates to multiple departments within the Hospice (see note 1 above)
⁴ The complaint relates to multiple departments within the Hospice (see note 1 above)
⁵ One complaint relates to the IPU and the Medical team, one complaint relates to multiple departments within the Hospice (see note 1 above)
⁶ The complaint relates to multiple departments within the Hospice, specifically, CPCT, FACST, Facilities, IPU and Medical
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. Compliments received include:

“I am forever in your debt for the care and dignity you graced my brother when he took his last journey to his resting place. The nursing team on shift were so lovely and understanding.”

“We would like to thank you sincerely for all the care and support you gave to our mum. We are so grateful that you supported us in fulfilling mum’s wishes to be cared for at home.”

“Thank you to all of you who I saw in the Day Hospice during my 12 sessions. Your support was valuable in allowing me to be myself and come to terms with my illness.”

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.

At the time of compiling the report, the Hospice has 7,274 Facebook page likes, with 98/102 with 5* rating and 4.9* rating overall. One of our Facebook reviews from March 2017:

“What a truly remarkable place, the care and attention given to my Grandfather was superb. You not only cared about his wellbeing but that of all of us too. Although we are all heartbroken that he has passed away, the team at St. Mary’s have helped us to no end. The support we’ve been given is amazing we couldn’t have asked for more. Grandad was treated with love and respect. The work that you all do is phenomenal from the nurses to the volunteers. Honestly you have made one of the worst times in our lives that little bit more bearable. Thank you again from the bottom of our hearts.”
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 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 2016 and 31st March 2017 a total of 63 audits were conducted, of which 28 were clinical, 15 were medication audits and 20 were related to Infection Prevention and Control audits.

### Medicines Management

**What we were good at:**
- Ensuring drugs are checked and signed for, twice a day by two registered nurses
- Documenting medication changes with rationale and communicating changes on discharge letters
- Recording of Oxygen saturations pre and post administration of Oxygen and signing of administration chart
- Storing medication appropriately according to room temperature and fridge storage
- Corticosteroid use on IPU dose appropriate for indication in all patients

**What we are working to improve:**
- Medical team teaching to reinforce target oxygen saturations
- Removing stopped items from POD lockers
- Use of steroid template for reviews and outcome

### Caring and Safe

**What we were good at:**
- Transferring written records successfully onto SystmOne for patients receiving care from Hospice at Home and BCHC services
- Ensuring patient slip, trips and falls are documented correctly and managed according to Hospice policy
- Including required information in discharge letters from our In-Patient Unit
- Ensuring reported incidents are investigated and signed off within a month of the incident occurring

**What we are working to improve:**
- Informing GPs of DNACPR status on discharge
- Being consistent with therapies information in discharge letters from In-Patient Unit
- Completing incident forms fully
Effective & Responsive

What we were good at:
- Documenting consent for invasive procedures
- Completing appropriate capacity assessments using MCA template on SystmOne
- Recording patients religious, spiritual and pastoral needs
- Acknowledging and/or responding to complaints

What we are working to improve:
- Documenting discussions held regarding risks and benefits of catheterisation procedure
- Documentation of best interest decisions regarding resuscitation decisions in patients who lack capacity as a formal capacity assessment
- Recording when patients are not religious or do not wish to see a chaplain
- Documenting learning outcomes from complaints

Well Led

What we were good at:
- Holding regular and effective 1:1 meetings with a standardised format for all

What we are working to improve:
- Enough appropriate time is allocated for 1:1 meetings

Audit Presentations 2016/17

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 3 presentations took place during 2016 and were attended by various disciplines:

<table>
<thead>
<tr>
<th>Date of Presentations</th>
<th>Presentation Titles</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2016</td>
<td>Response times for sending Clinical Letters</td>
</tr>
<tr>
<td></td>
<td>Hospice at Home/BCHC Collaborative Record Keeping Audit</td>
</tr>
<tr>
<td></td>
<td>CPCT Breakthrough Medication</td>
</tr>
<tr>
<td>July 2016</td>
<td>Referrals into the Team</td>
</tr>
<tr>
<td></td>
<td>Malignant Spinal Cord Compression</td>
</tr>
<tr>
<td>October 2016</td>
<td>DNA CPR Documentation Audit</td>
</tr>
<tr>
<td></td>
<td>Hospice at Home Waiting Times/Response Audit</td>
</tr>
<tr>
<td></td>
<td>Documentation of Capacity Assessments on the IPU</td>
</tr>
</tbody>
</table>
Part 3 – Review of quality of Performance

3.4 Feedback from patients and families on services

We continually review the way we collect feedback and engage with patients and carers, please see page 13.

