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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<thead>
<tr>
<th>Abbreviation</th>
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<tr>
<td>CGC</td>
<td>Clinical Governance Committee (part of the Hospice's governance framework)</td>
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<td>CQUIN</td>
<td>Commissioning for Quality and Innovation (payment)</td>
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<td>DTI</td>
<td>Deep Tissue Injury</td>
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<td>IPOS</td>
<td>Integrated Palliative Care Outcome Scale</td>
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<td>IPU</td>
<td>Inpatient 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 the Chief Executive

We celebrated the 40th Anniversary of Birmingham St Mary’s Hospice on March 2019; the first modern hospice in the Midlands and the 7th in the UK. Our founder, Monica Pearce was transformational in her day, in shifting thinking from “care of the dying” towards the best quality of living with life-limiting illness until death. This focus on the whole person is what we now refer to as palliative care.

Whilst palliative care has progressed significantly over the past 40 years, we continue to recognise that too many people are dying alone, without support or with care that comes too late. Across Birmingham and Sandwell, over 50% of people die in hospital, often after the distress of several emergency admissions in their last months of life, when many would prefer to be at home. The situation is very different when hospice support is involved: more than 78% of men and women cared for by Birmingham St Mary’s Hospice are able to live out their lives in the place they choose.

As we work with partners across the whole system of health and social care to ensure palliative and end of life care is better supported in more settings, it is all the more vital that attention is given to quality of care and our responsiveness to individuals’ needs.

What is the purpose of a Quality Account?

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 the 5 priorities in our Hospice Strategy (2016-2020) “Hospice Care for All”:
• Providing a better experience at the end of life
• Expanding our specialist centre of research and learning
• Locating our facilities so we can reach more people
• Being an employer and volunteering centre of choice
• Achieving growth, influence and financial stability

The production of an annual Quality Account is a statutory requirement that we also use as an opportunity to share with our public, the quality of specific aspects of our services in a way that gives assurance of our attention to high standards of care. We deliver many of our services under contracts to two NHS Clinical Commissioning Groups (CCGs):
• NHS Birmingham & Solihull CCG
• NHS Sandwell & West Birmingham CCG

The structure of a Quality Account follows a specific format. This year we have focused on aspects of patient safety, clinical effectiveness and patient experience that have resulted in new ways of working and that respond to patient feedback.

I am particularly proud of the many notable achievements in this report due to the compassion and commitment of staff and volunteers to keep improving and innovating within our diverse community. We recognise that the challenges of today require the transformational approach of our founders. In particular, this report aims to provide assurance of our commitment to quality and ongoing learning, and most critically, listening to patients, families, carers and partners.

Tina Swani
Chief Executive
1.2 Our Leadership
St Mary’s Hospice Limited - Board of Trustees

Our Board of Trustees are responsible for the overarching governance of the Hospice, ensuring the Charity operates within the Articles of Association.
Executive Directors
The Executive Team are responsible for ensuring the Hospice Strategy is delivered as well as making certain the day to day operational aspects of the Hospice are maintained. The Associate Directors support the Executive Team in this delivery:

- **Tina Swani**
  - Chief Executive

- **Lynsey Breeze**
  - Finance Director

- **Dr Debbie Talbot**
  - Medical Director

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

- **Hillary Barrett**
  - Director of Income Generation & Marketing (Interim)

Associate Directors

- **Emma Bryan**
  - Head of Financial Planning & Performance

- **Lucy Chatwin**
  - Head of Support Services

- **Christina Radcliffe**
  - Consultant in Palliative Medicine

- **Trish Squire**
  - Head of Service Improvement and Quality

This Quality Account illustrates, through specific examples, our commitment to continual improvement to service quality and through innovation.
1.3 Our Hospice Strategy 2016 - 2020
“Hospice Care for All”

Birmingham St Mary’s Hospice offers a range of services in a number of settings. We welcome individuals, families, partners and carers from our diverse population across Birmingham and Sandwell. Most of our care is provided in people’s homes, or community locations close by, in addition to progressive inpatient and day services at the Hospice.

Over the past year since the launch of our strategy, we have significantly increased the number of people we support. This includes; 1,699 individuals receiving palliative care, support to 419 family members, bereavement support for 368 individuals and 41 children who have experienced the loss of a family member. We want to continue to significantly improve the experience of living with terminal illness for a lot more people.

As a teaching Hospice, we work alongside other health and social care professionals in prison services, care homes, hospitals, community and mental health services. Our education programmes extend to this wide network of care providers, including GPs and District Nurses so that, together, we can strive to reach more people and achieve “Hospice Care for All”

Our Vision, Values and Priorities

Our Vision
A future where the best experience of living is available to everyone leading up to and at the end of life.

Our Values
• Delivering quality care
• Improving access for all
• Sharing expertise
• Working collaboratively
• Changing attitude

Our Priorities
1. Providing a better experience at the end of life
2. Expanding our specialist centre of research and learning
3. Locating our facilities so we can reach more people
4. Being an employer and volunteering centre of choice
5. Achieving growth, influence and financial stability
2.1 Priorities for improvement 2018-19 - what we achieved last year

Patient Safety

Quality Priority 1: Pressure Ulcer reporting and engagement
Standard: To improve patient care through better reporting and identification of pressure ulcers

How was it identified as a priority?
Pressure Ulcer reporting and engagement together with improved data collection was identified as a priority because it is a recognised Hospice UK quality indicator of patient care. The hospice wanted to ensure staff understood the prevalence of all forms for pressure damage within our cohort of patients.

It was also important we contributed to data collection, to ensure meaningful bench marking was available across hospices both locally and nationally. Data is verified monthly, by clinical and administration teams to ensure accuracy.

How was the priority achieved?
To achieve the priority, a review took place of the information requirements for: Hospice UK, benchmarking requirements, Care Quality Commission and the NHS Clinical Commissioning Group.

