Mary Ann Evans Hospice

Quality Account

Providing outstanding care for people approaching the end of life

Reporting period:

1st April 2017

to

31st March 2018

Our CQC Rating

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The impact of hospice services on our local community

I am extremely proud of the Hospice's achievements over the past year, as we have continued to extend our partnership working approaches and strengthen the impact of our services on our local community. The benefits of the local Working Together Board aspirations are evident in this report.

Elizabeth Hancock

Chief Executive

The exceptional work delivered by our staff and volunteers to the benefit of the community in northern Warwickshire is evident in this Quality Account. The Board of Trustees are extremely grateful for the whole team effort which achieves these standards of care.

Phil Robson

Acting Chair

Referrals

- A total of 693 referrals were received for our clinical services, with just over 370 people accessing care from our Day Hospice and Hospice at Home service, an average monthly caseload of 316 people receiving Lymphoedema treatment, 160 adults and 52 children benefitting from the support of our Bereavement team. Additionally, 127 of these received care from complementary therapy.
- The Day Hospice and Hospice at Home services provided care to 253 new patients. Approximately 55% were for people with cancer and 45% for non-cancer.
- Referrals continue to be received from primary and secondary care with a considerable number being from nurse specialists.
- The median age of patients receiving Day Hospice and Hospice at Home care was 65-74 years, however just over 25% of patients were aged over 85 years for Hospice at Home and 35% of Day Hospice being 75-84 years.
- Over 90% of patients receiving Hospice at Home care remain at home to die.

Caring for local people

Rapid Response (at night) service

- The 18 month pilot Rapid Response (at night) service provided in partnership with South Warwickshire NHS Foundation Trust (SWFT) commenced 1st November 2017 and together we provided 388 home visits for people with end of life care needs.
- Almost 100% of patients contacting the service received a home visit within 30 minutes of contacting the service.

Lymphoedema

- This service provided 3652 attended appointments
- 114 of the appointments provided assessments for new patients.
- 411 people attended our Healthy Steps – specific activity sessions for these patients.
- 97 attendances to our support group sessions.

Bereavement

- Over 300 adults and children were supported by bereavement service
- Over 2000 bereavement sessions were provided with an average of 8 sessions per individual.
- The service discharged approximately 40% of clients and has seen a reduction to, just under, 3 months approximately as the average length of time support was needed to be provided.

Patients' and Carers' Comments

"Excellent care and support for patient and carers. All staff/volunteers etc are very caring and approachable.

A very safe environment for patients. Would highly recommend to others."

I came with very complex needs; having a period of bereavement support has been life changing. I started to find myself, the fog cleared, and I let go of a huge weight of grief

"I found that the foot massage was beneficial with my circulation with my diabetes and swelling in my legs and feet."

"The staff we have dealt with have been very caring and supportive to myself and my wife. They are very friendly and kind and nothing is too much trouble."

"I think all staff are excellent in all areas, it's my first time to use the hospice. I couldn't believe what is provided; I would recommend it to all who need it."

"I cannot fault the service I receive from the lymphoedema clinic. The staff are very supportive and their treatment has vastly improved my quality of life."

"My experience of the day hospice is extremely good, and benefits me greatly. No matter how I feel when I arrive, I always go home relaxed and refreshed."

Our Chairman's statement about quality

The Quality Account for 2018 reflects the exceptional work delivered by our staff and volunteers to the benefit of the community in northern Warwickshire. Led by our Senior Leadership Team, the quality of clinical and bereavement services, including the support for carers is evident throughout. Less obvious, but equally important, is the effort of the staff and volunteers who run the shops and raise income for our charity. Without them none of the clinical outcomes would be possible and the care offered to families would suffer significantly. So, it is a whole team effort for which the Trustees are extremely grateful.

As a relative newcomer to Hospice Care, it still surprises me how little recognition there is for the locally relevant nature of our services and that as a charity we are substantially dependent on the generosity of beneficiaries, supporters and other philanthropic contributions. The grant received from the NHS has been frozen since 2012 and now constitutes 25% of our income rather than the 35% of 2012. At the same time, it has become increasingly challenging to generate income from other grant sources and donations. The Trustee Board is concerned that although national charities in the field can have the benefit of national widespread publicity, it is the local nature of the hospice movement which is its great strength, as illustrated in this Quality Account.

In this context, I am really pleased that we took the risk to enter an unfunded partnership with South Warwickshire Foundation Trust (SWFT) to deliver a rapid response service to patients and their carers living at home and facing crises outside normal working hours. SWFT provides community health care in northern Warwickshire and this partnership with the statutory sector is an example of the two sectors combining their resources to deliver synergy to the benefit of local people. A small amount of statutory resource has now become available in response to the initial success of the project reported in this document. This partnership approach with the statutory sector is very much the way the trustees want to see our services grow in the immediate future.

Phil Robson

Acting Chair

Registered Manager's Statement

Together with the Board of Trustees, I would like to thank all of our staff and volunteers for their achievements over the past year. It has been both an exciting and challenging year for us as we have developed and proposed a new clinical workforce structure. This structure aims to fulfil our ambitious strategy and vision ensuring we are able to continue to provide a vital palliative and end of life care service in partnership with other organisations. The Hospice is also committed to remaining focussed on partnership, sustainability and meeting local people's needs.

Over the past year, the Hospice has continued to provide a very good quality service however, financially this has been at times a concern and have had to apply for grants or use Hospice reserves to test new service approaches – for example our Rapid Response (at night) service, which is provided in conjunction with SWFT.

Our services are very much appreciated by our local population as testified in the previous direct quotes from feedback received. We have achieved this high level praise by providing the best possible cost-effective services we can to our patients and their families. The Hospice has a very lean clinical and bereavement structure and relies heavily on trained volunteers. The £1.2 million raised by our local community annually demonstrates how much our local community value the caring services we provide – Hospice at Home, Rapid Response, Day Hospice, Lymphoedema and Bereavement.

The Hospice has well-established business and clinical governance systems and processes. This also ensures we are able to critique the care provided by the Hospice and for this to remain a very high standard, whilst also encouraging us to strive for further improvement in the services delivered and the quality of the care we give. The Hospice takes its responsibilities under the Duty of Candour very seriously and has robust mechanisms in place underpinned by our culture of continuous quality monitoring.

We had our last unannounced Care Quality Commission inspection in August 2014, which was reported in January 2015. Our overall rating was "Good" for all aspects of the domains reviewed - safe, caring, effective, well-led and responsiveness. We submitted our most recent Provider Information Return in November 2016 at the request of the Commission.

The safety, experience and outcomes for all our patients and their loved ones are of paramount importance to us. To enable us to provide a caring and compassionate service, we continue to actively seek the views of our service users who have also contributed to this report.

I am responsible for the preparation of this report and its contents. To the best of my knowledge, the information contained in this Quality Account is accurate and a fair representation of the quality of healthcare services provided by our Hospice.

Mrs Kay Greene , Registered Manager

Background and summary information

The Mary Ann Evans Hospice (MAEH) underwent an unannounced inspection by Care Quality Commission (CQC) on 13th August 2014 under Section 60 of the Health and Social Care Act 2008. The Hospice achieved an overall rating of good, with grading's of good for safe, effective, caring, well-led and responsiveness. No areas of shortfall were identified. The Hospice continues to submit reports as necessary to the CQC which predominately are related to deaths of patients when a member of Hospice staff is present at the actual time of the death.

The Hospice has continued to provide quarterly activity reports to the NHS clinical commissioners of Hospice services using the framework provided. The Director of Clinical Services, who is the Registered Manager for the Hospice appreciates the opportunity to discuss the information contained in the Hospice's quarterly activity data and quality metric reports at the Hospice's Clinical Governance meetings. Through these discussions and reporting mechanisms, the Hospice is able to demonstrate its commitment to quality assurance and co-operation with others and to evidence the positive outcomes for patients and their families who receive Hospice care.

In developing the clinical services strategic plan, the Hospice has continued to pay regard to the rapidly changing health and social care environment and to embrace the local Working Together Board philosophy. The uncertainty and constant change mean that clinical services strategic plans have had to be reviewed to be flexible and realistic both in the short term as well as longer term.