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>75</td>
<td>9</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>The first three days of my stay have been satisfactory</td>
<td>76</td>
<td>17</td>
<td>0</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>73</td>
<td>17</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>I have found the staff approachable</td>
<td>79</td>
<td>13</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>I have been given the opportunity to discuss my care and treatment</td>
<td>77</td>
<td>13</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>I have been able to express any concerns or issues that I’ve had</td>
<td>77</td>
<td>15</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>The In-Patient Unit staff are doing everything I would expect them to do</td>
<td>77</td>
<td>13</td>
<td>1</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>56</td>
<td>21</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td>The service I have received could be improved</td>
<td>66</td>
<td>19</td>
<td>3</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>36</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I was satisfied with the care and treatments I received</td>
<td>32</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I always felt that I knew what was going on</td>
<td>31</td>
<td>6</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>The service I received could be improved in some way</td>
<td>30</td>
<td>8</td>
<td>1</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>101</td>
<td>8</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I have found the staff approachable</td>
<td>98</td>
<td>10</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I have been given the opportunity to discuss my care or treatments</td>
<td>88</td>
<td>17</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>I have been given the opportunity to express any issues or concerns I have</td>
<td>89</td>
<td>18</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>The Community Team is doing everything I would expect them to do</td>
<td>91</td>
<td>13</td>
<td>3</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>23</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I have found the staff approachable</td>
<td>22</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I have been given the opportunity to discuss my care or treatments</td>
<td>23</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>23</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>23</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hospice at Home have supported my family/carers</td>
<td>23</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>22</td>
<td>2</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.
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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 a programme with Hospice UK. This 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).

Last year we reported that this programme was still in development. The national group administering the project have now employed the services of an external data collection organisation and we are expecting to have robust data for benchmarking purposes by the end of the next financial year.
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3.6 Statements on Birmingham St Mary’s Hospice Quality Account for 2016/17

Statement of Assurance from Birmingham CrossCity CCG May 2017

1.1 Birmingham CrossCity Clinical Commissioning Group (BCC CCG), as coordinating commissioner for Birmingham St Mary’s Hospice (BSM), welcomes the opportunity to provide this statement for inclusion in the Hospices’ 2016/17 Quality Account.

1.2 A draft copy of the quality account was received by BCC CCG on the 23rd May and the review has been undertaken in accordance with the Department of Health Guidance. This statement of assurance has been developed in consultation with neighbouring CCGs.

1.3 The quality account is presented in a reader friendly and accessible manner and clearly demonstrates their commitment to providing high quality patient focused care with an emphasis on introducing innovative practices to improve overall patient experience.

1.4 Each of the priorities set for 2016/17 have been achieved with notable successes in delivering care closer to home through the Clinical Nurse Specialists outpatient clinics and the triangulation of staffing levels with patient incident data (such as slips, falls and pressure ulcers) to assist in monitoring the priority around patient safety.

1.5 The Hospice has also provided details on a range of initiatives such as BrumYODO, Butterfly Lounge relaunch, Roots and Wings Children’s Counselling room and revamp of the conservatory which has created a homely environment for all patients, especially those living with dementia. Each of these initiatives demonstrates an inclusive approach to improving patient, family and carers experiences, which were especially pleasing to read about.

1.6 It was encouraging to read about the high levels of employee engagement for which the Hospice received an award for in 2016; in particular 99% of respondents to the staff survey indicated that they were clear on how their role contributes to hospice objectives and that 93% would know how to report any wrong-doing if they saw it.

1.7 The CCG fully supports the three improvement priorities for 2017/18; each of which are accompanied by a rationale and description of how it will be achieved, monitored and reported on.

1.8 Information outlining the CQUINs for 2016-17 has been included in the quality account, however this would have benefitted from more narrative to describe the Hospices actual performance/achievements against this payment framework.

Hospice response to 1.8: We have updated the Quality Account and included recommendations and completed outcomes in respect of the two CQUINS covering Advance Care Plans (ACPs) and Staff Wellbeing.
1.9 It has been noted that the overall score on Information Governance was at 66%; the CCG would like to know what actions are being taken to improve this score to increase performance above satisfactory.

**Hospice response to 1.9:** We are pleased that we have consistently achieved level 2's and deem the score as acceptable given the IT resource and size of our organisation. We have noted in the Quality Account that our focus moving forward will be on ensuring compliance with the new General Data Protection Regulations (GDPR).

1.10 Detailed information on the MRSA and Clostridium Difficile outbreaks and the lessons learned are missing from the quality account.

**Hospice response to 1.10:** The wording used in this section of the Quality Account has given rise to a misunderstanding and we have revised it. For clarity we did not have any ‘outbreaks’ of MRSA or Clostridium Difficile. We did however have suspected Norovirus on four occasions which were reported to Public Health England and managed in line with their guidance.

1.11 It was pleasing to read the positive feedback received from the Care Quality Commission on complaint handling, in particular the way in which lessons are learned and changes implemented as a result.

1.12 As commissioners we have worked closely with BSM over the course of 2016/17, meeting with the Hospice regularly to review the organisations' progress in implementing its quality improvement initiatives. We are committed to engaging with the Hospice in an inclusive and innovative manner and are pleased with the level of engagement from the Hospice. We hope to continue to build on these relationships as we move forward into 2017/18

Barbara King  
Accountable Officer  
Birmingham CrossCity Clinical Commissioning Group
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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