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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<td>CGC</td>
<td>Clinical Governance Committee (part of the Hospice’s governance framework)</td>
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<td>CQUIN</td>
<td>Commissioning for Quality and Innovation (payment)</td>
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<td>DTI</td>
<td>Deep Tissue Injury</td>
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<td>IPPO</td>
<td>Integrated Palliative Care Outcome Scale</td>
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<td>IPU</td>
<td>In-Patient Unit</td>
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<td>MHRA</td>
<td>Medicines and Healthcare Products Regulatory Agency</td>
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<td>National Institute for Health and Care Excellence</td>
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<td>NIHR</td>
<td>National Institute for Health Research</td>
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<td>OACC</td>
<td>Outcome Assessment and Complexity Collaborative</td>
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Part 1 – Statements

1.1 Statement from Tina Swani, Chief Executive

At Birmingham St Mary’s Hospice 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.

This Quality Account provides an overview of how we are working towards this vision and in particular through Patient Safety, Clinical Effectiveness, and Patient Experience.

Hospice Care for All

Our Hospice Strategy (2016-2020) “Hospice Care for All” sets out a number of priorities to improve the experience of living with life-limiting illness for more people, whether delivered by the Hospice, through our education of other health & social care professionals, and supported by research.

This Quality Account reflects how the hospice team is achieving change through innovation:

Referrals have risen (20% in 2016-17 and 13% on top of that in 2017-18). Last year we provided care to 1,662 men and women in addition to supporting their families, carers and loved ones.

Most of our care is in individuals’ homes; our five hospice Satellite Clinics now offer the choice of seeing a member of the hospice team at a location close to home, four of which are in local GP surgeries and one located at the hospice.

Reflecting a commitment to the needs of our communities, the Hospice Board of Trustees is signed up to the Diversity in the Boardroom pledge. It is also positive that our Support at Home service volunteers can speak 13 languages between them.

We are also looking to the future as people of all ages are living longer with wider range of multiple conditions. Research shows that more people are dying alone, unsupported and with frequent admission to hospital in the last months of life. We are working with citizens and communities as a wholesale effort to encourage more people to talk about death, dying and loss, so that everyone is better able to plan ahead and support others. We have also appointed a nurse to work with care homes.

Transformation cannot be done alone. Over the year we have led a number of planning events and are grateful to all the decision makers, colleagues and citizens across Birmingham, Sandwell and Solihull for working with us to improve and design hospice care that will be fit for the changing needs of the future.

Our aim is that Birmingham and the whole locality in which we operate is an exemplar of hospice, palliative and end of life care. This will achieve a better experience for more people at the end of life and is best said in the words of a patient who attends one of our Satellite Clinics:

“The Hospice and its staff have shown me that I am living at this moment in time, and not waiting to die”

Thank you to all our supporters across Birmingham and Sandwell for making this difference and to the incredible Birmingham St Hospice team.

Tina Swani, Chief Executive

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1 The Effective Board Member Programme (in partnership with the Association of Corporate Governance Practitioners)
2 Research (Aston Research Centre for Healthy Ageing): risks associated with isolation are significantly greater across parts of Birmingham
Our Board is made up of 15 Trustees drawn from a variety of professions and backgrounds.
The Executive Team are responsible for the Hospice on a day to day basis and the Team is made up as follows:

- **Tina Swani**
  - Chief Executive

- **Susan Newcombe**
  - Director of Income Generation & Marketing (Until March 2018)

- **Helen O'Halloran**
  - Nursing Director

- **Dr Debbie Talbot**
  - Medical Director

- **Lynsey Breeze**
  - Finance Director

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

### 2.1 Priorities for improvement 2017-18 - what we achieved last year

<table>
<thead>
<tr>
<th>Patient Safety</th>
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<td><strong>Priority:</strong> Improve practice in respect of drug incidents</td>
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<tr>
<td><strong>Standard:</strong> Reduce the severity of incidents reported and the frequency</td>
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**How was it identified as a priority?**
During 2016 it emerged that the number of medication incidents had increased by 25% compared to the previous year. The senior medical and nursing team met to review incidents and created an action plan to address this.

In reviewing, it emerged that whilst there had been some improvement in reporting, in some areas decisions were still being taken to resolve issues without registering them formally as incidents. The team wanted to address this.

**How was the priority achieved?**
In 2017 we recruited a Professional Development Nurse to the In-Patient Unit. Part of her remit was to educate the nursing team about the role of clinical governance in their nursing practice. By taking this approach, we have ensured there is a greater understanding of the incident reporting process and how this can enhance patient safety, quality and learning.

As a result of coaching and training from senior managers, linked to a culture of openness and duty of candour, we have seen a substantial increase in the number of incidents and the figures we now report are a true reflection of our drug errors.

By understanding the reporting process and a genuine interest in learning from incidents, the culture has radically shifted from not reporting, to focusing on where errors can be reduced. The checking of drug charts has been introduced and has contributed to errors in documentation being rectified before each nurse ends their shift.

Drug incident reporting is a standard agenda item at the Hospice’s Medicines Management Committee and Clinical Governance Committee. As a result of our work on this priority, there is now a more detailed breakdown provided on the type and circumstances of the errors.

In October 2017, the Medicine Administration Competency toolkit was nationally revised and is the re-assessment tool completed following a drug error. We are using the tool to understand detailed information on drug calculations and research on commonly used drugs to support our understanding about a drug’s use and side effects. The tool is a positive and meaningful way for the Hospice’s clinical teams to continually learn and evaluate their practice.

**How was progress monitored and reported?**
Progress on the number, severity and the type of drug incidents reported was monitored and reported at both Medicines Management Committee and the Clinical Governance Committee. Feedback from the Medicines Management meeting is given at both staff meetings and via the noticeboard in the drugs room on the In-Patient Unit.
The types of incidents are broken down in categories to understand the causes involved and any themes. One of the issues that nurses raised was the distraction and interruption by other people during nurse rounds. This was a contributing factor to a number of drug errors.

An action plan was implemented to reduce this and as a result nurses now wear tabards during drug rounds to politely prevent interruptions. This is also communicated via posters to encourage the cooperation of patients, staff and visitors when nurses are administering medication.

In conclusion, these interventions have improved our approach overall to managing incidents and in particular drug errors. Strong clinical leadership and the promotion of duty of candour means we are open to learning from errors and have radically changed our practice to embrace openness. **The severity of our drug incidents remains low.**
Clinical Effectiveness

Priority: Going from ‘good’ to ‘outstanding’

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

Through the course of the year, innovations in both practice and overall monitoring of performance have been introduced at the Hospice. The overarching governance framework is in place to reduce risk through the current structure of reporting, learning and further improving the quality of care provision.

Extending reach
Hospice multidisciplinary teams have continued to engage in prioritising the provision of safe, compassionate and high quality care, whilst introducing and implementing changes to service design and delivery. The Hospice has seen a 13% increase in referrals to all services during 2017/2018.