Local context

The end of life population in the Warwickshire North Clinical Commissioning Group (WN CCG) area is approximately 1,400. Typically, 44% of deaths locally happen at home, either in a care home facility or in a private residence – MAEH at Home service will have been involved in approximately 25% of these deaths. Deaths in the acute setting are slightly above national average. The local Out of Hospital agenda sets out ambition to deliver care closer to home, and enable individuals to be seen and supported outside of an acute setting.

Delivering Cost-Effective Services

The Hospice receives approximately 25% of its funding from the NHS and the remaining 75% from the local community.

The 25% funding is provided by an NHS grant from WN CCG. The grant for 2017-18 remained static, which has been the case for the past seven years.

The Hospice has received confirmation of the NHS grant for 2017-2018, which has again remained static and is unlikely to contain any uplift in 2019-20. However, through our partnership working and as key provider organisation engaged with the local "out of hospital" collaboration: the Hospice will receive some funding towards the Rapid Response (at night) service for 2018-19.

The Hospice is very conscious of the continuing financial pressures on the charity and the need to improve income generation and continue to ensure services are cost effective. Our ambition is to continue to improve and develop services in accordance with local needs, whilst ensuring that this is accomplished within the realms of affordability.

Part 2 Priorities for Improvement

The improvement priorities we have identified for 2018-19 include feedback from some of our existing as well as previous patients and carers, as well as knowledge from our relationships with key partner providers and the strategic aspirations of the North Warwickshire End of Life Care Pathway.

Priority 1

Improving responsiveness of community end of life care services in partnership

The Hospice aims to improve the responsiveness of their community services to enable

- rapid assessments of urgent new referrals 24/7;
- rapid response to known patients whose condition is changing acutely;
- rapid commencement of Hospice at Home services.

This improvement to the service will further support enabling timely discharge from hospital for patients wishing to die at home and responsive Hospice at Home provision to patients in the community whose condition is deteriorating.

This improvement will be achieved by

- the introduction of a new Advanced Nurse Practitioner post – a shared funded post with SWFT. This post will directly support MAEH staff and community nursing teams with rapid assessment and support for changing needs of those at the end of life;
- continuing to evaluate and learn from the rapid response (at night) pilot and further developing the support provided to care homes
- exploring in partnership innovative rapid response services to cover across the 24 hour day – including review of the current 'rapid home to die' processes established with local acute trusts
- to assist with real-time service evaluation, an electronic (and paper) patient and carer satisfaction survey is being introduced in summer of 2018 – iWantGreatCare, further details available from: https://www.iwantgreatcare.org

This priority is in line with the North Warwickshire Working Together Board End of Life Care Pathway and fits with the strategic and operational aims of the collective partner providers.

Priority 2

Progress and embed new clinical workforce structure

The Hospice has reviewed the clinical workforce structure with an aim to fulfil our ambitious strategy and vision. The Hospice is very aware of the imminent impact of professional workforce challenges and seeks to prepare for this by the following:

- Introduction of a shared Advanced Nurse Practitioner position
- Introduction of a new role of Clinical Practice Educator to support professional development of existing staff, new staff recruited – looking towards Nursing Associates and Assistant Practitioner roles
- Additional remit of the Clinical Practice Educator is to initiate roles for clinical care volunteers
- Introduction of Clinical Services Team Lead with devolved leadership and day to day coordination responsibilities to Registered Nurses

The impact and effectiveness of this new workforce model will be evaluated over the 5 years of the strategic plan with an annual review to ensure flexibility and adaption as necessary to align with local and national workforce pressures.

This priority also fulfils the North Warwickshire Working Together Board End of Life Care Pathway and fits with the workforce development required for sustaining future service provision.

Priority 3

Newly bereaved partnership contact points

The MAEH bereavement service has been successful in obtaining a grant from the Masonic Charitable Foundation who kindly donated a large sum of money to Hospice UK for bereavement work. The service aims to make contact with bereaved people at a much earlier time of their bereavement. This improvement will be achieved by:

- Starting in May 2018 we will be working with the local Funeral Directors and the Crematorium to offer drop-in sessions for people who are newly bereaved.

- Working in partnership the drop in sessions will either be held at funeral directors or at our bespoke building, the Warren.
- People can stay with the drop in sessions or be signposted to one of the other strands of bereavement support within the Hospice.

The Director of Family Support will evaluate the impact and achievements of this project and report this to Hospice UK as part of the grant obligation. This feedback will be reported in the subsequent Quality Account.

The importance of pre and post bereavement support is included in the North Warwickshire Working Together Board End of Life Care Pathway and this priority contributes to fulfilling this particular domain of the pathway.

Our progress with improvement priorities identified for 2017-18

Priority 1

The Day Hospice rehabilitative and re-enabling 16 week programme of care will continue to be refined and developed to ensure patients care needs are fulfilled. The service will also complete a workforce planning review inclusive of a thorough appraisal of the skills and the training required to further advance service provision.

Progress:

1. The Director of Clinical Services (DCS) led a workforce planning review establishing more integrated working across clinical services. The review was completed and discussed with staff in January 2018. The new workforce structure became operational from 1st April 2018.

2. The Day Hospice team have successfully introduced the following:
   - Provided management of breathlessness training for staff supported by George Eliot Hospital NHS Trust specialist nurse.
   - Provided level 2 communication skills training to increase the confidence in dealing with difficult conversations and help recognise the need to escalate for more advanced support when necessary.
   - Trained a Senior Care Support Worker to provide FABS – a Flexibility/Aerobic/Balance/Strength programme for patients following the ethos of re-enablement in palliative care.

3. The clinical services have been involved in the Hospice's "I Matter" working group – see Chaplaincy.

Priority 2

The Hospice at Home service will have a key role in the recently developed innovative local end of life care pathway and will need to be able to respond timely to service developments such as "rapid response" and core level end of life care beds.

The steps towards this have been:

Progress:

1. The DCS and Advanced Nurse Practitioner contributed to a collaborative approach with key partners across Warwickshire and Coventry introducing an individualised plan of care (iPlan). The iPlan ensures all services can meet the requirements of the National Institute for Health and Care Excellence's (NICE) Quality Standard – Care of dying adults in the last days of life (March 2017).

Priority 3

The lymphoedema service had several key ambitions – extending patient self-management, sourcing prescription pads and securing much needed funding, they achieved the following:

Progress:

1. Developed a set of patient related information to assist with self-management of their treatments.
2. Unfortunately due to budgetary assignment complexities one of the Lymphoedema Nurse Specialists continues to wait for a prescription pad to enable patients to receive accurate hosiery prescriptions in a timely, efficient and effective manner.
3. The service was chosen as the Nuneaton and Bedworth Mayor's appeal for 2017-18 which has provided vital funding to raise awareness, provide updated equipment and to ensure the service continues.

Priority 4

The clinical services will continue to be a key provider of palliative and end of life care across North Warwickshire, and also further develop quality assurance and understanding of services provided through the following aspirations:

Progress:

1. DCS contributed to the local Out of Hospital Care Collaborative Design Board (OHCC) and facilitated progression of the aspirations of the OHCC End of Life Pathway. DCS has

become a member of the North Warwickshire Working Together Board which oversees and governs the OHCC.
2. Established a project team and within six months to provide pilot rapid response (at night) service – therefore contributing to meeting local needs in a timely manner, enhancing quality of life for people with long term conditions/end of life care needs, ensuring people have a positive experience of care, treating and caring for people in safe environments and protecting them from avoidable harm - key NHS Outcomes Framework Domains and Indicators.
3. Embedded the clinical dashboard and quality metrics framework ensuring all staff are reporting consistently and comprehend the purpose and benefits of data review.
4. Introduced the Karnofsky Score measure - one of the nationally established Outcomes Assessment Complexity Collaborative (OACC) measures subsequently further developing understanding of patient care needs.

Priority 5

The MAEH supports the 'Commitment to carers strategy' National Health Service – England (NHSE, 2016) and also seeks to ensure carers of people receiving the Hospices services are identified, involved, informed, engaged and supported in their caring roles.

Progress:

1. The Hospice has evaluated their carers café which commenced April 2016 and is delighted with the engagement and feedback received from local carers. The carers café have introduced information sessions on subjects or services requested by the carers attending.
2. Completed a review of data reporting of carers supported through introduction of the Carer Support Needs Assessment Tool© which has highlighted opportunities to improve in respect of Day Hospice patient carers in particular.

Priority 6

The MAEH is passionate and committed to engaging with our local communities and working with key stakeholders collectively contributing to the development of wider understanding of death and dying and building of community capacity.