The information requirements were applied to a template; this ensured the data was captured and stored in one central area for verification by Clinicians. A new reporting database has been established and introduced, the data of which is then reviewed by the Clinical Governance Committee.

The data also provides us with information to support any education and equipment needs and to identify areas of risk outside of the hospice. For example, certain clinical areas within acute trusts may have a high prevalence of pressure damage. This ensures patient safeguarding can be protected and other services such as social services can be made aware.

How was progress monitored and reported?
The new form was presented at a Tissue Viability Roadshow, delivered by the Professional Development Nurse and the Tissue Viability Link Team. The event presented an opportunity to review our knowledge of pressure damage prevention as well as introduce the new forms. In addition, nurses who tested the forms had an opportunity to comment and make suggestions for improvement.

These have now been in use for nearly 12 months and have to-date provided the required information in a timely and accurate manner.
How was it identified as a priority?
The Hospice Strategy and Vision 2016-2020 sets out five priorities to enable ‘Hospice Care for All’. Implementing Non- Medical Prescribing (NMP) has helped to achieve this by supporting more people at home and developing our staff through learning and education. NMP enhances the patient experience by providing easier access to essential medications that help with symptom control at the end of life.

How was the priority achieved?
As confirmed in our 2017/18 Quality Account, this is a 3-5 year project, due to the time required for all appropriate staff to receive training and to ensure proper support. The specific focus last year was to identify funding, to put in place a good governance framework and to engage with our GP stakeholders.

Funding has been identified and will support 3 Clinicians each year for the next 3 years. Three Nurses have successfully completed their NMP course in 2018-19 and a further three have applied to undertake the NMP course in 2019-20. Two of the Nurses qualified this year are Clinical Nurse Specialists and the other is our Triage Nurse on the Inpatient Unit.

During the year, a NMP Policy was developed and approved by the Clinical Governance Committee. An NMP Forum has been set up to support the NMP’s and to ensure good governance and robust monitoring is in place. For assurance, this forum reports directly into the Medicines Management Committee, which in turn reports into Clinical Governance Committee. The two Community NMP’s have liaised with their cohort of GP practices and informed them of their registration. They will continue to work collaboratively to embed NMP as part of their Specialist Palliative Care offer in the community.

We have also kept the CCG up to date with progress of this initiative and they have supported us with obtaining prescription pads for the Community Nurses.

How was progress monitored and reported?
Progress of this initiative continues to be monitored by the Medicines Management Committee as a regular standing item on the agenda. The Clinical Governance Committee receives regular updates and implementation is also tracked via the Hospice’s Operational Plan.
Patient Experience

Quality Priority 3: Rapid response bereavement service pilot

Standard: To evaluate the impact of a rapid response service on bereavement services

How was it identified as a priority?
A Rapid Response Bereavement Service was identified as a priority because, whilst the feedback received from the families and carers of the patients who have used our service has been positive, our Family and Carer Support Team (FACST), with the support of Volunteer Bereavement Counsellors and Bereavement Workers, have seen a growing need for urgent bereavement support.

More urgent bereavement support 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 and heightened demand on the whole FACS team.

The aim of this pilot scheme was to provide a rapid responsive adult bereavement support service for our clients, by changing the way we work.

How was the priority achieved?
The pilot scheme involves a modified initial assessment, where clients are offered a range of support and up to ten counselling sessions, in the first instance.

During these sessions, a further assessment takes place with the client to understand if additional support is required thereafter.

For reasons outside of the control of the project lead, progress has been slower than hoped with only six clients seen through the pilot scheme to-date. The plan; however is to continue the scheme into 2019-20.

How was progress monitored and reported?
The Rapid Response Bereavement Service pilot is monitored through client feedback. To-date the one client who has completed their trial has provided positive feedback.

A second client has just reached the halfway point of their support, but has already talked of improvements and a clearer perspective. Four further clients have yet to reach the halfway point, as their sessions are not as regular as the others are.

We are encouraged by initial indicators. Our intention is to enter further clients into the scheme and fully evaluate when numbers are higher.
2.2 Other notable achievements 2018 - 2019

**Space to Breathe**

In January 2019 a new service was launched in our Day Hospice called **Space to Breathe**.

This is a five-week programme of one cohort of patients and carers per programme and is based on the Cambridge Model of Breathing, Thinking, and Functioning.

The programme will run each Monday from 1.00 – 3.30pm and transport will be available if needed. Referrals can be made via our teams or via the Hospice, website and patients with any symptoms of uncontrolled breathlessness can be referred to the programme. The programme is supported by the full range of our multi-disciplinary team and has been developed in collaboration with our partners in both the acute and community setting.

**Community Development and Partnership Lead**

The Community Development and Partnership Lead commenced this new role in August 2018. During this time, they have met people from marginalised communities, listening to their stories in order to strengthen the hospice role and presence within communities. This has included partners in Homelessness Support, the LGBT Community and Communities in Highgate.

They have also been developing partnerships with colleagues and teams across local Sustainability and Transformation Partnerships (STP). This has included the STP Enhanced Support to Care Homes Steering Group to ensure the hospice’s work with Care Homes is integral to future service design, improving the experience of end of life care for people in Care Homes.

Work with the Heart Failure and Palliative Care Teams at University Hospital Birmingham is underway to design a Heart Failure and Palliative Care course that will enable both our staff and staff across the region to learn from each other on how to provide dignified end of life care for people with heart failure.

In partnership with Birmingham Community Health Care Trust, the ReSPECT process was implemented. ReSPECT is available to anyone with complex health needs and reflects their personalised choices, helping health care professionals to make immediate decisions about that person’s care and treatment during emergency situations.