The In-Patient Unit workforce has responded to the increase in requests for admission by monitoring the phase of illness and dependency of patients, whilst assuring safe staffing levels. This has required a targeted multidisciplinary approach to waiting list and admission management. Consequently bed occupancy rates were 88% overall for the year, which adheres to NICE guidelines for safety.

The role of the Triage Nurse has been critical in managing the number of referrals to the Hospice. This role provides a more responsive service to referrers and ensures effective support and communication between health and social care professionals and service users.

Promoting outstanding practice
The recent appointment of a Professional Development Nurse is focused on continually assessing team culture and observing practice by working alongside nursing staff. This provides oversight of practice, including the promotion of more openness and transparency in medicines management and pressure ulcer reporting. It has been effective in the implementation of targeted specific learning and development opportunities.

Expanding services
To support integration and a ‘one team’ approach, the Day Hospice team, Hospice at Home nurses and the Clinical Nurse Specialist led Community Palliative Care Team have been integrated into one service. This is to support a more flexible and responsive approach to Hospice service provision within day therapy and community services.

Over the last two years Day Hospice has developed into an integrated and therapeutic approach to palliative care. It provides a therapeutic approach which includes advanced care planning, disease focused clinics, arts, exercise and individualised therapeutic programmes. This
programme, together with collaborative partnership working in the locality, has improved cross boundary understanding of Hospice services available. In particular it has increased awareness that the Hospice supports people with non-cancer and cancer, reflecting the growing number of people living with multiple long term conditions. Data collection shows that in 2016-17 33% of our Day Hospice attendees had a non-malignant diagnosis and in 2017-18 this had markedly improved to 49%.

Hospice at Home enables a personalised response to advance care plan wishes, and for patients to return to their preferred place of care and death. Over 54% of Hospice at Home referrals during the winter period were used to bridge the gap between hospital/hospice and home. We have successfully recruited nursing staff to extend the current service from 5pm to 10pm each day from autumn 2018. The team have also set up a rapid response resource to assess and support patients, families and carers at home.

The Community Palliative Care Team have had an 18% increase in referrals. In response to this, the team have initiated the role of duty Clinical Nurse Specialist to answer any questions, and respond to more urgent contacts from patients, families, carers and referrers requesting advice and support on a daily basis.

Enhancing local services
The pilot Satellite Clinic service was evaluated and positive outcomes were achieved. As a result, Clinical Nurse Specialists (CNS) have opened two more Satellite Clinics in the area based at Cape Hill and Druids Heath medical practices. 10% of the community caseload attend the CNS led Satellite Clinic service.

A working group led by the Head of Service Improvement and Quality has developed governance around Non-medical Prescribing through the course of this year, working alongside guidance and support from NHS Birmingham and Cross City CCG. A group of senior nurses have completed the Non-Medical Prescribing courses and a rolling programme of training has been activated to expand these specific skills within the Hospice In-Patient Unit and community services.

The Hospice Family and Carer Support team has successfully implemented a new Support at Home service, which supports people at home with befriending and sitting. Skilled and trained volunteers provide the service to the patient and their families or carers to improve the psychological wellbeing of those facing life-limiting illness and to reduce the social isolation of those most in need.

Understanding impact
Patient and carer evaluation tools, including the OACC Suite (Outcome Assessment and Complexity Collaborative Suite of Measures) and IPOS (Integrated Palliative Care Outcome Scale) have been embedded in practice across clinical teams. These tools measure patients’ physical symptoms, psychological, emotional and spiritual, and information and support needs. They are a validated evaluation methodology that can be used in clinical care, audit, research and training.

Learning from positive and negative feedback is key and is shared with teams to promote high standards and further improve our services.

Feedback from service users has been positive. Based on data up to the end of December 2017, 98% of patient/carers ‘agree’ or ‘strongly agree’ that every effort has been made for them to
have the support, care and treatment they need to help them to be as comfortable and as free from distress as possible.

Creating community networks and developing education opportunities
Our Community Development and Partnerships Lead Nurse role works closely with the Hospice Clinical Education Lead to develop partnerships to benefit everyone at end of life.

An Education Strategy was drafted during 2017/18 to expand the reach of Hospice services through this new approach to education, learning and community development. This is being finalised in 2018/19. The provision of more support and education for health care practitioners, community workers, patients, carers and the general public will enable a better understanding of holistic end of life care through sharing knowledge and expertise across the locality. This approach, when developed, will lead to even more effective partnership working, and work towards compassionate local communities and compassionate city status.

The above are examples of some of the service design initiatives from the 2017/2018 Hospice Operational Plan.
The Hospice experienced a substantial increase in referrals in 2017/18, which meant that clinical services were focused on supporting those in need of end of life and palliative care. As a result, we have made improvements in three priority areas, below, and will take forward the digital interface planned into 2018-19.

- **Focus on capturing patient and carer outcome data** (see previous section). This has involved continually developing our feedback forms and working collaboratively with our partners to reduce some of the barriers to accessing our services. Our feedback forms now contain a section for patients or carers to leave their contact details if they would like our Community Fundraising Team to contact them. This allows us to hear more about the experiences of their Hospice services and for patients or carers to become more involved in service improvements.

- **Efforts to ensure that person centre care was provided** for those we supported during the year in the way we delivered our services, for example, in changes to Day Hospice, the integration of our nursing team and expansion of services to bring care closer to people’s homes.

- **Investment in a Triage Nurse**, which is the first point of contact for most of our clinical referrals or enquiries. The service is open Monday - Friday 8-4pm and so far, the role has reduced duplication, improved the patient referral pathway and improved relationships with other health and social care professionals.

There remains a strong commitment to achieve digital support to improve patient engagement in 2018/19 as follows:

**Clinical referrals to come into one secure email account and replace faxed communications.** GPs will be asked for email details so we can communicate electronically which will improve responsiveness and adherence to GDPR (General Data Protection Regulation).

**Website interactivity**, to allow for direct patient feedback and general enquiries. This priority has been carried forward into the 2018/19 Hospice Operational Plan given an interactive site could significantly improve patient, carer and donor information experiences.

The groundwork we have implemented this year for GDPR compliance has been a significant priority and will enhance the digital aspects of improving patient and carer experience and communication on referral and making contact.
Part 2 – Priorities for Improvements and Statements of Assurance

2.2 Other notable achievements 2017 - 2018

Infection Prevention Control Roadshow

In addition to the standard mandatory training, an Infection Prevention and Control Roadshow took place in March 2018. The ‘glow’ box, which highlights areas missed during hand washing, was used alongside promotional materials to promote the importance of infection control. The roadshow was also held in the Welcome Group in Day Hospice to allow individuals to encourage people to take part.

Information was also available on the early detection of sepsis, antibiotic resistance and the role we can play in keeping antibiotics working in the future. The event was publicised to patients, visitors/relatives, volunteers and staff with posters and word of mouth and was well received and attended.

Step Together Challenge – promoting staff wellbeing

During February and March 2018, staff and volunteers joined to “Step Together” to collectively walk 16 million steps, the total number of strides it would take to lap once around the world. The challenge was launched by the Hospice Social and Wellbeing Committee to support staff and volunteer wellbeing.