Progress:

1. The Chief Executive Officer is contributing to Warwickshire's "Compassionate Communities" concept.
2. In May 2017, in conjunction with North Warwickshire Clinical Commissioning Group, George Eliot Hospital NHS Trust and Myton Hospice led on raising awareness across local communities by hosting four "Good Death Cafés" events across the area – Polesworth, Bedworth, Coleshill and Atherstone.

Priority 7 & 8

Bereavement & Chaplaincy

To further develop the children's services, review Light Up a Life service and model of spiritual care.

Progress:

1. Comprehensive training packages have been provided for volunteers specifically for the children's work.
2. The establishment has increased by one person one more day a week as planned; the staff member has received training to enable them to become familiar with all aspects of the children's work.
3. More volunteers have been recruited to work with children on a 1:1 basis and subsequently the provision of further training during the year and releasing some people from the adult work to work with youngsters.
4. A young people's drop in / support group once the youngsters have had the necessary immediate bereavement support was trialled however this did not evolve and is no longer operational.
5. Annual Light up a Life event was brought indoors at the Hospice event offering a more intimate space for people. The other three events held elsewhere in the Community remained the same.
6. The model of spiritual care was reviewed having visited another Hospice to gain some new ideas concerning this. A small team of staff and volunteers have supported the Director of Family Support to roll out this new model known as "I-Matter" and initial focus has been on ethos of Hospice staff.

Statements of assurance from the Board

The following are a series of statements that all providers must include in their Quality Account which demonstrate the Hospice's drive for quality improvement. Many of these statements are not directly applicable to Hospices.

Review of services

Between 1st April 2017 and 31st March 2018, the MAEH provided the following services:

- Day Hospice
- Hospice at Home
- Rapid Response (at night) from 1st November 2017

- Complementary Therapy
- Lymphoedema
- Family Support – including bereavement

The MAEH's Clinical Governance Committee (CGC) is a sub-committee of the Board, which meets three monthly. The CGC receives quality metrics and activity reports, which enables the group to review the quality of care provided by all clinical services. A Clinical Governance dashboard and a summary report are submitted to the Board of Trustees on a two monthly basis. A further CQC inspection is awaited and the Hospice will respect the request for specific quality data information to be reported to the WN CCG 2018-19.

Our participation in clinical audits

During 2017/18, the MAEH did not participate in any national audits. The Hospice does have a local clinical audit programme which is reviewed and approved each year, through the Clinical Governance committee. Priorities are selected in accordance with what is required by our regulators and any areas where a formal audit would inform the risk management processes within the Hospice. In 2017/18 the following audits were proposed, and where completed the results and subsequent actions required reported to the Clinical Governance committee:

Mary Ann Evans Hospice

CLINICAL AUDIT PROGRAMME 2017-18

AUDIT	CLINICAL DEPARTMENT	PERSON RESPONSIBLE	DATE & OUTCOME
INFECTION CONTROL	Day Hospice, Hospice at Home, Lymphoedema & Complementary Therapy	GEH IPC Lead Nurse & TL Anita Ashby	September 2017
PATIENT AND CARER SATISFACTION	Day Hospice & Complementary Therapy, Hospice at Home	ANP Lorna Manders	May – July 2017 (in progress of reporting)
	Lymphoedema	TL Kay Hill	
MOVING & HANDLING	Day Hospice & Complementary Therapy, Hospice at Home	TL Anita Ashby	December 2017
	Lymphoedema	TL Kay Hill	
DOCUMENTATION	Day Hospice & Complementary Therapy, Hospice at Home	ANP Lorna Manders	October 2017
	Lymphoedema	TL Kay Hill	
INFORMATION GOVERNANCE	All	Liz Hancock & Kay Greene	Completed April 2017
PHASE OF ILLNESS	Day Hospice & Complementary Therapy, Hospice at Home	ANP Lorna Manders	November 2017
	Lymphoedema	TL Kay Hill	
NURSE PRESCRIBING	All (except complementary therapy)	ANP Lorna Manders & TL Kay Hill	January 2018
CARER SUPPORT PLANS	All (except complementary therapy)	TL Anita Ashby	August – September 2018
CLINICAL POLICY & PROCEDURE AWARENESS	All	Kay Greene	July 2017 (in progress – awaiting Team Lead feedback)
NICE Clinical Guidelines for Care of the Dying Adult (2015)	Hospice at Home	TL Anita Ashby	By March 2018
NICE Quality Standard for End of Life Care (2011)	Day Hospice & Complementary Therapy, Hospice at Home	ANP Lorna Manders	By March 2018
NICE Supportive Palliative Care for Adults with Cancer (2004) – note currently being revised to cover adults with all conditions (anticipated January 2018 – await this)	(anticipated January 2018 – await this)	(anticipated January 2018 – await this)	(anticipated January 2018 – await this)

Department: Clinical Services
Originator: Director of Clinical Services
Date of development: 24th March 2017
Date of next review: November 2017

Due to workforce challenges, in particular senior staff absences the following audits were completed:

1. Infection Control	2. Information Governance
3. Patient and carer satisfaction	4. Clinical Policy and Procedure awareness
5. Documentation	

Audit summary

Through the Clinical Governance Report, the Board of Trustees is kept fully informed about the audit results and any identified shortfalls. Through this process, the Board receives assurance of the quality of the services provided and the management of clinical risks.

Research

During 2017-18, the Mary Ann Evans Hospice has continued to be research active, and maintains a research register. In particular the Hospice has contributed to the following:

- We continued to participate in the – the PLACE trial (Prevention of Lymphoedema after Axillary Surgery by External Compression) – a national trial. Last year we reported that three patients continued in the study, this year two patients are receiving regular follow up as per the research guidelines.

- The DCS in their voluntary capacity as Research Lead for the National Association for Hospice at Home is a co-applicant on a three year national research study investigating optimal Hospice at Home provision. An article is due to be published in the British Medical Journal outlining the progress of Phase 1 of this study.

What others say about us

The MAEH is required to register with the CQC and its current registration status is unconditional. The CQC has not taken any enforcement action against the MAEH during 2017/18.

The MAEH is subject to regular inspections by the CQC. The last on-site inspection was undertaken in August 2014, and reported January 2015. The Hospice achieved an overall rating

of good. A Provider Information Return was requested by CQC, completed and submitted in November 2016. In December 2016, two Trustee representatives of the Hospice Clinical Governance sub-committee undertook a mock inspection. All subsequent suggested actions or ideas were responded to by the DCS and the Clinical Services Team Leaders. (See page 1 of this report for an image of our CQC rating).

Data quality

In previous years, in accordance with agreement with the Department of Health, the MAEH has submitted a National Minimum Dataset (MDS) to Hospice UK (formerly to the National Council for Palliative Care). However since April 2017 the submission of this data to Hospice UK is entirely voluntary and MAEH has chosen to continue to provide this data.

In the previous Quality Account, one of the priorities for improvement was in respect of development and embedding of a key activity data matrix and quality metrics dashboard. This has been successfully achieved and is shared for discussion with relevant staff, Clinical Governance group and Board of Trustees.

Information Governance Toolkit attainment levels

The Information Governance Assessment Report (provided by our IT supplier George Eliot Hospital NHS Trust) overall score for 1st April 2017-31st March 2018 was 76% and was graded green.

IG Toolkit Assessment Summary Report: GEORGE ELIOT HOSPITAL NHS TRUST (Acute Trust)
Prepared on 29/03/2018

Overall

Assessment	Stage	Level 0	Level 1	Level 2	Level 3	Not Relevant	Total Req'ts	Overall Score	Self-assessed Grade
Version 14.1 (2017-2018)	Published	0	0	31	13	1	45	76%	Satisfactory
Version 14 (2016-2017)	Latest	0	0	32	12	1	45	75%	Satisfactory

Assessment	Stage	Level 0	Level 1	Level 2	Level 3	Not Relevant	Total Req'ts	Overall Score	Self-assessed Grade
Version 14.1 (2017-2018)	Published	0	0	31	13	1	45	76%	Satisfactory
	Target	0	0	39	5	1	45	70%	Satisfactory
Version 14 (2016-2017)	Published	0	0	32	12	1	45	75%	Satisfactory
	Target	0	0	42	2	1	45	68%	Satisfactory

This paper was prepared following the review, and submission of V14.1 IG Toolkit Assessment on 29th March 2018. The minimum requirement to obtain a satisfactory rating is Level 2, with supporting evidence. This submission shows an overall improvement on Version 14 submission in

2016/17 at 75%. 31 requirements were submitted as Level 2 (32 V14) and 13 at Level 3 (12 V14). This level of submission had been achieved despite an annual increase in robustness of criteria/evidence required.