The Community Development Partnership Lead sits on the Steering Group for the local Neighbourhood Network Scheme in Selly Oak, which explores our role in working with Communities to improve support and connections for those who are caring and bereaved. They also work with local schools to deliver teaching around death, dying and bereavement within the curriculum. Future plans include launching local Bereavement Hubs, employer support and growing a Compassionate Community for Birmingham.
Equality and Diversity

We have received the Investors in Diversity Award, making us the first Hospice in the UK to achieve the prestigious equality standard. The award was for our commitment to embedding Equality, Diversity and Inclusion practices into the Hospice – benefitting both the people receiving care and the staff and volunteers who work here. The Hospice was awarded the status by the National Centre for Diversity (NCFD) and they particularly praised our hard-working Equality, Diversity and Inclusion committee. Over the past two years, the committee has driven forward a programme of equality activities to ensure the Hospice has inclusivity at its heart.

The committee has welcomed community leaders to deliver educational workshops, produced information leaflets in seven different languages to meet the needs of Birmingham’s diverse population; it has participated in key community events across the city such as Pride, and run cultural celebration days for staff and volunteers to inform them about different faiths and holy festivals.

The charity was also commended by the NCFD for the work of the new Community Development and Partnerships Lead. As a senior specialist community nurse, this member of staff works alongside different community groups to better understand their specific end of life care needs and how the hospice can meet them.

Learning from Excellence

We know staff are proud to work for the hospice and feel valued in their roles and to continue to recognise the excellent work of staff and volunteers; we launched a “Learning from Excellence” system for all the hospice team in May 2018.

Various opportunities are available for Staff and Volunteers across the Hospice to access and submit forms, which allow them to formally recognise and celebrate good practice they have witnessed. A small team reviews the forms and feedback to the named individual or team. Once collated, the forms are reviewed and themes of excellent practice identified which are then fed back to all staff. The intention of sharing positive practice is to facilitate learning and encourage replication by others.

In addition to this, we circulated appreciation postcards around the hospice, for Staff and Volunteers to informally feedback to their colleagues about things they appreciated about them, this was also an opportunity to spread a positive message about the good work we are doing.

Freedom to Speak Up

In 2018, the Hospice launched its Freedom to Speak Up campaign. This encourages people to speak up and promote a culture of openness and honesty. The campaign predominantly focussed on larger concerns including unsafe patient care or working conditions, suspicions of fraud or a bullying culture.

We support the national Freedom to Speak Up campaign and encourage staff to raise any comments or concerns they may have. We are proud that 95% of respondents from our latest staff survey said that if they had any concerns, they would know how to report it. Staff are encouraged to raise concerns with their line manager, however if they are not able to do so, we have a Freedom to Speak Up Guardian and a range of Freedom to Speak Up Champions who are available to support, which includes Trustee Champions.
If for any reason staff do not feel comfortable raising their concern internally, they are also advised they can raise it with external bodies (further details are included in the Speaking Up Policy). When a concern is raised, we listen and thank the individual for bringing it to our attention.

The complaint will then be investigated and will be focused on identifying and rectifying any issues. We also focus on learning lessons to prevent problems recurring so we can continue to improve the service we provide to patients and to the working environment. The concerns will be discussed with the individual and they will be kept up to date on the investigations progress.

Where possible, the investigation report will be shared with the individual raising the concern, while respecting the confidentiality of others. The Executive team are responsible and committed to creating a culture whereby people feel comfortable to speak up about issues without detriment. If any individual felt that they had received a detriment as a result of speaking up, they are encouraged to raise it with the HR department.

Staff Survey

The Hospice launched its Staff Survey in November 2018 and received a 64% response rate.

The high level of employee engagement recorded (81%), resulted in us winning the Agenda Consulting Award for the second time running.

Results from the survey are reported to Trustees and our Executive Team.

The Business Development Team are working with their individual teams on areas for improvement and results workshops are being delivered to all staff in May 2019.
The Hospice’s Social and Wellbeing committee has done a lot of work to reduce the stigma around mental health in the workplace, and its popular awareness days have started conversations and encouraged staff and volunteers to pick up information and take part in workshops to grow their understanding in this area.

We recognised mental health awareness week via Curry and Chaat (May 2018), held our first annual Employee Well-being day with the theme of stress awareness (April 2018), delivered 10 resilience workshops across the year, and held a Blue Monday event (Jan 2019).
Part 2 – Priorities for Improvements and Statements of Assurance

2.3 Statements of assurance

Review of services
In 2018-19 Birmingham St Mary’s Hospice supported NHS commissioning priorities in Birmingham and Sandwell, providing specialist palliative care services. A brief outline of these services, funded through charitable giving, is provided below:

- **Inpatient Unit**
  A mixture of single rooms with en-suite facilities and small multi bedded bays for those needing intensive palliative and end of life care. Nursing assessments are conducted daily and there is access to medical advice 24 hours per day. Two ‘home from home’ beds are also available for Sandwell patients who need nursing care but less medical intervention at the end of life.

- **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, 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/Outpatient Services**
  The Day Hospice holds several clinics during the week which include a Therapeutic Programme, a clinically led educational programme focusing on living well with a life limiting illness. A Clinical Nurse Specialist clinic runs weekly by appointment and there is also a weekly Medical outpatients where patients can be referred to be seen by one of our Palliative Medicine Doctors. A weekly volunteer led Welcome Group provides social and peer support for patients who have a life limiting or terminal illness. This is a non-clinical service supported by a Senior Healthcare Assistant can see up-to 20 patients per session.

- **Hospice at Home**
  The Hospice at Home service, delivered by Registered Nurses and Health Care Assistants, provides patients with a palliative diagnosis care in their own home whilst nearing the end of life, or waiting for a package of care. In addition, Hospice at Home offers an Urgent Response service for patients known to the hospice. Co-ordinated by the duty Clinical Nurse Specialist, patients needing more urgent assessment or symptom management can be seen in a timely manner.