At the end of the nine week challenge, the teams had collectively walked an amazing 42,133,260 steps: the equivalent of 2½ laps around the world.
Over the last 12 months our Equality and Diversity group has developed momentum. The group has been working to increase awareness about the Hospice in communities across Birmingham and Sandwell.

Led by the Head of Support Services and Chaired by one of our Community Fundraisers; the group is made up of members of staff from various departments, who each have a shared desire to help raise the Hospice’s profile in different communities across the city.

Some of the group’s proudest achievements over the past year include recruiting Support at Home volunteers who speak over thirteen different languages; being accredited as a Disability Confident employer; hosting an educational talk by a Dementia Friends representative; and delivering mental health awareness training during Mental Health Awareness Week. Staff and volunteers continue to embrace initiatives set up by the
group, such as themed lunchtime menus and celebrations outside of work to showcase and enjoy different cultural celebrations.

From a strategic perspective, our Board of Trustees remain signed up to the Diversity in the Board Room pledge, reflecting the commitment of our Board to actively work towards reflecting the diversity of the communities we serve.

A full range of activities are planned for 2018 including community events such as Pride and Eid in the Park.

The Hospice has also appointed a Community Development and Partnerships Lead who will engage with a wide variety of clinicians, stakeholders and community groups to improve services to patients, families, carers locally and nationally.

### Day Hospice Therapeutic Programme

In August last year we extended our therapeutic programme in Day Hospice. It was recognised by staff and patients there was a gap for meaningful creative activity. As a result we partnered with a local artist to design an arts programme with a focus on 'Hope, Meaning and Legacy'. Funding from the Arts Council was secured and an Artist in Residency programme has now commenced in Day Hospice and the In-Patient Unit, to work with patients and staff to explore their feelings through art.

Additional funding has been secured to extend this programme and begin a programme of Dramatherapy in Day Hospice. This will be supported by a Drama Psychotherapist, who has worked with the Hospice in our Bereavement and Day Hospice services in the past.

### Supporting people with Dementia and Frailty in Care Homes

In our Hospice Strategy 'Hospice Care for All' we have recognised the need to support people living and dying with Dementia and Frailty in care homes in Birmingham.

Our elderly population is growing and we need to do more to support them with excellent end of life care in their homes. We have seconded a Clinical Nurse Specialist from our Community Team to explore end of life care provision in care homes and provide us with recommendations for how we can help to improve care, support and systems for patients and families at the end of their lives.

We will then begin a programme of support in the autumn 2018/19.

### Supporting Crisis: Urgent Two-Hour Response Service

Our Community Teams are working much more closely together to ensure our care is responsive and patients and carers receive the right care when and where they need it. We began a pilot of an Urgent Two Hour Response service in February 2018 and so far have seen all patients referred within that time. Examples include the assessment and care provision during a carer crisis and urgent management of spinal cord compression.
In our 2016/17 report, we confirmed our Board of Trustees support for the Research and Scholarship Strategy 2017-2020 and identified the actions we needed to take to become Research active.

Following progressive work during 2017/18, we have ensured that research strategies have been firmly embedded across the organisation. As a result, Birmingham St Mary’s Hospice was awarded the Hospice UK and British Medical Journal Supportive & Palliative Care Award, presented at the National Institute for Health Research (NIHR) Conference. They stated ‘the Hospice has made a significant move forward in becoming active in contributing to research’. This award is the first of its kind specifically for hospices and charities who have joined together to discuss hospice and palliative care research.

The Hospice was particularly commended for leading and taking part in many high-quality clinical studies and for making research and learning a top priority in the Hospice’s overall business strategy.

The ‘Research Champions’ were also praised, especially as they included both clinical and non-clinical members of staff. Champions regularly attend research steering group meetings and help to integrate findings into day-to-day practice and publicise activity hospice wide.

We are delighted to have received this prestigious accolade.
Developing a Future Model of End of Life Care

Given one of the CCG’s Sustainability and Transformation Plan priorities is to effectively integrate palliative care services across the city, the Hospice has taken a lead role in driving this forward. Our Medical Director has initiated and established an effective group of providers who are exploring greater opportunities for integration. The intention is to galvanise energy and resources to create a seamless journey for people needing palliative and end of life care. This will reduce duplication, strengthen partnership working and provide a better experience for people and carers who need these essential services.

This work has strategic alignment with the Hospice’s own vision for transforming end of life care in the future. During the course of 2017/18 work has taken place to identify a new future model of care working with clinical teams and the broader city wide partnership. The Hospice is the driver for making this happen and is liaising with senior stakeholders across the health and care economy, to take forward this transformational change. This will support the changing demographics and need in the city.

A stakeholder event was held on 10th November 2017 involving organisations and community groups to express their view on the current issues and challenges in palliative care and what is needed in the future.
Part 2 – Priorities for Improvements and Statements of Assurance

2.3 Priorities for Improvements 2018 - 2019

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<td><strong>Priority:</strong></td>
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How was this identified as a priority?
Pressure damage is a well-established marker of quality nursing care. To understand the prevalence of pressure damage within the Hospice In-Patient Unit a decision was made to record all pressure damage and ensure the language and terminology was universal. Prior to this, only pressure ulcers of stage 3 and 4 were reported as required by the CCG and Care Quality Commission.

Improved reporting in 2017-18 demonstrated the number of patients experiencing pressure damage and the differences in reporting terminology highlighted the need to identify reasons; track the patient journey; collate evidence to allow thorough investigation of all the causes of pressure damage; and introduce changes and accountability across all providers of care.

Furthermore, this approach will ensure improved education and that changes in practice are targeted effectively.

National benchmarking from Hospice UK has identified significant variances in pressure ulcer reporting. Therefore robust information on the prevalence of this is currently challenging. However, this is a clear indication that more should be done to achieve consistent reporting across health and care.

How will the priority be achieved?
A new incident form has been devised to ensure all information regarding pressure damage can be captured; this includes where pressure damage occurs (source location), the type of damage occurred and potential causes of the damage.

This data will be captured at a single point of reporting, which can be used to supply different data streams such as benchmarking, regulatory reporting, Root Cause Analysis, Quality Reports or reports to the Clinical Governance Committee.

The new incident report form will be launched early 2018/19 by the Tissue Viability Link team and the Professional Development Nurse.

How will progress be monitored and reported?
Progress will be monitored regularly and reported to the Clinical Governance Committee. A secure spreadsheet will be used to capture all information. All regulatory reporting will continue as before. We will share our learning with partners and across the hospice network to improve understanding of these issues.
How was this identified as a priority?
Non-Medical Prescribing has been identified as a priority, as a way to improve pain management and symptom control for people receiving care in a community setting. This fits with our strategic intention to provide as much care and choice for people who want to be supported at home. It will also provide increased learning and development for nurses who will be able to prescribe a range of additional medication they can only currently access via medical staff.

The Hospice believes this will improve patient and carer experience for people at end of life. The Hospice Board of Trustees and Executive team are fully supportive of the development.