Duty of Candour

The Hospice takes its duty of candour very seriously. All clinical related incidents are reported through the Hospice incident reporting system. The DCS is also the Hospice's nominated "Freedom to Speak Up Guardian". All staff, including volunteers, are able to report incidents. All clinical incidents are evaluated by the collective Senior Leadership Team and subsequently the Hospice's Clinical Governance Sub-Committee and ultimately reported to the Hospice's Board of Trustees.

Patients and their carers have ready access to the Clinical Services Team Lead should they wish to discuss any concerns. All incidents, adverse comments, and complaints are reported in the quarterly quality reports.

Learning From Deaths

In July 2017, the Department of Health and Social Care published an amendment to the NHS (Quality Accounts) Regulations which added a new mandatory disclosure relating to 'Learning From Deaths'. The Hospice's core business is to contribute to the care of the local dying population and ultimately whilst death is unavoidable, it is understood on occasions death is untimely, unexpected. The DCS is a contributory member of the WN CCG's Mortality Oversight Group and more recently is also a reviewer, on behalf of the WN CCG, for the LeDeR programme – a national programme investigating the deaths of people known to have a learning disability.

Part 3 A review of quality performance

As part of the quality performance review, the Hospice has chosen to present information from their MDS submissions, which is the only Hospice activity information presently collected by Hospice UK on behalf of Hospices nationally.

The figures below provide information on the activity and outputs in relation to care provided to patients and clients and a short analysis of this data is provided for each service presented.

Quality markers and patient safety incidents are reported subsequently.

DAY HOSPICE	2017-18	2016-17	2015-16
Total patients	175	147	99
New patients	67	105	47
% New patients	40%	70%	47.5%
Continuing patients	55	42	52
New patients 25 – 64 years	16	17	15
New patients 65 – 74 years	21	24	12
New patients 75 – 84 years	19	43	15
New patients over 85 years	8	17	5
All female patients	108	85	58
All male patients	67	62	41
All cancer diagnoses	65	77	68
All non-cancer diagnoses	108	70	31
% New patients with non-cancer diagnoses	44%	64%	31.3%
Day care sessions	251	253	232
Day care places	3765	3795	3480
Day care attendances	1570	1645	1706
Number booked attendances – did not attend	719	655	587
% Places used	42%	43.5%	49.0%
Deaths and discharges	134	178	53
Average length of attendance (days each week)	12.1	39.2	39.1

The above data demonstrates the significant move towards rehabilitative and enabling palliative care as well the encouraging increase of care provided for patients with a non-cancer diagnosis. There continues to be a pleasing increase in the total number of patients receiving Day Hospice care and the average length of attendance is as expected at circa 12 days for each patient attending one day a week in the 16 week programme of care. As the patients who are attending are living with long term conditions and/or at the end of the lives it is not surprising that people are often too unwell to attend or may be receiving outpatient treatment e.g. chemotherapy or inpatient hospital care as a palliation of their illness.

There has been some impact upon the Hospice at Home service (see table below) in relation to receiving a reduced number of referrals for people rapidly approaching the end of life in hospital and wanting to be cared for at home. This was swiftly reported to our colleagues when a trend became noticeable. Both partners worked together to raise the profile of what the service has to offer. This continues to be monitored with 10 cases in quarter 4 of the year as opposed to 3

cases in quarter 3. The overall percentage of people remaining at home to die when receiving care from Hospice at Home remains high at 90%.

HOSPICE AT HOME	2017-18	2016-17	2015-16
Total patients	200	246	236
New patients	186	228	228
% new patients	94%	93%	95.9%
Continuing patients	14	17	8
New patients 16 -24 years	0	1	2
New patients 25 – 64 years	37	37	44
New patients 65 – 74 years	57	75	58
New patients 75 – 84 years	52	87	70
New patients over 85 years	54	42	60
All female patients	84	116	120
All male patients	116	130	116
All cancer diagnoses	148	191	166
All non-cancer diagnoses	52	54	64
% all patients with non-cancer diagnoses	35%	28.5%	39%
Deaths and discharges	186	229	234
Deaths	163	162	168
Home deaths	146	133	140
Care home deaths	0	1	0
% home and care home deaths	90%	93%	83%
Average length of care	8.8	9.3	7.6

LYMPHOEDEMA	2017 -18	2016 - 17	2015 - 16
Total patients	325	296	275
New patients	96	101	117
% New patients	29.5%	34.1%	42.5%
% New patients 16 - 24	0%	0%	1.3%
% New patients 25 - 64	49.4%	46.9%	49.4%
% New patients 65 - 84	49.4%	48.4%	42.6%
% New patients over 84	1.2%	6.25%	6.7%
All female patients	286	265	249
All male patients	26	31	26
All cancer diagnoses	325	296	275
Appointments (1 hour average)	3536	3406	3124
Support Group Attendance	97	127	144
Healthy Steps Attendance	411	587	582
Deaths and discharges	56	48	49

The lymphoedema service continues to have an ever expanding caseload. Discharge rates have increased showing the team are trying to reduce the caseload once patients are managing the condition independently. The number of referrals has dipped slightly this year, however, the total number of contacts have increased which is pleasing given the 0.4 WTE reduction in staffing establishment. The reduced attendance at the Support Group and Healthy Steps has led the team to consider ways to ensure these two valuable additions to the lymphoedema service are more widely utilised.

Our bereavement services continue to demonstrate growth and the need for this care and support for local people, including children – over 65% increase in new service years in two years from 2014-15 to 2016-17. Although not demonstrated in the data below, the children's work in 2017-18 provided 220 specially trained volunteer contacts on a 1-1 basis.

BEREAVEMENT	Hospice 16-17	Hospice 15-16	Hospice 14-15
Total service users	325	267	193
New service users	178	164	107
% new service users	54.8%	61.4%	55.4%
All female service users	234	194	140
All male service users	91	73	53
Total contacts	2367	2291	1585
Contacts per service user	7.2	8.6	8.2
Phone calls per service user	1.0	1.0	0.4
% of contacts which were group sessions	39.7%	31.9%	38.2%
Average length of support	70.0	132.0	n/k
Discharged	182	110	175
% discharged	56%	41.2%	40.3%

**Note this data is exclusive of report year.*

The following extract of data demonstrates the impact the pilot Rapid Response (at night) service is having in a very short space of time since onset:

RAPID RESPONSE DATA & OUTCOMES				
2018	**JAN**	**FEB**	**MAR**	**TOTAL**
Total home visits requested in month	96	68	101	**265**
Total home visits carried out in month	96	68	101	**265**
Total number of patients seen in month	38	35	49	**122**
Timeliness				
% visits within 30mins of call received	99	96	99	**98**
% visits within 30mins-2hrs of call received	1	4	1	**2**
% visits within 2+hrs of call received	0	0	0	**0**
Primary Intervention Delivered at Each Visit:				
Pain & symptom management, incl. syringe driver	7	3	3	**13**
Pain & symptom management, not syringe driver	44	32	37	**113**
Personal care	2	3	1	**6**
Reduce patient and/or carer anxiety	17	6	20	**43**
Provide advice and information on EoL care	7	0	0	**7**
Other	17	14	23	**54**
Verification of Death	2	10	17	**29**
Patient outcome from visit:				
Patient remained at home	33	25	31	**89**
Patient died at home	5	10	17	**32**
Patient went to hospital – clinical need	0	0	0	**0**
Patient went to hospital – patient/carer preference	0	0	1	**1**
System outcomes:				
No. visits that prevented going to hospital	0	2	5	**7**
No .visits prevented 111/999 call out	3	0	0	**3**
No visits prevented Out of Hours call out	54	48	54	**156**

QUALITY METRICS DATA				
2018	***JAN***	***FEB***	***MAR***	***TOTAL***
Service Feedback				
No. Rapid Response Feedback Questionnaires returned - Total	13	4	9	**26**
Other forms of positive feedback	2	4	1	**7**
Concerns (verbal, written - via feedback cards) - Total	0	0	0	**0**
Complaints – Total	0	0	0	**0**