- **Physiotherapy and Occupational therapy**
  Physiotherapy and Occupational therapy services are provided by the Hospice and through service agreements with University Hospital Birmingham NHS Foundation Trust. The Therapists specialise in palliative care support and are an essential part of our Multi-disciplinary team, enabling us to deliver holistic care to patients.

- **Complementary Therapies**
  A range of complementary therapies are provided by volunteers managed and supervised by the Senior Physiotherapist.
• **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. They also coordinate a number of volunteer services, providing different types of befriending and practical help and support to patients and families.

• **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 with grief and loss. They are managed by a full time Senior Social Worker and receive one to one supervision from external counsellors paid for by the Hospice.

• **Support at Home**
  The ‘Support at Home’ service provides a trained volunteer service for patients in their homes and offers friendly companionship and a listening ear for up to 3 hours per week on a flexible weekly, fortnightly or monthly basis. The service allows carers to get a small break knowing someone is making sure their loved ones are being looked after.

A research engaged and research generating hospice

We have continued to progress our research strategy during 2018-19. Our research team and staff members are actively recruiting patients and their carers to a variety of research projects, including national studies researching models of hospice at home, prognostic markers in palliative care and opioid induced constipation. Research adds value to care; our patients are generous with their time and dedication to research.
Our journal club continues to flourish, with both clinical and non-clinical staff attending, and many different individuals and grades of staff being supported to present papers by the hospice Research Nurse.

The Hospice took part in a National Institute for Health Research (NIHR) video promoting the advantages of research within hospices, which is now on their website and has been publicised on social media.

We were supported by a relative of a patient, who had been involved in research who agreed to talk about their experience. These films, published nationally by NIHR, coincide with World Hospice and Palliative Care Day.

https://www.youtube.com/watch?v=Hq_TqIQEAr4&feature=youtu.be

Following our NIHR award in April 2018, the hospice was approached to support other hospices in becoming research ready. As a result, a West Midlands Hospice and Community Research Group was founded. Supported by the NIHR, the group meeting regularly to provide peer support for the research agenda.

Our Research Nurse was invited to present our journey to becoming research active at the West Midlands supportive and palliative care research showcase in October 2018. Five posters and one oral presentation was given at the Hospice UK conference in November 2018.

The research champion’s role has expanded to include more departments and we now have research champions in Hospice at Home; Community Palliative Care Team; Inpatient Unit; Family and Carer Support Service Team; Fundraising and PR and Marketing. The research champions help promote an understanding of the research conducted in the hospice and the integration of research into day-to-day working practice.

We are in the process of recruiting a Patient Research Ambassador to support our research agenda and advocate for patients and their carers.

Our staff continue to provide support and clinical supervision for students who are engaging in their own research projects. Birmingham St Mary’s Hospice is proud of the research work it has, and continues to do, and is planning for research to be a core pillar of the hospice strategy from 2020 onwards.
2,170 Health and Social Care professionals have benefited from placements and education programmes delivered by Birmingham St Mary’s Hospice this year.

**Placements**
In addition to placements for Nursing and Medical students, we continue to support placements for Aston University Pharmacy students who undertake a short interdisciplinary visit to the Hospice. For the first time this year, we facilitated a Works Experience placement for a student from the Social Mobility Foundation.

**Education programme**
The Education programme has delivered 25 courses/study days, which approximately 108 staff and volunteers have accessed.

Two members of staff undertook the Quality End of Life Care for All train the trainers course (QELCA), which enabled delivery of the course to key workers from the Bosnia UK network. It is envisaged that this will become part of our future education programmes and community development work.

The Hospice also offers bespoke education sessions to various organisations when requested.

**Implementation of the Education Strategy 2018-2020**
Outputs from the September to March Education Strategy implementation plan are detailed below:

- Education Champions from teams across the Hospice have been recruited
- An Education Steering Group created to discuss internal and external education provision.
- Learning and Development application forms have been revised to encourage a culture of reflective practice and sharing of learning
- Aston Medical School contacted to offer to be involved in the design and delivery of the Medical Undergraduate Palliative Care curriculum
- Bursary opportunities for staff identified and advertised to optimise the efficient use of Learning and Development
- Alternative methods of providing education reviewed
Guideline development and review

The Hospice has developed a joint working forum with a partner (John Taylor Hospice), to look at national guidelines, decide on applicability to our care settings, review and provide recommendations for change in practice.

A review of the following applicable National Institute for Health and Care Excellence (NICE) guidelines, guidance and standards has taken place during the year:

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<td>NG71 Parkinson’s Disease</td>
<td>NG107 Renal replacement therapy &amp; conservative management</td>
<td>NG96 Care and Support for people who are growing older</td>
<td>NG97 Management / support for people living with dementia &amp; their carers</td>
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<td>CG32 Nutritional support for adults</td>
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<td>MTG 36 Transanal irrigation System</td>
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<td>NG112 Recurrent UTI</td>
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Use of CQUIN payment framework 2018 - 2019
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 2018-19 it was agreed to focus on improving how we measure patient outcomes and to put in place an action plan of how we would achieve this.

A scoping exercise was undertaken to establish a baseline of implementation of the OACC tools to date and then an action plan was developed in partnership with the clinical leads to identify how the outcome measures could be rolled out and embedded into practice.

It was also important to work with our colleagues at John Taylor Hospice, St Giles Hospice and Marie Curie Hospice to share good practice and embed a local approach to measuring patient outcomes, in order that our Commissioners have a standardised approach to measuring patient outcomes.

In February 2019, all four local Hospices jointly delivered an OACC workshop for staff working in end of life care. The event was a real success with over 40 people attending and feedback demonstrated an increased knowledge of the OACC toolkit.

In order to develop the good work already completed, one recommendation of this year’s CQUIN will be to continue implementing the OACC framework into 2019/20 and for the Clinical Commissioning Group to support with the IT systems required. The recognition of the value that the outcome measures have on clinical effectiveness has provoked the identification for this work to become one of our quality priorities during the next reporting year.