How will the priority be achieved?
Non-Medical Prescribing in all clinical areas will be achieved over a 3-5 year period. The focus for 2018/19 will be to establish the service and ensure effective governance arrangements are in place.

During 2018/19 funding will be identified; appropriate staff will train to become non-medical prescribers; policies and procedures and governance arrangements will be developed and external stakeholders such as GPs will be engaged with the service development.

Roll out will be gradual and a phased approach, combined with robust governance arrangements will ensure the safety of our patients is maintained.

How will progress be monitored and reported?
This initiative will be included in the Hospice 2018/19 Operational Plan and three year business plan. Progress will be monitored and reported internally to the Non-Medical Prescribing Forum, Medicines Management Committee and the Clinical Governance Committee. We will share our learning with clinicians across the area and with other hospices.
How was this identified as a priority?
We know that bereavement care is a priority to our patients, their carers and families.

Our Bereavement Service supports families and carers of the patients who have used our service and has received positive feedback for the work it provides.

The service is run by our Family and Carer Support Team (FACST) with the support of volunteer bereavement counsellors and bereavement workers.

The team have seen a growing need for urgent bereavement support, which can be challenging to provide within existing resources. Increasing referrals and take up of support has meant that there are growing numbers of people who need bereavement care.

The aim of this pilot scheme is to provide a rapid responsive adult bereavement support service for our clients.

How will the priority be achieved?
The pilot scheme will start in April 2018. An initial assessment will be carried out where clients will be offered a range of support and up to ten counselling sessions in the first instance. During these sessions further assessment will take place with the client to understand if additional support is needed.

How will progress be monitored and reported?
Feedback on the pilot will be obtained verbally and through evaluation forms, which will be collated on an on-going basis to understand the impact of the service. A one year evaluation will be compiled at the end of March 2019 and will be sent to the Clinical Governance Committee for review.

Learning will be shared across the hospice network.
Part 2 – Priorities for Improvements and Statements of Assurance

2.4 Statement of assurance from the Board

Review of services
In 2017-18 Birmingham St Mary’s Hospice supported NHS commissioning priorities in Birmingham and Sandwell, providing specialist palliative care services. A brief outline of these services, which were funded through charitable giving, is provided below:

- **In-Patient Unit**
  This provides support for those needing intensive palliative and end of life care in the Hospice. Medical and nursing assessment is carried out daily and there is access to medical advice 24 hours per day. There are a mixture of single rooms with en-suite facilities and small multi bedded bays for people. The Hospice also has therapeutic space for families, a dementia friendly conservatory and well maintained gardens for patients and families to use.

- **Community Palliative Care Team**
  This team includes Clinical Nurse Specialists, Doctors, Occupational Therapists and the Family and Carer Support staff who provide end of life support and advice to patients, families and carers at home. They work as part of a multi-disciplinary team to meet the needs of patients and will work with other health and care professionals to deliver quality care.

- **Satellite clinics**
  Satellite clinics, based in GP practices, aim to reach more people across Birmingham and Sandwell by bringing care closer to home. The Clinics are by appointment and run by Clinical Nurse Specialists from the Community Palliative Care Team.

- **Day Hospice**
  The Day Hospice Therapeutic Programme is a clinically led, 12 week educational programme for people living with a life limiting illness. The programme encourages and promotes people to live well and share experiences with others in a similar position. Day Hospice takes place every Tuesday and Thursday, and on Wednesdays there is an Outpatient Transfusion Clinic and Welcome Group.

  The Welcome Group is a weekly volunteer led service which provides social and peer support for patients. It is run by a senior Healthcare Assistant and an experienced team of volunteers and can accommodate up-to 20 patients per session.

- **Hospice at Home**
  This service is for patients at the end stage of illness who have expressed their wish to die at home. Care is delivered by Registered Nurses and Health Care Assistants.

- **Physiotherapy and Occupational therapy**
  Physiotherapy and Occupational therapy services provide palliative care support to people so they can live well. They are part of the Hospice multi-disciplinary team and most therapists work with us through a special agreement with University Hospital Birmingham NHS Foundation Trust.

- **Complementary therapies**
  A range of complementary therapies are offered to patients at the Hospice. These promote physical and mental well-being for patients at end of life. The service is provided by volunteers and is managed and supervised by the Senior Physiotherapist through a Service Level Agreement.
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**
The Bereavement Support Service provides counselling to people with grief and loss. This is to help families and carers cope with the loss of a loved one. The service is managed by a full time Senior Social Worker.

### Becoming ‘Research Active’ to realise the values of the Hospice

Birmingham St Mary’s Hospice has continued to build on the investment and progress into research in palliative and end of life care. All clinical areas have now been involved in at least one research project, and together with learning events, this has contributed to many staff feeling more confident about the values and benefits of taking part in research.

Staff from both clinical and non-clinical areas of the Hospice are invited to attend Journal Club, which is the Hospice forum that promotes learning and discussion on research in practice. Papers have been presented by a wide variety of team members including Healthcare Assistants, physiotherapists, nurses, doctors and social workers. The Research Team summarise and disseminate key points from the sessions to aid those unable to attend.

Discussions with the PR and Marketing team have taken place to identify opportunities for raising awareness with respect to research in palliative care. Several blogs have been published and photographs have been taken to promote the Hospice as ‘research active’ – the Hospice has also included a research page on its website.

Named research champions have been identified from teams within the Hospice. These colleagues have been invited to attend the research steering group and assist in dissemination of information about research activity within the Hospice, but also to seek feedback from their own team about useful future research projects.

The Research Team have also continued to recruit a total of 52 patients, and those close to them to take part in research and have recruited strongly for several active projects, locally and nationally, giving patients and their loved ones the opportunity to contribute a lasting legacy of future care.

We also support individual researchers in their smaller scale projects to approach and recruit staff and patients, these figures are not captured in these figures. We have been recognised for our approach through the NIHR award. For further details see page 16.

### Promoting Education to our staff and other healthcare professionals

The Hospice takes an active role in promoting education to our staff and wider health and care network. During 2017/18 we held a range of education activities to improve end of life care.
Supporting local health and care practitioners
We have supported pre-registration of nursing and medical students through placements. We have also hosted inter-disciplinary placements for pharmacy students from Aston University. As part of our involvement with the Birmingham Community Healthcare Trust Nursing Associate role pilot, we have supported 13 Trainee Nurse Associates for a one week placement and 14 sessions on Hospice Care for Student Nurses. We have also carried out triennial reviews for Student Nurse Mentors. We also promote access to the British National Formulary (BNF) resources and various journals.

Our education programme
We have held 19 courses which have been attended by Hospice staff and the local health and care workforce. We have also run two European Certificate in Essential Palliative Care courses and a Gold Standard Framework programme as part of our local centre agreements with the Princess Alice Hospice and the Gold Standard Framework organisation.