DEMOGRAPHIC DATA of PATIENTS SEEN				
2018	**JAN**	**FEB**	**MAR**	**TOTAL**
Visits by primary diagnosis of patient:				
Cancer	15	16	19	**50**
Leukaemia	1	0	1	**2**
Heart Failure	0	0	2	**2**
Chronic respiratory disease	3	1	3	**7**
Dementia / Alzheimer's	6	6	8	**20**
Chronic renal failure	0	1	0	**1**
All other non-cancer	13	11	16	**40**
Age of patients visited:				
Under 65	7	6	8	**21**
65 – 74	11	6	15	**32**
75 +	20	23	26	**69**
% Patients Male	68%	46%	53%	**56%**
% Patients Female	32%	54%	47%	**44%**
Monitoring Demand				
Call received between 21.45 –12pm	33	20	29	**82**
Call received between 00.00 – 4am	38	28	34	**100**
Call received between 4 – 8.15 am	25	20	38	**83**
No. patients seen more than 10 times in Qtr	X	X	X	**1**
No. patients seen more than 15 times in Qtr	X	X	X	**0**
No. patients seen more than 20 times in Qtr	X	X	X	**0**

The service is receiving high praise not only from patients and carers – some of whom have written directly to the CQC commending the service but also from local GP's, Macmillan nurses, secondary care frailty colleagues.

National currency

For the core clinical services provided the Hospice has continued to capture the currency units likely to be introduced by NHS England subsequent to a national Hospice pilot. The patient population profiles in term of phase of illness are shown below:

OACC *phases of illness* ***(Outcomes Assessment Complexity Collaborative*)***	**Hospice at Home**	**Day Hospice**	**Lymphoedema**
Number of patients in stable phase	189	655	1226
Number of patients in unstable phase	62	40	16
Number of patients in deteriorating phase	178	70	10
Number of patients in dying phase	124	0	2
Number of carer support plans	320	Not recorded	Not recorded

The phase of illness enables the Hospice to capture at what stage of palliative and/or end of life care each person may be in. Patients move between phases – not always in a linear mode, hence the numbers may seem much greater than the total Hospice patient cohort. Given that the majority of lymphoedema patients for example are not palliative it is not surprising that many of these patients are "stable". Similarly, a significant proportion of Day Hospice patients will be at a more stable phase of the long term/palliative condition when receiving our care – this helps the Hospice to prepare patients and their families for their end of life care and discuss advance care planning wishes too. Hospice at Home will by the nature of their service see the majority of patients, whom are dying or deteriorating, and when patients start accessing the service many of them are close to dying but are stable before they deteriorate and then become "actively" dying.

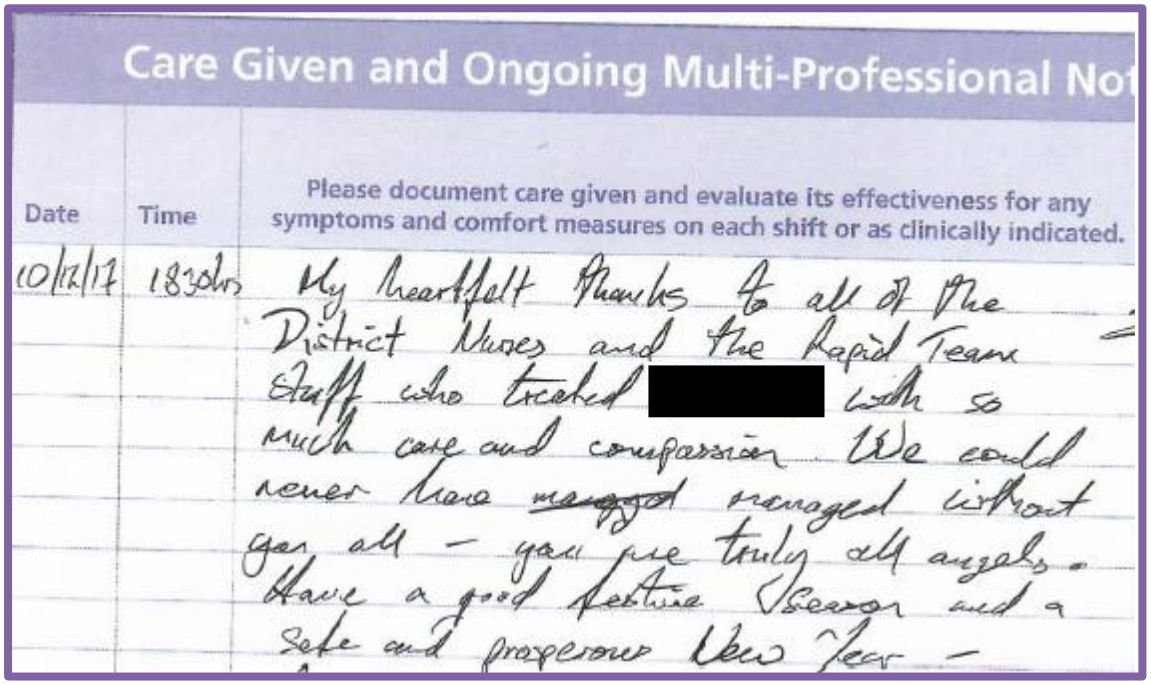
*Palliative Care Outcomes Collaboration (PCOC) Assessment Toolkit. University of Wollongong, Australia: PCOC; 2012. *As cited in the Outcome Assessment and Complexity Collaborative (OACC) 2015 and having been piloted in respect of NHSE palliative care funding initiatives.*

Quality Markers and Patient Safety Indicators

INDICATOR	2017/18	2016/17
Complaints		
Number of Complaints (clinical)	1	4
Number of Complaints (non-clinical)	4	2

INDICATOR	2017/18	2016/17
Patient Safety Incidents		
Number of Serious Patient Safety Incidents (excluding falls)	0	0
Number of Slips, Trips and falls	2	0
Number of Patients who experience a Fracture or other Serious Injury as a result of a Fall	0	0
Other Incidents Directly involving patients = 10 Total clinical related = 16	14	6

What patients say about the Hospice



Care Given and Ongoing Multi-Professional Not

Date	Time	Please document care given and evaluate its effectiveness for any symptoms and comfort measures on each shift or as clinically indicated.
10/12/17	1830hrs	My heartfelt thanks to all of the District Nurses and the Rapid Team staff who treated [redacted] with so much care and compassion. We could never have ~~managed~~ managed without you all – you are truly all angels. Have a good festive season and a safe and prosperous New Year –

From: XXXXXX
Sent: 12 April 2018 20:46
To: Greene Kay
Cc: email-enquiries@cqc.org.uk;
Subject: XXXXXX

Hospice Personal Care at Home Team
Mary Ann Evans Hospice

[redacted]

Reference - [redacted]

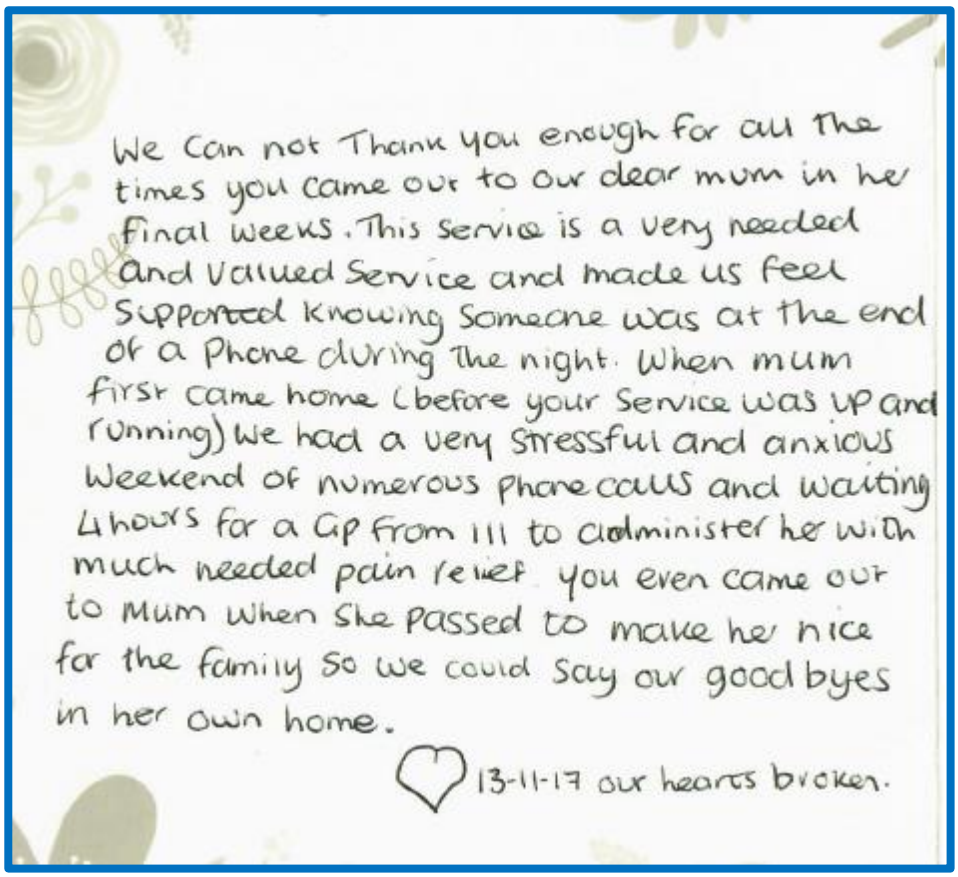
Bernard, Carol and Colin would like to take this opportunity to pass on our most grateful thanks for the excellent and sympathetic, personal care and attention received by Betty and the family, during her recent end of life care programme.