Data Quality
Birmingham St Mary’s Hospice did not submit records during 2018-19 to the Secondary Users Service.

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

Achieving information governance standards across all of our departments remains a high priority for the hospice and is reported as a standard agenda item to the Compliance Committee (Information Governance) and Board of Trustees.

As part of our commitment to information governance, the Hospice submitted in March 2018 annual evidence to the Health and Social Care Information Centre (HSCIC) for compliance with the NHS Information Governance Toolkit; maintaining our Level 2 status as required by the NHS Commissioners.

In readiness for the General Data Protection Regulations (GDPR), a Task and Finish group was formed with representation from all key data handling departments. An action plan was devised and approved by the Compliance Committee.

The plan was successfully delivered on schedule by May 2018 to ensure compliance with the new regulation. The areas of focus included the recording of consent (children and adult), a public facing Privacy Policy, the development of a comprehensive process to manage subject access requests, a Data Breach Management Policy, appointment of a Data Protection Officer and the updating of our information governance training programme to include cyber security risks.
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. The Hospice has updated its data protection framework in line with the new General Data Protection Regulation.

Birmingham St Mary’s Hospice Information Governance Assessment Report overall score for 2018-19 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, analysing for themes and variance in expected performance.

Duty of Candour
We have an accident and incident reporting policy, which includes references to duty of candour and a supporting duty of candour policy. Staff have received training as part of clinical mandatory training and new staff must read these policies. We have taken a positive approach to duty of candour and have given full responses to a number of incidents, engaging patients and families in an open approach to investigation. We also have a programme of learning from excellence as well as incidents, allowing the hospice to learn from positive events and reinforce positive actions. Freedom to Speak Up guardians and champions have been instituted within the hospice this year, and publicity in this area has aimed to encourage staff to speak up where they have concerns about patient safety.
Part 2 – Priorities for Improvements and Statements of Assurance

2.4 Priorities for Improvements 2019 – 2020

Patient Safety

Quality Priority 1: Incident and Accident reporting and learning

Standard: To develop and implement an electronic Incident Reporting System across the Hospice, which is accessible to all staff regardless of working location.

How was it identified as a priority?
Incident reporting across the Hospice has significantly grown over the last few years. This increase can be due to a number of factors including but not limited to:

- Open reporting encouraged
- Increased data capture requirements for CCGs
- Changing needs, and therefore risks, of the patients we care for

The Incident and Accident form is paper based. Updated in 2012 and again in 2016 the incident reporting form was developed as a ‘capture all’ form, for both clinical and non-clinical incidents. It also replaced the staff accident log following agreement from the Department of Work and Pensions. Additional reporting forms have been introduced to support Pressure Ulcer and Drug Incident reporting.

Despite procedures in place, the physical movement of incident forms once completed has had its challenges. The current system has become insufficient and a more robust incident reporting system is required.

How will the priority be achieved?
Through the implementation of an electronic incident reporting system for the Hospice, accessible for all staff regardless of their working location. This will ensure our incident management will:
1. Offer a wider reach
2. Save time
3. Eradicate risk of lost forms
4. Ease of use
5. Will be time responsive
6. Eradicates risk of file corruption and loss of data
7. Greater reporting opportunities
8. Supports quality improvement processes

A working group will be established, to design a robust system of reporting which meets the reporting requirements of the Hospice, CQC, CCGs and other regulatory bodies.

How will progress be monitored and reported?
The input quality will be monitored. Any concerns will be fed back accordingly. Incident reporting will continue to receive robust scrutiny at each of the Governance Committees as applicable.
**How was it identified as a priority?**

Health services and health care professionals are required to demonstrate that they meet the needs of individual patients and their families, and that they do this in an effective and efficient way.

To achieve this, and to strive towards higher standards of care, services and staff must be able to show that they are making a measurable and positive difference to patients and families receiving their care. The Outcome Assessment and Complexity Collaborative (OACC) has collated a suite of fit-for-purpose measures designed to capture and demonstrate this difference for palliative care services.

The Outcome Assessment and Complexity Collaborative (OACC) measures can be used to improve team working, drive quality improvement, deliver evidence on the impact of services, inform commissioning and, most importantly, achieve better results for patients and families.

**How will the priority be achieved?**

To repeat an organisational assessment of how OACC measures are already being used and where we should initiate or improve their utilisation, to enhance our understanding of the impact we have on service users. A report will be compiled, detailing the findings from the assessment and an agreed action plan.

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

We will hold a second event with other hospices and commissioners to share learning. Quarterly reports will provide update on the action plan implementation. A final report will highlight next steps in continuing to improve our impact measurement.
How was it identified as a priority?
Identification of the Breathlessness Clinic priority came via our Day Hospice team, who recognised breathlessness as a key symptom burden for many of our existing patients. They also recognised that we are currently not reaching many patients, including those with a primary diagnosis of respiratory disease, who could potentially benefit from expert symptom control, education and advice around self-management of breathlessness. The aim of the clinic, therefore, is to reach more patients with non-malignant disease, to create better integration/collaboration between primary and secondary care, introduce new and clearer pathways for referral and build on the symptom control provided within the Day Hospice therapeutic programme.

The new service has been developed in collaboration with the acute hospital and community healthcare teams. It is anticipated that a Case Manager from Birmingham Community Health Care Trust will be involved in the programme most weeks.

How will the priority be achieved?
The clinic will act as a stand-alone service and/or can be extended to patients referred onto other hospice services. Initially the clinic will be managed by the Hospices own Multi-Disciplinary Team, however, it is hoped we can improve engagement with case managers, heart failure and respiratory teams in the future, so that they are actively involved in delivering aspects of the programme. During the five weeks, patients will have access to therapists, exercise practitioners, Family and Carer Support Service, palliative care Clinical Nurse Specialist and/or Doctor.