In house education sessions
The range of topics provided in addition to regular mandatory training, include:
- Pancreatic Cancer UK awareness session
- Dementia friends
- Mentor update - three mentor update session was provided for mentors on the Hospice’s mentor database
- Recording of medications session - provided by pharmacist from Aston University
- A variety of learning and development sessions have been provided by the HR department. These included:
  - Equality & Diversity training
  - Appraisal training
  - Appraisee training
  - Performance Management
  - Recruitment & Selection training
  - DBS (Disclosure and Barring) Workshop provided by Worcestershire Council

Bespoke education sessions
The range of topics include:
- Supportive Care Plan commissioned for Birmingham Community Health Care Trust
- Gastrointestinal & Respiratory disease session – Birmingham Community Health Care Trust
- Care Home Syringe Drivers
- Care Home Palliative Care
- Loss & grief session for University Hospital Birmingham
- Trainee Nurse Associate Palliative care session
- Badger CPD session
- SAGE & THYME (communication skills) workshops for pharmacy students from Aston University

University education sessions
The range of topics include:
- Medical School delivery of the MSc module
- Complementary Therapy session at Birmingham City University
- Psychological Care session at Birmingham City University
- Concept of caring session at University of Birmingham
- The Role of the Social Worker in End of Life care session at University of Birmingham
- The role of the Community Nurse session at University of Birmingham
- Specialist and Generalist Palliative Care session at University of Birmingham
- Chinese Introduction to British Health Care at University of Birmingham
We also hosted and attended
- West Midland Pride Care - Best Practice workshop
- Hospice UK Community Development workshop
- Hospice UK Care compassion and community workshop
- Dialogues in Cancer – live streaming of education symposium from a London conference
### 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:

<table>
<thead>
<tr>
<th>Month</th>
<th>Code</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2017</td>
<td>KTTO</td>
<td>Safer Insulin Prescribing</td>
</tr>
<tr>
<td>May 2017</td>
<td>QS86</td>
<td>Falls in Older People</td>
</tr>
<tr>
<td>June 2017</td>
<td>NG63</td>
<td>Antimicrobial Stewardship: Changing risk related behaviours in the general population</td>
</tr>
<tr>
<td></td>
<td>CG139</td>
<td>Healthcare associated infections; prevention and control in primary and community care</td>
</tr>
<tr>
<td>July 2017</td>
<td>CG174</td>
<td>Intravenous fluid therapy in adults in hospital</td>
</tr>
<tr>
<td>October 2017</td>
<td>NG74</td>
<td>Intermediate Care including re-ablement</td>
</tr>
<tr>
<td>December 2017</td>
<td>PH 56</td>
<td>Vitamin D: supplement use in specific population groups</td>
</tr>
<tr>
<td></td>
<td>MIB 121</td>
<td>Farco-fill Protect for indwelling urinary catheterisation</td>
</tr>
<tr>
<td></td>
<td>NG28</td>
<td>Type 2 diabetes in adults: management</td>
</tr>
<tr>
<td>January 2018</td>
<td></td>
<td>Quality Standard – QS161 Sepsis</td>
</tr>
</tbody>
</table>

### Use of CQUIN payment framework 2017 - 2018

Birmingham St Marys Hospice committed to completing a quality improvement and innovation goal achieved through the Commissioning for Quality and Innovation (CQUIN) Payment framework. During 2017/18 it was agreed to focus on End of Life Care in order to strengthen the care pathway.

A joint submission between Birmingham St Marys Hospice, John Taylor Hospice and St Giles Hospice captured and reviewed patient experiences at end of life. The stories were analysed using a root cause analysis approach to identify where, why and the changes that should be put in place to improve care within the community and reduce avoidable hospital admissions.

The Hospice submitted nine patient stories in total, highlighting areas where care was high quality, and where there were gaps in provision within the whole system of end of life care. Together with the stories and analysis from other hospices locally, themes were identified and fed back to the CCG. They will review these in order to improve care.

### Participation in clinical audit

As a provider of specialist palliative care Birmingham St Mary’s Hospice was not eligible to participate in any of the national clinical audits or national confidential enquiries. This is because the scope of the 2017-18 audits or enquiries did not relate to specialist palliative care.
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 2017-18 was 66%, maintaining a satisfactory score and graded green.

Clinical coding error rate
Clinical coding is ‘the translation of medical terminology as written by the clinician to describe a patient’s complaint, problem, diagnosis, treatment or reason for seeking medical attention, into a coded format’ which is national and internationally recognised. We were not subject to the payment by results clinical coding audit during 2017-18 by the Audit Commission because we receive payment through block contracts.

Our Clinical Information Officer collects and collates data extracted from SystmONE, our electronic patient record system, and a data integrity sub-group reviews this data monthly.

Duty of Candour
We have updated our Incident/Accident reporting policy to include references to Duty of Candour. Discussion 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 must 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 an apology as soon as practicable and reiterated in writing.
- Information regarding the investigation process and timescales, and how they can contribute should they wish to
- Point of contact for ongoing communication throughout process
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’ details are entered into. We have chosen therefore, to present data extracted from that system for the year 1 April 2017 to 31 March 2018 for the following services:

In-Patient Unit
- There were 346 admissions to our In-Patient Unit – this includes those patients that may have been admitted more than once

![Inpatient Unit Admissions 2017 / 18](image)

Community Palliative Care Team (CPCT)
- 988 new referrals were received for this service
- 15,543 patient contacts and 3,994 multi-disciplinary team and 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 2017 / 18](image)
Day Hospice

- Overall, 1590 attendances at our Day Hospice
- Patients were unable to attend Day Hospice for a variety of reasons on 376 occasions (see the breakdown on the next page)
### Day Hospice Non-Attendance 2017 / 18

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>10</td>
</tr>
<tr>
<td>May</td>
<td>10</td>
</tr>
<tr>
<td>June</td>
<td>20</td>
</tr>
<tr>
<td>July</td>
<td>20</td>
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<tr>
<td>August</td>
<td>30</td>
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<td>September</td>
<td>30</td>
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<td>October</td>
<td>30</td>
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<td>November</td>
<td>30</td>
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<tr>
<td>December</td>
<td>40</td>
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<tr>
<td>January</td>
<td>40</td>
</tr>
<tr>
<td>February</td>
<td>20</td>
</tr>
<tr>
<td>March</td>
<td>30</td>
</tr>
</tbody>
</table>

### Reasons for non-attendance – Day Hospice

<table>
<thead>
<tr>
<th>Reason</th>
<th>Total for 2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient appointment</td>
<td>32</td>
</tr>
<tr>
<td>In hospital</td>
<td>57</td>
</tr>
<tr>
<td>In Hospice Inpatient Unit</td>
<td>32</td>
</tr>
<tr>
<td>Unwell</td>
<td>139</td>
</tr>
<tr>
<td>On holiday/away</td>
<td>11</td>
</tr>
<tr>
<td>Other (Visitors – family/district nurse/friends/workmen/delivery)</td>
<td>44</td>
</tr>
<tr>
<td>Reason unknown</td>
<td>0</td>
</tr>
<tr>
<td>Cancelled by service</td>
<td>61</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>376</strong></td>
</tr>
</tbody>
</table>

### Hospice at Home

- 244 referrals were accepted by this service.
- 2,821 visits to patients were made during the year. The majority of which were made by two nurses.