This enabled Betty to be at home with her family around her for her remaining days
Your compassion, excellent care and humour lightened the mood, for her and all of us at this most difficult of times.
Our most grateful thanks and appreciation are more than due to each and everyone of you

Sincerely

Bernard, Carol and Colin

**Names published with kind permission of Bernard, Carol and Colin*



We can not Thank you enough for all the times you came out to our dear mum in her final weeks. This service is a very needed and valued Service and made us feel supported knowing someone was at the end of a Phone during the night. When mum first came home (before your Service was up and running) we had a very stressful and anxious Weekend of numerous phone calls and waiting 4 hours for a Gp from 111 to administer her with much needed pain relief you even came out to Mum when she passed to make her nice for the family so we could say our goodbyes in her own home.

13-11-17 our hearts broken.

[redacted]

you have helped me so much physically and emotionally during our treatment times.

I can't thank you enough.

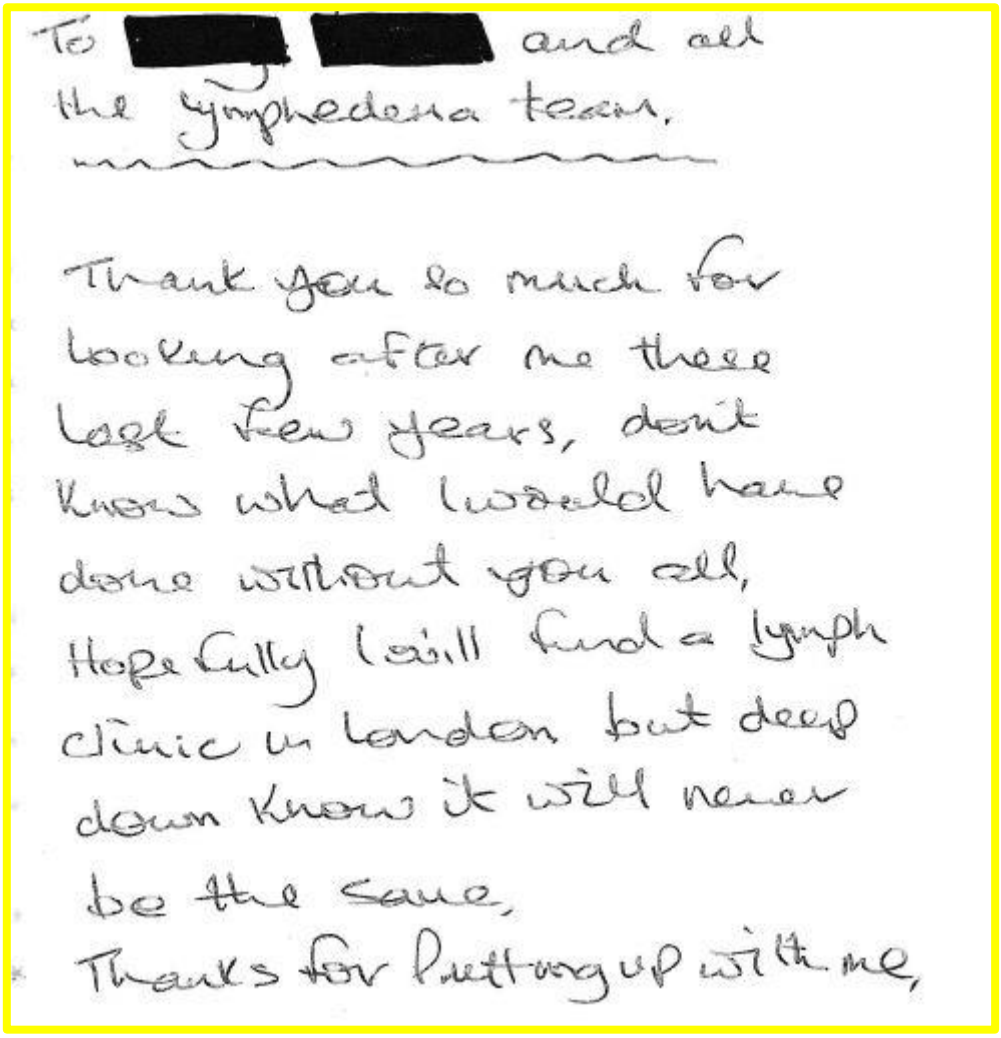
Love

[redacted]

xxx

Please add any comments / suggestions you would like to make about your experience with the Hospice's Bereavement service

The Bereavement support I received was more than helpful, it made me a much stronger person and in the way that I learnt to overcome my emotions most of the time by way of acknowledging what I had and being able to talk myself back to a positive place. It was a time where I could express my emotions and feel understood at what was the most difficult time in my life.


To [redacted] [redacted] and all the lymphedema team,

Thank you so much for looking after me these last few years, don't know what I would have done without you all, Hopefully I will find a lymph clinic in London but deep down know it will never be the same,
Thanks for putting up with me,

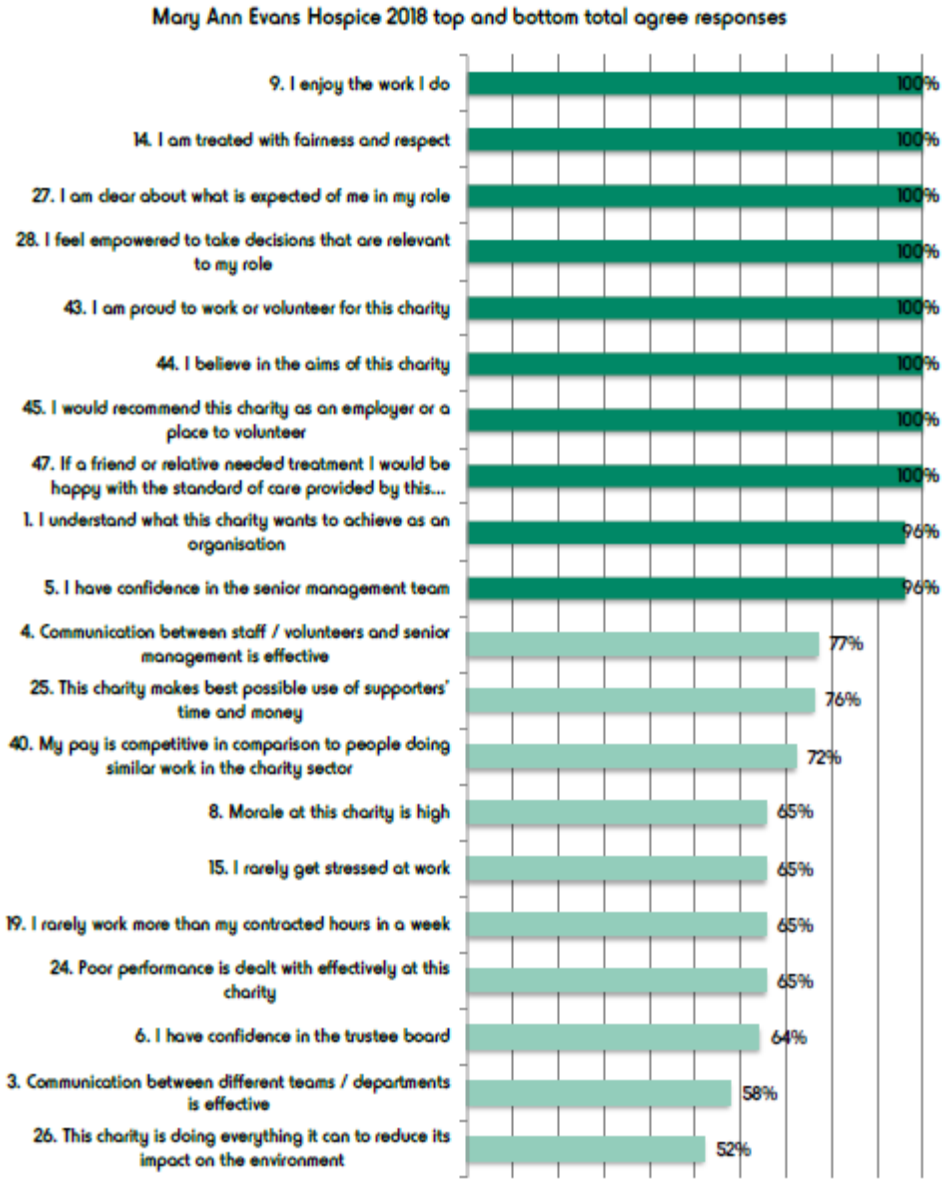
How we capture patient and carer feedback provided during episodes of care