A Steering Group will oversee the implementation of this new service. It will include a five-week programme (for one cohort of patients and carers per programme). There will be a maximum of 8 programmes run each year on Mondays from 13.00-15.30hrs.

Referred Patients will come from existing Hospice services or from Case Managers, Specialist Teams in the acute or primary care, GP’s etc.
How will progress be monitored and reported?
The first programme will be used as a test clinic and will determine if the programme content and structure works. An interim evaluation of the service will be conducted at this point and any adjustments will be made.
After the first four programmes during the year, there will be a break for one week where further evaluation and learning can take place. A final end of year review will also be completed.

The findings of each of the evaluations will be reported to the Clinical Governance Committee.
Part 3 – Review of Quality 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 chosen therefore, to present data extracted from that system for the year 1 April 2018 to 31 March 2019 for the following services:

**Inpatient Unit (IPU)**
- There were 364 admissions to our IPU – this includes those patients that may have been admitted more than once

**Community Palliative Care Team (CPCT)**
- 1,241 referrals were accepted by this service
- 17,894 patient contacts and 2,743 MDT & professional contacts were made during the year
- There were between 250-300 patients per month on the Team's caseload during the year
Day Hospice
- Overall attendance in our Day Hospice was 1,736
- Patients were unable to attend Day Hospice for a variety of reasons on 460 occasions (see the breakdown on the next page)
Reasons for non-attendance – Day Hospice

<table>
<thead>
<tr>
<th>Reason</th>
<th>Total for 2018/19</th>
</tr>
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<tbody>
<tr>
<td>Outpatient appointment</td>
<td>48</td>
</tr>
<tr>
<td>In hospital</td>
<td>98</td>
</tr>
<tr>
<td>In Hospice Inpatient Unit</td>
<td>23</td>
</tr>
<tr>
<td>Unwell</td>
<td>215</td>
</tr>
<tr>
<td>On holiday/away</td>
<td>8</td>
</tr>
<tr>
<td>Other (Visitors – family/district nurse/friends/workmen/delivery)</td>
<td>46</td>
</tr>
<tr>
<td>Reason unknown</td>
<td>22</td>
</tr>
<tr>
<td>Cancelled by service</td>
<td>0</td>
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Hospice at Home
- 287 referrals were accepted by this service.
- 2,915 visits to patients were made during the year. The majority of which were made by two nurses.
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 patient slips, trips and falls are reported internally using the Hospice incident reporting process. During 2018 / 19 an increase in the number of patient slips, trips and falls, have been reported compared to 2017/2018.

This increase is related to two patients who, due to their complex care needs and frailty, fell on more than three occasions. We plan care with patients individually, supporting their independence where appropriate, whilst at the same time trying to ensure their safety. We regularly monitor the falls data, which we use for education purpose and staff awareness sessions.

Serious incidents are reported to the Care Quality Commission under the statutory notification framework and a Root Cause Analysis (RCA) is conducted. An RCA is an investigation technique that helps structure any investigation to understand the underlying cause and environmental context in which the incident occurred.

RCAs are routinely conducted (not an exhaustive list):
- 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.
Pressure Ulcers

2018/19 saw a significant increase in the number of patients who were admitted to the hospice with Pressure Ulcers and Deep Tissue Injury (DTI). 219 patients were admitted in 2018/19 with Pressure Ulcers/DTI compared to only 137 in 2017/18.

There has been some increase in the number of patients admitted from home with a Pressure Ulcer/DTI with 57 patients admitted in 2018/19 compared to 46 in 2017/18. Patients admitted from hospital with a Pressure Ulcer/DTI have also decreased with 40 admissions in 2018/19 compared to 43 in 2018/19.

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 Inpatient 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 Inpatient 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 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**
There were no outbreaks of infection on the Inpatient Unit between 1st April 2018 and 31st March 2019.

**Surveillance of MRSA and Clostridium Difficile**
The total numbers of patients known to have MRSA/C-Diff on the Inpatient Unit between 1 April 2018 and 31 March 2019 are:

<table>
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<tr>
<th>Micro-organism</th>
<th>Total number of patient known to be colonised</th>
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<tr>
<td>MRSA</td>
<td>4</td>
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<tr>
<td>Clostridium Difficile</td>
<td>6</td>
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<tr>
<td>MSSA</td>
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All patients with MRSA were known to be colonised from recent routine hospital screening and prescribed decolonisation treatment. Patients identified as C. Diff positive while inpatients at Birmingham St Mary's Hospice were reported and investigated with a root cause analysis followed up by learning outcomes.

**Medicines Management**
Quarterly Medicines Management meetings are held, chaired by a Consultant in Palliative Medicine. A Pharmacist from a local Trust also attends these meetings. The Medicines Management Committee review all drug related incidents and near misses as part of the Governance Framework.

The Accountable Officer for Controlled Drugs at the Hospice is our Nursing Director and is a statutory role as 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 they are not in attendance at the hospice. The deputy is the Head of 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 2018/19, the hospice has raised 2 concerns to the network.