### Hospice at Home Accepted Referrals 2017 / 18

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>20</td>
</tr>
<tr>
<td>May</td>
<td>20</td>
</tr>
<tr>
<td>June</td>
<td>10</td>
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<tr>
<td>July</td>
<td>10</td>
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<td>August</td>
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<td>September</td>
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<td>October</td>
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<td>November</td>
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<td>December</td>
<td>10</td>
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<tr>
<td>January</td>
<td>10</td>
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<tr>
<td>February</td>
<td>10</td>
</tr>
<tr>
<td>March</td>
<td>20</td>
</tr>
</tbody>
</table>
Part 3 – Review of quality of Performance

3.2 Quality Markers

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

Patients Slips, Trips and Falls
All incidents involving patient slip, trips and falls are monitored and reported through the Hospice’s incident reporting process. Any serious incidents are reported to the Care Quality Commission via the statutory notification framework.

![Slips, Trips and Falls 2017-18](image)

During 2017/18 there was a small decrease in the number of patient slips, trips and falls, with 47 reported compared to 50 reported in 2016/17. During the year two serious incidents involving patient slip, trips and falls were reported. Following appropriate statutory notifications, a full Root Cause Analysis (RCA) was conducted for each patient. The RCAs were presented to the Commissioning Care Group (CCG) for assurance and recommendations included education, improved documentation and creation of guidelines for supervision assessment.

An RCA is a systematic investigation technique that looks beyond the individuals concerned and seeks to understand the underlying cause and environmental context in which the incident happened. It is a set of tools to help structure an investigation and analysis of events designed to get to the root of the problem.

Root Cause Analyses are routinely conducted (but 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.
Slip, trips and fall data is regularly monitored and used for education purposes and safe awareness sessions.

**Pressure Ulcers**

2017/18 saw a significant increase in the number of patients who were admitted to the Hospice with Pressure Ulcers and Deep Tissue Injury (DTI). 137 patients were admitted in 2017/18 with Pressure Ulcers/DTI compared to only 62 in 2016/17.

There has been some increase in the number of patients admitted from home with a Pressure Ulcer/DTI with 46 patients admitted in 2017/18 compared to 35 in 2016/17. Patients admitted from hospital with a Pressure Ulcer/DTI have also increased with 43 admissions in 2017/18 compared to 27 in 2016/17.

To ensure appropriate and safe reporting of pressure sores and deep tissue injuries (DTI) and the monitoring of grades and trends, our In-Patient Unit are now reporting all pressure ulcers and DTIs 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.

For patients whose Pressure Ulcer progressed 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 CCG. **There have not been any root cause analyses completed in respect of grade 3 pressure ulcers during this 12 month period.**

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 In-Patient 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.
To further support staff in enhanced detection, prevention of the damage caused by pressure ulcers and improved documentation and checking of the damage, the SSKIN tool is used. This 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.

**Infection, Prevention and Control**

**Outbreaks**
The Hospice had one confirmed outbreak of Clostridium Difficile (c. diff) in July 2017 and a suspected outbreak of diarrhoea over the weekend of 15th/16th September 2017. These were reported to Public Health England and closely managed by the Director of Infection, Prevention and Control, Nursing Director and the Infection, Prevention and Control Resource Nurse.

As a result of these outbreaks, the outbreak guideline was fully reviewed to ensure it is fit for purpose. A flowchart was also developed to assist with decision making regarding the potential closure of the In Patient Unit to admissions.

**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 2017 and 31 March 2018 were:

<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>1</td>
</tr>
<tr>
<td>Clostridium Difficile</td>
<td>1</td>
</tr>
<tr>
<td>MSSA</td>
<td>1</td>
</tr>
</tbody>
</table>

**Medicines Management**
Quarterly Medicines Management meetings are held and chaired by one of our Consultants in Palliative Medicine. A pharmacist from a local Trust attends these meetings. The Medicines Management Committee also reviews all drug related incidents and near misses as part of the Hospice governance framework.

The Accountable Officer for Controlled Drugs at the Hospice is the Nursing Director and this is a statutory role outlined in the Controlled Drugs (Supervision of Management and Use) regulations 2013. The role requires the Accountable Officer to ensure the safe and secure management, as well as use, of Controlled Drugs. A deputy has been appointed to cover this role when the Nursing Director is not available. This is the Head of Service Quality and Improvement.

Birmingham St Marys Hospice is a partner organisation of the Birmingham, Solihull and Sandwell Local Intelligence Network for Controlled Drugs Governance. The network of organisations have agreed to a confidentiality agreement to share information in respect of the use, prescribing and management of Controlled Drugs. Meetings are held on a quarterly basis throughout the year. During 2017/18, the Hospice raised 2 concerns to the network, one of which was externally related.

Clinical Pharmacy services are provided by the University Hospital Birmingham NHS Foundation Trust. The agreement includes the following provisions:
Pharmacist to visit the Hospice 3 days per week
Pharmacy Technician to visit the Hospice every day
Supply of stock drugs review storage quantities, expiry dates and storage conditions
Monitor prescription charts and comprehensive medication reconciliation
Advice on medications to Patients, Doctors and Nurses
Operating a dispensing service on discharge

During 2017-18 there have been 227 medication related incidents of which 7 of these were externally related incidents where errors were made by others but identified by hospice staff.

Complaints and Compliments
The Hospice is committed to delivering high standard of service to anyone who comes into contact with our work. The views of our patients help us to reach this commitment and ensure we are continuously improving our service. All our patients receive information regarding our Complaints and Compliments process.

A summary of the complaints received between 1 April 2017 and 31 March 2018:

<table>
<thead>
<tr>
<th>Total No. of Complaints</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nursing:</strong></td>
<td></td>
</tr>
<tr>
<td>• Clinical Education</td>
<td>0</td>
</tr>
<tr>
<td>• Community Palliative Care Team (CPCT)</td>
<td>1</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>1</td>
</tr>
<tr>
<td><strong>Medical:</strong></td>
<td>1</td>
</tr>
<tr>
<td>• Family and Carer Support Team (FACST)</td>
<td></td>
</tr>
<tr>
<td>• Medical</td>
<td>0</td>
</tr>
<tr>
<td>• Occupational Therapy</td>
<td>0</td>
</tr>
<tr>
<td>• Physiotherapy</td>
<td>0</td>
</tr>
<tr>
<td>• Support at Home</td>
<td>0</td>
</tr>
<tr>
<td><strong>Income Generation and Marketing:</strong></td>
<td>3</td>
</tr>
<tr>
<td>• Community</td>
<td>3³</td>
</tr>
<tr>
<td>• Corporate</td>
<td>0</td>
</tr>
<tr>
<td>• Direct Marketing</td>
<td>1⁴</td>
</tr>
<tr>
<td>• Events</td>
<td>0</td>
</tr>
<tr>
<td>• Individual Giving</td>
<td>8</td>
</tr>
<tr>
<td>• PR and Marketing</td>
<td>0</td>
</tr>
<tr>
<td>• Trading</td>
<td>6</td>
</tr>
<tr>
<td>• Trusts and Grants</td>
<td>0</td>
</tr>
<tr>
<td><strong>Support Services:</strong></td>
<td>0</td>
</tr>
<tr>
<td>• Administration and Governance</td>
<td>0</td>
</tr>
<tr>
<td>• Facilities</td>
<td>0</td>
</tr>
<tr>
<td>• Finance</td>
<td>0</td>
</tr>
<tr>
<td>• Housekeeping</td>
<td>0</td>
</tr>
<tr>
<td>• Human Resources</td>
<td>0</td>
</tr>
<tr>
<td>• IT</td>
<td>0</td>
</tr>
<tr>
<td>• Maintenance</td>
<td>0</td>
</tr>
<tr>
<td>• Reception</td>
<td>0</td>
</tr>
</tbody>
</table>