To assure patient and carer satisfaction, the Hospice used an annual questionnaire survey to monitor the quality of the services provided. Feedback is of course welcomed and encouraged all through the year, and to demonstrate our commitment to providing opportunities for real-time monitoring the Hospice is introducing iWantGreatCare in 2018. Real-time monitoring is consistent with the requirements of the fundamental standards of care and enables staff to take immediate action to address any issues raised.

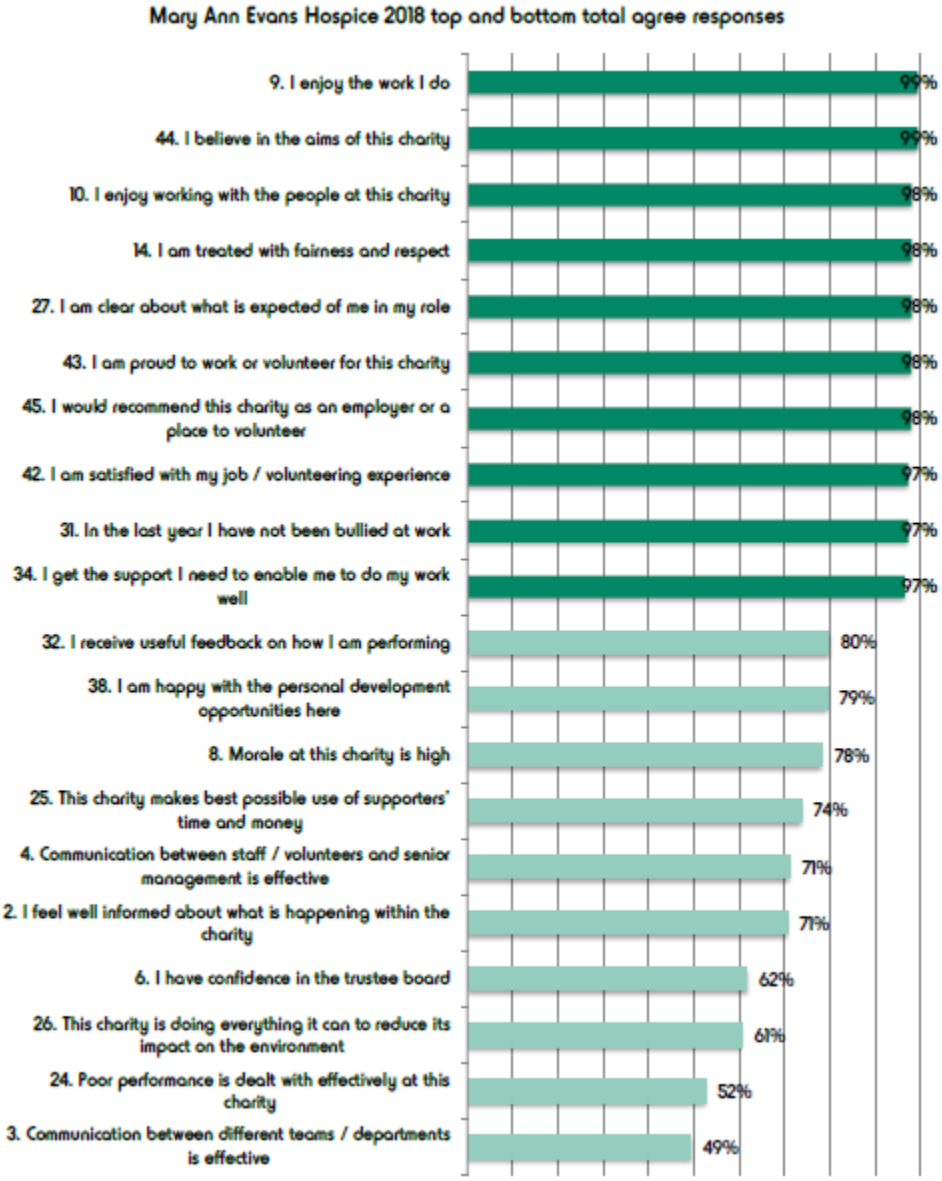
What our staff and volunteers say about us

National staff survey

We took part in the Hospice UK national Birdsong survey in January 2018, this enabled the Hospice an opportunity to compare themselves to other Hospices across the UK. Below is a snap shot of the top and bottom 10 things staff said about MAEH:



Additionally this is what our volunteers said:



Overall we are delighted with the feedback received and plan to use the constructive feedback throughout 2019 to further develop our relationships with our staff and volunteers.

Staff Turnover

The Hospice has a vast volunteer workforce and paid staff headcount is kept to a minimum. The staff turnover as a collective figure for all Hospice staff (including retail etc) is 14.66% (an average of previous 3 years) – this figure includes all zero hour contract staff.

Recruitment and retention of staff and volunteers remains a key priority for the Hospice. The Hospice recognises there has been a degree of essential organisational change and therefore any uplift in turnover is unsurprising.

Who has been involved with this report

The DCS has involved hospice patients and carers, the Clinical Services Team Lead and the Director of Family Support and Bereavement in the first draft of this report. Subsequently the report has been circulated to the Chief Executive Officer, Chairman of the Hospice's Board of Trustees, and on 18th May to all Trustees and to the following Commissioners, local scrutineers and key partner providers, inviting feedback by 19th June 2018 for inclusion in the final published report:

1. Warwickshire North Clinical Commissioning Group
2. Warwickshire HealthWatch
3. Nuneaton and Bedworth Borough Council Overview and Scrutiny Committee
4. Warwickshire County Council & Public Health Warwickshire
5. North Warwickshire Borough Council
6. Nuneaton and Bedworth Borough Council
7. Coventry & Warwickshire Partnership Trust
8. Chief Executive, George Eliot Hospital, Nuneaton
9. South Warwickshire NHS Foundation Trust

The Hospice was delighted to receive formal responses from the Warwickshire North Clinical Commissioning Group, the George Eliot Hospital NHS Trust and the South Warwickshire NHS Foundation Trust. The responses are included on the following pages:

NHS
Warwickshire North
Clinical Commissioning Group

Nursing and Quality
2nd Floor, Heron House
Newdegate Street
Nuneaton
Warwickshire
CV11 4EL

Telephone: 02476 324399

21st June 2018

Dear Kay,

Re: CCG Response to Mary Ann Evans Hospice Quality Account 2017/18

NHS Warwickshire North Clinical Commissioning Group (CCG) welcomes the opportunity to comment on the Mary Ann Evans Hospice Quality Account. The CCG believes that the Quality Account for 2017/18 meets the minimum required content as set out in national guidance and contains an accurate reflection of the quality of services provided by the Hospice.

The data fields which have been completed in the draft account have been reviewed by the CCG against data sources available to the CCG as part of quality, contracting and performance to confirm them as accurate.