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 2018 -19 there have been 228 medication related incidents of which 12 of these were externally related incidents where errors were made by others but identified by hospice staff.
Complaints and Compliments

Complaints Summary – 01.04.18 – 31.03.19

All complaints are handled in accordance with our policy and are fully investigated, with written summary of the findings provided to complainants and appropriate cascading of actions and learning to teams.

| 2018/2019 |  
|-----------|---|
| Total number of formal complaints | 14  |

**Nursing:**
- Clinical Education: 0
- Clinical Reception: 1
- Community Palliative Care Team (CPCT): 0
- Day Hospice: 0
- Hospice at Home: 0
- Inpatient Unit (IPU): 3
- Nursing Services: 1

**Medical:**
- Family and Carer Support Team (FACST): 2
- Medical: 0
- Occupational Therapy: 0
- Physiotherapy: 0
- Support at Home: 0

**Income Generation and Marketing:**
- Community: 0
- Corporate: 0
- Direct Marketing: 0
- Events: 1
- Individual Giving: 3
- PR and Marketing: 0
- Trading: 3
- Trusts and Grants: 0

**Support Services:**
- Administration and Governance: 1
- Facilities: 0
- Finance: 0
- Housekeeping: 0
- Human Resources: 0
- IT: 0
- Maintenance: 0
- Reception: 1

1 One complaint also relates to FACST
2 This complaint also relates to IPU
Compliments and “Thank You’s”
The Hospice receives thank you cards and letters during the year. These are normally sent to individual departments. Compliments, thank you cards and letters are retained for a short period of time after they have been displayed in individual departments. Particular phrases and expressions of gratitude are anonymised and reported in some Hospice documentation.

An example of some compliments received include:

- I was moved at the way the staff all sang happy birthday to (named patient), and for the lovely cake they made for him (IPU)
- I am reassured “palliative” is not “end of life” (CPCT)
- St Mary's listens to my moans and explains in layman's terms what's going on. I appreciate that (CPCT)
- Feels like you are almost part of a family …which allows us to help each other and this for me, makes me feel at least a little useful in life. Benefit from making new friendships which endure outside of the Welcome Group. Love the arts and crafts stuff (DH Welcome Group)
- I have absolutely no doubt that angels do exist. They all work for St Mary's (Hospice at Home)
- Nothing but praise for the way I've been looked after by all staff, doctors to cleaners and cooks (IPU)
- If all your counsellors are like (name), you couldn't do any better. Thank you. (Adult Bereavement Counselling)
- …a massive thank you to (named social worker) for helping sort out the legal help I needed. (Social Work)
- I am so grateful to have had my volunteer. I don't think I would have got through sometimes without her. At times, I certainly felt she was the only one I could turn to, knowing I could rely on our visits kept me going. (Volunteer Support Worker Service)
Part 3 – Review of Quality Performance

3.3 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 2018 – 19 audits or enquiries related to specialist palliative care.

We do however have an extensive programme of internal clinical audit, which is an essential component of good clinical governance practices. Our focus is continually improving on quality of life for patients and their families, ensuring a positive experience in a safe environment.

The regulatory assessment framework from the Care Quality Commission (CQC) is built around five key lines of enquiry (KLOE); is the service caring, safe, effective, responsive and well led. Our audit teams oversee our audit programmes using national and local designed tools. This multidisciplinary approach includes dissemination of reports, monitoring action plans and re-audit where required.

Some of the outcomes from the audits reviewed during 2018-19 are detailed below and outline the Hospices commitment towards quality improvement.

### Caring

**What we were good at:**
- Contacting relatives following bereavement in a timely way and taking action based on their individual needs
- Safeguarding our patients against Pressure Ulcer damage through close monitoring and tailoring care to the individuals wound care needs

**What we are working to improve:**
- To ensure next of kin details are recorded to ensure smoother transition between services
- To continue to build upon the pressure ulcer knowledge through evidence based practice, tissue viability educational displays and teaching sessions

### Safe

**What we were good at:**
- Ensuring our medications are recorded to encourage the safe delivery of care, particularly where multiple professionals may be giving medication advice
- Medicines administered via the Patient Group Directive are done so within the guidelines providing safe administration

**What we are working to improve:**
- To improve reminder alerts for patients having Chemotherapy/Immunotherapy to highlight risks. Pop-up reminder for SystmOne is being developed
- Awareness to improve documenting “via PGD” on prescription
Effective

What we were good at:
- Documenting ‘Package of Care’ status earlier in the Hospice at Home service and appropriately following this up, enabling patients to access appropriate services in a timely manner
- Monitoring and prioritising patients on our waiting list daily and identify reasons for non-admission

What we are working to improve:
- To work with our Clinical Commissioning Group and collaboratively with our partners to ensure patients receive End of Life Care in their preferred place of death

Responsive

What we were good at:
- Monitoring the drug fridge actual minimum and maximum temperature, by initiating daily temperature and expiry date checks
- Improvements made to the quality and data included within our Discharge letters by using standard templates

What we are working to improve:
- To consistently clearly document the action taken when the drug fridge temperature is out of range
- To continue to monitor the quality of letters across the clinical teams

Well Led

What we were good at:
- Computer screens are locked when left unattended
- Smartcards are never left unattended
- Acknowledging all complaints received and investigated by a designated lead
- 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

Birmingham St Mary’s Hospice hold Audit Presentation meetings on a quarterly basis throughout the year. These meetings offer members of staff and volunteers an opportunity to learn more about the variety of clinical and corporate audits reviewed and discuss learning outcomes.
3.4 Feedback from patients and families on services

Patient and Carer feedback continues to be collected by way of questionnaires which 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 clinical department. This is now a routine part of all hospice departments, and questionnaires are returned initially to service leads for potential action or follow up where necessary, before the data is collated onto a spreadsheet and analysed.

As for last year, quarterly reports are produced for each hospice service from the data collected. These are then sent to the Service Leads, the Nursing Director and to a 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 patients and carers feedback – see next page.

Since these questionnaires were first developed in 2016-17, response rates have risen steadily. The total number of returns for 2017-18 was 248. This year it is 380.

Work continues to be done to ensure any new hospice services have questionnaires developed appropriate to the service offered, and that processes are in place to ensure all patients and carers are given the opportunity to complete a questionnaire during or following their episode of care with the hospice.
PATIENT/CARER EXPERIENCE REPORT:
SUMMARY 2018-19

What our Patients and Carers are saying about us

Support and care
96% ‘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.