³ One complaint relates to IG&M (Community) and Direct Marketing
⁴ One complaint relates to IG&M (Community) and Direct Marketing — see note 1 above
Compliments and “Thank You’s”
The Hospice received 108 thank you cards and letters during the year. Compliments, thank you cards and letters are retained for a period of time after they have been displayed. Particular phrases and expressions of gratitude are anonymised and used in Hospice material.

An example of the compliments include:

“Just a small note to say thank you for all your love, care and attention given to my friend xxxx. You have no idea how much you guys put my mind, heart and soul at peace. xxxx lived alone pre-admission to Birmingham St Mary’s.”

“We would like to express our sincere appreciation for all the care and attention that you gave to xxxx during the last few weeks of their life. We are very much aware of how much difficult and painful this time would have been for him and us without you. xxxx particularly mentioned your friendliness and good humour which was demonstrated by everyone towards him and on the care taken in making him and us as visitors feel welcomed and comfortable.”

“Thank you so much for making xxxx last moments as comfortable as possible. The care and compassion you showed her meant a great deal to us as her family. You all do so much a fantastic job! Sending deep appreciation and our warmest love to you all.”

At the time of compiling the report, the Hospice also received 10,067 Facebook page likes. An example of Facebook reviews include:

“All the staff here are amazing, can’t do enough for you. The care compassion and dignity they gave my mom till the end and comforted my dad till we got there, words can’t describe how thankful we are.”
Part 3 – Review of quality of performance

3.3 Clinical Audit

**Medicines Management**

**What we were good at:**
- Self-assessment of controlled drugs – Appointment of the Accountable Officer and the discharge of their responsibilities in the management of controlled drugs.
- Management of controlled drugs, security, examination of stock, administration, prescribing and destruction of controlled drugs.
- Antimicrobial prescribing, correct drug, dose and route

**What we are working to improve:**
- A specific guideline for management, supply, administration and destruction of controlled drugs is in the process of being written.
- Management of delirium. Education needed for clinical teams to continue to improve diagnosis and management of delirium. This includes communication to families.
- Public areas – general environment in the public areas audited is in good repair; a maintenance schedule to be developed to ensure specific areas are inspected and repairs carried out in a structured manner.

**Caring and Safe**

**What we were good at:**
- Advanced Care Plans – Patients’ preferences and choices are documented in an advanced care plan and this is communicated to appropriate professionals.
- Hand hygiene – Training is part of all clinical staff mandatory training. Appropriate measures and equipment are available to staff, regular audits are carried out to ensure good hand hygiene is maintained.
- Day Hospice – Multi-disciplinary team meeting and ways of working to integrate care for people.

**What we are working to improve:**
- Trialling use of ledgers in SystmOne for patients next planned visit
- Improving how we escalate out of hours telephone calls

**Effective & Responsive**

**What we were good at:**
- Ensuring attendance at Gold Standard Framework meetings held by GP Practices.
- Continuing to maintain a high standard for response time with patient letters.
- Integrated Palliative Care Outcome Scale (IPOS) completed at first assessment, with some or all identified problems addressed within the plan of care.
- Improving the daily care of patient urinary catheters.

**What we are working to improve:**
- Improving the number of patients who receive information on their risk of developing spinal cord compression
## Quality Account 2017/18

### Well Led

**What we were good at:**
- Computer screens are locked when left unattended
- Smartcards are never left unattended
- All complaints receive an acknowledgement and/or response from the organisation
- Designated person to investigate complaints
- Holding 1:1 meetings

**What we are working to improve:**
- Communicating to staff the importance of patches/updates and the need to restart computers and not interrupt installations
- Formally documenting learning outcomes from all complaints
- Allocating more time during 1:1 meetings

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### Audit Presentations 2017/18

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 presentations took place during 2017 and were attended by various disciplines:

<table>
<thead>
<tr>
<th>Date of Presentations</th>
<th>Presentation Titles</th>
</tr>
</thead>
</table>
| **July 2017**         | On Call Activity of CNS Teams  
|                       | DNA CPR Forms  
|                       | Phase of Illness |
| **October 2017**     | Referrals Audit  
|                       | Survey of Nutritional Care  
|                       | Income Generation & Marketing Data Capture Forms, Ensuring compliance with GDPR |
Part 3 – Review of quality of Performance

3.4 Feedback from patients and families on services

Following the successful pilot of the new ‘How are we doing?’ patient and carer experience questionnaires last year, these were rolled out across all hospice services during 2017-18. Some of the questions included were specific to the service concerned, and others common to all hospice services. These latter were based on the National Council for Palliative Care ‘Ambitions for Palliative & EoL Care’, the NHS Friends and Family Test and the OACC Suite of Measures (Dame Cicely Saunders Institute and Kings College London).

Questionnaires are posted out to patients / carers with a stamped addressed envelope, or given out as part of information packs, at a pre-determined point in the service delivery for each department. Responses on the completed returns are collated onto a spreadsheet and analysed.

Quarterly reports are produced for each hospice service from the data collected which are sent to Service Leads for comment and to action if necessary. These are then sent to the Nursing Director and Clinical Governance Committee for assurance. Once they have gone through this process, service leads will feed back to their teams and a quarterly poster is also produced by the PR and Marketing Team summarising the responses, which is displayed around the Hospice and can also be used with external stakeholders to showcase our patient and carer’s feedback – see next page.

The total number of returns for 2017-18 was 248. This is expected to rise in subsequent years as questionnaires for some services were not introduced until later in the year.

**Ongoing work:** Questionnaires are still being piloted for the Children’s Bereavement service for children and their parents / carers. Results for these should be available from next year.
PATIENT / CARER EXPERIENCE REPORT: SUMMARY 2017-18

How are we doing with what matters to you?

Support and Care
97% ‘Agree’ or ‘Strongly Agree’ that every effort has been made for them to have the support, care and treatment they need to help them to be as comfortable and as free from distress as possible.