The Hospice has worked in the spirit of openness and partnership with the CCG over the last year to further develop and strengthen working relationships. This is demonstrated by their participation in a range of quality and patient safety related working groups, forums and committees across the health economy, including:

- Membership of the Warwickshire North Palliative Care Network.
- A key partner on the Out of Hospital Design Board.
- Working closely with the local acute hospitals and setting out a joint ambition for End of Life (EoL) care.
- Successfully commencing a new Rapid Response End of Life at Night service to provide out of hours support to people and their carers at home, in partnership with South Warwickshire NHS Foundation Trust.
- Being commissioned to support primary care with the roll out and implementation of an Electonic Palliative Care System (EPaCCs).
- Engagement with young people at a local college on the subject of death and dying for Dying Matters week 2018.

Mary Ann Evans Hospice is also involved in work at a national level and was recently noted in a British Medical Journal article for a project completed in collaboration with others.

Mary Ann Evans Hospice care includes day hospice, hospice at home, lymphoedema treatment and bereavement support.

Patient feedback is obtained through the annual questionnaire survey and individuals sending in expressions of thanks for the care given to their relatives. The CCG also receives feedback from patients and GPs whose patients have benefitted from the services.

The CCG is pleased to be working with Mary Ann Evans Hospice in supporting patients approaching End of Life. Their input has had a positive effect across the whole health economy.

Quality & Equality First

Chair: Dr Deryth Stevens
Chief Officer: Andrea Green

In conclusion, we recognise that the Mary Ann Evans Hospice has worked tirelessly to improve its services in collaboration with the local area in the last year and can confirm that we fully support the priorities identified by the Hospice in its Quality Account for 2017/18.

Yours sincerely

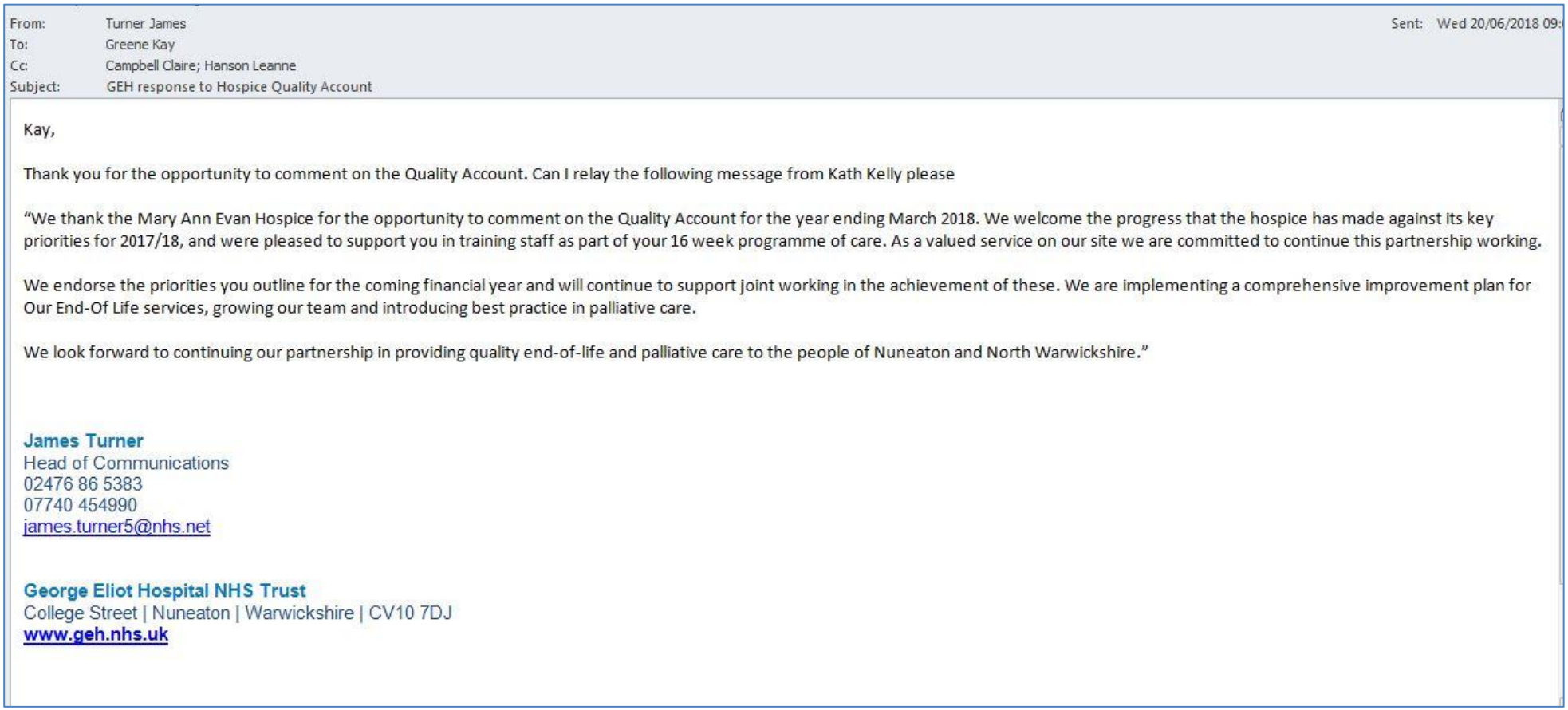
Rebecca Bartholomew
Director of Nursing and Quality

Quality & Equality First

Chair: Dr Deryth Stevens
Chief Officer: Andrea Green

Annex

What others say about the organisation



From: Turner James
To: Greene Kay
Cc: Campbell Claire; Hanson Leanne
Subject: GEH response to Hospice Quality Account
Sent: Wed 20/06/2018 09:

Kay,

Thank you for the opportunity to comment on the Quality Account. Can I relay the following message from Kath Kelly please

"We thank the Mary Ann Evan Hospice for the opportunity to comment on the Quality Account for the year ending March 2018. We welcome the progress that the hospice has made against its key priorities for 2017/18, and were pleased to support you in training staff as part of your 16 week programme of care. As a valued service on our site we are committed to continue this partnership working.

We endorse the priorities you outline for the coming financial year and will continue to support joint working in the achievement of these. We are implementing a comprehensive improvement plan for Our End-Of Life services, growing our team and introducing best practice in palliative care.

We look forward to continuing our partnership in providing quality end-of-life and palliative care to the people of Nuneaton and North Warwickshire."

James Turner
Head of Communications
02476 86 5383
07740 454990
james.turner5@nhs.net

George Eliot Hospital NHS Trust
College Street | Nuneaton | Warwickshire | CV10 7DJ
www.geh.nhs.uk

From: Rosie.Mcdonnell2@swft.nhs.uk
To: Greene Kay
Cc: Anne.Coyle@swft.nhs.uk
Subject: Quality accounts
Sent: Mon 18/06/2018 15:23

Hi Kay please see below our response for your quality accounts . Please let me know if you need anything else.

South Warwickshire NHS Foundation Trust have worked in partnership with Maryann Evans for several years now. In the past year we have worked together in designing and launching an overnight service for the residents of Nuneaton , Bedworth and North Warwickshire, with great success and high praise from the CQC .

We hope to continue to work together to co-produce more services for the residents of Nuneaton, Bedworth and North Warwivkshire.

Many thanks

Rosie

Rosie McDonnell
Head of Nursing for the Out of Hospital Care Collaborative Division
South Warwickshire NHS Foundation Trust

maryannevans.org.uk
Mary Ann Evans Hospice
Eliot Way, Nuneaton, Warwickshire, CV10 7QL
t. 02476 865440 e. maehenquiries@geh.nhs.uk

Our Mission Statement

Vision

Patients, families and carers in our community experience a journey towards end of life and into bereavement that is supported, comfortable, safe and personalised and is in a place of their choice

Mission

The Mary Ann Evans Hospice will provide comprehensive, high quality support and end of life care across our community through all the services we provide to patients and those close to them

We will do this in collaboration with others where appropriate
We are committed to training, supporting and encouraging our staff and volunteers to achieve our mission

Strategic Aims

The Mary Ann Evans Hospice will be recognised as being the lead provider for comprehensive and high quality community end of life care and support

The Mary Ann Evans Hospice will promote open attitudes in our community towards death and dying and provide bereavement support to all that need it

The Mary Ann Evans Hospice will maximise organisational impact through robust financial management and growing support of our community