Quality of life
83% say that things have got ‘A little’ or ‘Much’ better in terms of their overall quality of life.

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

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

Conversations
92% ‘Agree’ or ‘Strongly Agree’ that they’ve been given the opportunity to have honest, informed and timely conversations about what matters most to them.

Benefit
88% say the hospice is giving ‘Some’ or ‘A lot’ of benefit to how things are going for them at present.

Service user testimonials

The staff care a great deal about their patients. This shows all of the time. They are respectful, caring to not only their patients but also to family members like myself. (Inpatient Unit)

As a registered nurse myself, I thought I would find it difficult to allow anyone else to care for my Mum as I thought no-one else could possibly provide care better than me. I can honestly say that I was so wrong. All the nurses and nursing assistants from the Hospice at Home team have given my mum, myself and my family exceptional care, kindness and support. This in turn has allowed me to find comfort and strength at probably the most upsetting and difficult time in my life and I will be forever grateful. (Hospice at Home)

Our voluntary worker has been fantastic. Mom classes her as a friend. (Support at Home)

Nothing but praise for the way I’ve been looked after by all staff, doctors to cleaners and cooks. (Inpatient Unit)

As a daughter whose mother is terminally ill, I cannot thank (named Community Nurse) enough. She phones frequently and visits often. I can phone her anytime with any concerns I may have. (Community Team)

My son started counselling before the passing of his father and I really feel this helped him deal with the event...his counsellor was wonderful with him. (Child Bereavement Support)

A massive thank you to (named social worker) for helping sort out the legal help I needed. (Family and Carer Support)

Questions based on the DAOC Suite of Measures, Dame Cicily Saunders Institute & Kings College London. Also the Ambitions for Palliative & End of Life Care, NCPC and NHS Friends and Family. Total number questionnaires returned: 412
Part 3 – Review of Quality Performance

3.5 Benchmarking Activity

We have participated in the following benchmarking exercises:

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

We have been participating in this programme now for four years. Approximately 100 hospices participate nationwide and data is benchmarked per 1000 occupied bed days on a quarterly basis, focusing on the following 3 core patient safety metrics:

- Pressure ulcers
- Patient falls
- Medication incidents

Quarterly data is shared with the participants, with benchmarks established in categories by size of IPU (number of beds). These and other benchmarks are also applied to a Quality Dashboard which includes data from all clinical services and is reviewed quarterly by our Clinical Governance Committee.

Birmingham St Mary’s Hospice also takes part in Hospice UK benchmarking webinars with up to 40 participants from other hospices nationally, to ensure validity of the data submitted and discuss any changes in definition of metrics.

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

Birmingham St Mary’s Hospice has continued to be part of the West Midlands Regional Forum of ECLiHP, which aims to establish a network for support, information exchange and learning. From within this group, 10 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 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**

A new Quality Dashboard was developed last year for quarterly scrutiny by our Clinical Governance Committee. This dashboard includes data from all clinical services in the hospice, and work is ongoing to establish appropriate benchmarks for this data to enable us to identify any issues or trends in a timely fashion and act to determine the underlying causes. For example, as mentioned above, we have adopted Hospice UK benchmarks for some IPU 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. Work is now ongoing to investigate whether suitable comparison data can be identified to enable benchmarking of these indicators in the future.
3.6 Statements on Birmingham St Mary’s Hospice Quality Account for 2016/17

Statements requested from:

- NHS Birmingham and Solihull Clinical Commissioning Group (CCG)

See below

- NHS Sandwell and West Birmingham Clinical Commissioning Group (CCG)
Birmingham & Solihull Clinical Commissioning Group (BSOL CCG), as coordinating commissioner for Birmingham St Mary’s Hospice (BSMH), welcomes the opportunity to provide this statement for inclusion in the Hospice’s 2018/19 Quality Account.

A draft copy of the Quality Account was received by the CCG on the 14th June 2019 and the statement has been developed from the information presented to date in accordance with Department of Health guidance. This statement of assurance has been developed in consultation with neighbouring CCGs.

The Quality Account is presented in a reader friendly and accessible manner, and shows clear, quality based values. We note the 3 quality priorities for 2018/19 but would have like to have seen evidence of the outcome and clinical impact of this work on patients. We acknowledge that external influences impacted the slow progress of the bereavement service pilot.

The CCG recognise the level of service provided to patients as described in section 2.3.

Commissioners are pleased with the success of the 2018/19 CQUIN (Outcome Assessment and Complexity Collaboration (OACC)) and are fully supportive of this CQUIN continuing for a further year in 2019/20.

The Hospice are commended on their extensive collaborative working with other providers, and the CCG extend their congratulations on the awards received this year.

We note the increase in the number of patients admitted to the hospice with pressure ulcers and as a CCG are committed to working as a system to reduce all pressure ulcers. We were not clear from the report whether patients have acquired pressure ulcers during admission to the Hospice, but recognise the complexities of prevention at end of life.

We are pleased to see the compliments that St Mary’s have received from patients and families, however it would also have been helpful to have known whether the number of complaints had changed from last year.

There remains a clear focus on improving medicines management, with quarterly meetings held to discuss drug related incidents. It is positive to see that the Hospice has signed a confidentiality agreement to share information in order to collaborate with the local intelligence network for controlled drugs governance to improve the use, prescribing and management of controlled drugs.

There were 228 medication related incidents in 2018/19. BSol CCG would have like to see what steps the Hospice has taken to minimise the risk of the incidents reoccurring and how learning from incidents is shared across the organisation staff.

It is good to see that an internal audit showed evidence of safe and effective medicine management and administration were within guidelines. The Hospice has highlighted areas of focus to improve.
The Quality Account demonstrates a strong commitment by BSMH to education for their own staff and other health care professionals.

As Commissioners, 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 2019/20.

Paul Jennings
Chief Executive Officer
Birmingham and Solihull CCG
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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