Recommend our services
97% are ‘Likely’ or ‘Extremely likely’ to recommend our service to friends and family if they needed similar care.

Honest conversations
97% ‘Agree’ or ‘Strongly Agree’ that they’ve been given the opportunity to have honest, informed and timely conversations about what matters most to them.

Quality of life
82% say that things have got ‘A little’ or ‘Much’ better in terms of their overall quality of life.

Airing concerns
81% say that things have got ‘A little’ or ‘Much’ better in terms of their main problems and concerns.

Benefit
93% say the hospice is giving ‘Some’ or ‘A lot’ of benefit to how things are going for them at present.

Service user testimonials

“Since the nursing team have been attending my father in his own home words cannot describe how superb they have been. Ten out of ten, fantastic people.”
(Community Team)

“ALL STAFF at every level take the time to talk to me and my family which helps make everyone comfortable. Thank you!”
(Inpatient Unit)

“When I first came I was not in a good place and the thought of coming to a Hospice worried me so much, but after the first time of coming I was relaxed, and it is one of the best things I have been involved with...”
(Day Hospice)

“The Hospice and its staff have shown me that I am living at this moment in time (not waiting to die) and I am most grateful for giving me that mind set.”
(Satellite Clinic)

“I was in a dark place when I began with no hope. However now because of the help I received the sun has started to shine again.”
(Bereavement Service)

“The help from a VSWS has been a godsend - I'd be lost and I keep burying my head, hoping that problems will go away - but she's done wonders.”
(Volunteer Support Worker Service)

“They helped to improve the quality of my mother’s life in her last days.”
(Hospice at Home)

Questions based on the QMCC Suite of Measures, Dame Gillian Saunders Institute & King’s College London.
Also the Redstone for Palliative & End Care, NICE PC and NHS Friends and Family. Total number questionnaires returned: 248.
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3.5 Benchmarking Activity

We are currently participating in the following benchmarking exercises:

**Hospice UK: Patient Safety (In-Patient Unit) Clinical Benchmarking Programme**

This programme has now been running for three years. Over 100 hospices participate in this programme nationwide and data is benchmarked per 1000 occupied bed days on a quarterly basis in the following 4 areas:

- Bed occupancy
- Pressure ulcers
- Patient falls
- Medication incidents

Quarterly data is shared with the participants, with benchmarks established in categories by size of In-Patient Unit (number of beds).

**Executive Clinical Leads in Hospice & Palliative Care (ECLiHP): West Midlands Regional Group Benchmarking Exercise**

Set up by Hospice UK, ECLiHP provides a forum for executive clinical leaders who are engaged in the strategic plans and operational delivery of hospice and palliative care across the UK. Birmingham St Mary’s Hospice is part of the West Midlands Regional Forum, which aims to establish a network for support, information exchange and learning. From within this group, ten hospices take part in a benchmarking exercise which aims to highlight any quality issues in the region and to enable learning from good practice. The group meets quarterly and data is benchmarked in the following areas:

- A more detailed breakdown of bed occupancy, pressure ulcers, patient falls and medication incidents
- Infections
- Deaths and Discharges
- Average Waterlow Scores (risk matrix for pressure ulcer development)

**New Quality Dashboard for Clinical Governance**

This year Birmingham St Mary’s Hospice has have applied the Hospice UK benchmarks to a new Quality Dashboard which is reviewed quarterly by our Clinical Governance Committee. This enables us to quickly identify significant differences between our data and that of other hospices.

This new dashboard includes data from all clinical services and we are working hard to identify and agree baselines for benchmarking. In future this will enable us to identify issues and trends and understand the underlying causes. We have adopted the Hospice UK benchmarks for some In-Patient Unit data.

**Benchmarking for Diagnosis & Ethnicity**

Data on Diagnosis and Ethnicity has been routinely collected for a number of years. However, although positive trends have been demonstrated, there has been no benchmarking of this data historically. In 2017/18 work began to investigate whether suitable comparison data can be identified and will continue to support benchmarking in the future.
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3.6 Statements on Birmingham St Mary’s Hospice Quality Account for 2017/18

Birmingham and Solihull CCG

See Below
Birmingham St Mary’s Hospice
Quality Account 2017/18
Statement of Assurance from Birmingham and Solihull CCG May 2018

1.1 Birmingham and Solihull Clinical Commissioning Group (the CCG), as coordinating commissioner for Birmingham St Mary’s Hospice (BSM), welcomes the opportunity to provide this statement for inclusion in the Hospices’ 2017/18 Quality Account.

1.2 A draft copy of the Quality Account was received by the CCG on the 15th May 2018 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 There remains a clear focus on patient care and this is demonstrated in the Quality Account with an update against the Hospice’s strategy that clearly outlines the satellite unit’s ability to offer patient choice.

1.5 There is detailed information on what activities have been undertaken in order to achieve the priorities that were set; it would have been helpful to see a clear statement that indicates whether the priorities that were set for 2017/18 have been achieved or not.

1.6 The appointment of the professional development nurse has enabled an increase reporting of drug incidents; this has enabled the Hospice to meet this priority. It is good to see that the level of harm remains low.

1.7 The impact of the increase in referrals and admissions to the hospice has been clearly assessed and it is good to see that there are mechanisms in place to monitor the impact of this increase whilst maintaining safe staffing levels and ensuring patient safety is conserved, together with promoting excellence in care.
1.8 Closely linked to the above statement is the drive to capture patient and carer experience and it is positive to see that there have been amendments to the feedback form to enable people to leave there contact details to enable follow-up. It would have been beneficial in this section to have provided examples of what information has been received and how this has improved patient outcomes, there are some examples of patient/carer feedback later in the account.

1.9 It is positive to note that the Hospice has achieved the CQUIN requirements for 2017/18; they have worked collaboratively with the other Hospices to develop shared learning based on the patient’s journey. Commissioners will continue to work with the hospices to encourage innovative schemes to improve patient outcomes.

1.10 There have been initiatives put in place to drive the ambition for the Hospice to improve their CQC rating from Good to Outstanding, they achieved a rating of Good published in October 2016, it is not known when the next CQC inspection will be, therefore achievement against this priority is difficult to assess.

1.11 Throughout the Quality Account there is a strong emphasis on staff development and support and there has been successful nursing recruitment. It is positive to note that there is development of an educational strategy that is multifaceted and will lead to even more effective partnership working.

1.11.1 Commissioners also are pleased to see the other areas notable achievements reported on in the quality account. There is a variety of initiatives that include infection prevention roadshows and raising awareness of Equality and Diversity these should be commended.

1.11.2 There have been three priorities set for 2018/19, a focus on patient safety, with the improved identification and reporting of pressure ulcers, support the development on Non-Medical Prescribing across the Hospice and embed it in clinical practice and rapid response bereavement service pilot. Commissioners would have liked to see an additional element to the first priority to ensure that the organisation also incorporates learning from increased identification/reporting of pressure ulcers.
1.12 As Commissioners we have worked closely with BSM over the course of 2017/18, 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 2018/19.

Paul Jennings
Chief Executive Officer
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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