John Taylor Hospice

Quality Account 2015/16
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In-Patient Unit staff with a patient celebrating her 90th birthday
Part 1 - John Taylor Hospice statements

1.1. Chief Executive statement

I am delighted to present the second Quality Account on behalf of John Taylor Hospice Community Interest Company, detailing the work of our company and the quality initiatives we want to take forward in 2016/17. We are a hospice service which provides specialist palliative and supportive care to Birmingham and the surrounding areas. Founded in 1910, we are the oldest non-denominational hospice in the UK and, after commencing our journey as part of the NHS, staff at John Taylor Hospice took the decision in 2011 to become a community interest company limited by guarantee and continue to develop as a successful membership organisation.

We continue to believe that ‘every moment matters’ and work to keep quality at the heart of the organisation, striving to provide holistic care when and where our patients need it, 24 hours a day, 7 days a week. This year we have strengthened our approach to how we monitor quality and safety of the services we provide by increasing and revising the information we collect to assure ourselves we are doing the right thing and reporting this to the Audit, Risk and Assurance Committee (ARAC) which is our Board subcommittee which focuses on the overall quality of the organisation. Some of this information we share with you in this Quality Account.

We also continue to be externally regulated which provides us with the external assurance that our services are safe and effective. The latest inspection by the Care Quality Commission (CQC) was in November 2013 and all standards inspected were fully met, the inspection report affirmed that our patients were protected and care was delivered safely. We were visited by the CQC in May 2016 and are awaiting the resulting inspection report. We completed and submitted our Provider Information Return in April 2016. We also continue to be regulated by Social Enterprise UK and hold the Social Enterprise Gold Mark standard.

In 2015/16 we also saw the extension and development of partnership working with other colleagues across the city both within the acute hospital sector and with our clinical commissioning group (CCG) and neighbouring hospice colleagues. We are committed to building on this to ensure that the population of Birmingham and surrounding areas have access to high quality end of life services that are safe, responsive, effective and efficient. We welcome the views of our commissioners and other local stakeholders on our Quality Account.

Finally I would like to take this opportunity on behalf of the Board of Directors and Membership Councillors to thank all of our staff, volunteers and supporters for their commitment and hard work over the last year. We move ahead into 2016/17 continuing to be proactive and embracing innovation across all areas of the specialist palliative care we provide.

To the best of my knowledge the information reported in this Quality Account is an accurate and fair representation of the quality of healthcare services provided by John Taylor Hospice Community Interest Company.

Penny Venables
Chief Executive
1.2. Board of Directors and owner statement

The Board of Directors of John Taylor Hospice have satisfied themselves that this Quality Account presents an accurate and realistic assessment of the hospice’s performance during 2015/16 via the ARAC committee. There have been adequate controls in place over the collection and reporting of information and data collection conforms to specific data quality standards. ARAC oversees the Clinical Governance Committee, which is shared and reviewed by the Membership Council. As a community interest company, John Taylor Hospice is a membership organisation and the owners are the people who work in the company. The company is overseen by a Membership Council made up from staff elected by their peers. The Articles of Association of our company set out specific duties for all Membership Councillors, these include those detailing the Councillors’ responsibilities in participating in the governance of the company and holding the Board of Directors to account. These responsibilities have been fulfilled during 2015/16.
Part 2 - Our principles

2.1. Articles of association

John Taylor Hospice is established as a community interest company and is not for profit organisation with any profits or assets used principally for the benefit of the community. It is established in line with the following objectives, based on activities that reduce the individual economic and social cost of illness and death:

1. Providing timely multi-disciplinary health and social care services that are ‘Taylor-made’ for individuals and families and buffer the impact of loss and bereavement;
2. Promoting and raising awareness of the impact of untreated pain and suffering in all its guises and the wealth of practical, clinical, creative, spiritual approaches to change this;
3. Promoting interventions that enable people to understand the determinants of ill-health; to relearn or regain independence and control and promote well-being;
4. Providing education and training services to tackle the stigma associated with death and dying and provide leadership on best practice to improve the confidence and knowledge in the health and social care community, volunteers and the general public.

2.2. Duty of Candour

Occasionally people in our care are involved in an incident, some of which have the potential to cause harm. Then we have a duty to inform our patients and their families what has happened. This is very much part of our open and honest culture.

We are committed to talking to patients and their carers at a very early stage following any such incident to understand what happened and, where necessary, learn the lessons that will prevent it happening again to improve the safety of our future patients. We have recently carried out a review of ALL of our incidents (even where there was no harm) to learn from “what might have happened”.

If any harm happens, we investigate the incident and ask how much the patient and their relatives or carers wish to be involved in the investigation.

We share our findings with the patient, their family or carers and share learning and improvements across the company.

We are very careful to ‘analyse’ and learn but not to ‘judge’ all incidents as this is essential to make sure that a culture of openness is established and preserved. We do this in such a way that we can be highly confident of the number and type of incidents in John Taylor Hospice (JTH). If in any month there is a slight change, we investigate not just each incident but the wider process of reporting and responding to incidents.

2.3. Equality and diversity

We take our responsibilities in relation to equality and diversity extremely seriously and scrutinise ourselves on the basis of transactional and relational data. We are never complacent and we are unequivocal about dignity in life and death. We have a range of training, information, reflection, guidance and support to keep the risk on prejudice on the agenda. John Taylor Hospice’s annual equality and diversity mandatory training has a 94% pass rate of all staff across the company. The remaining 6% of staff are due for renewal.
Part 3 - Strategic aims

Our company’s strategic aims surround the provision of supportive end of life, palliative and specialist palliative care across all illnesses or conditions that foreshorten adult life together with practical help and support pre and post-bereavement. We are also equally concerned with prevention and early intervention and evidence and measurement of what we do. These aims have led to the development of our strategic objectives. Those relevant to this Quality Account are listed below:

1. Care where it is needed across the 24 hour day.
2. Continuing to be an excellent palliative care centre with a 95% tolerance in meeting standards.
3. Maintaining our data standards to ensure evidence-based decision making.
4. To aim for 90% of people cared for by us achieving their preferred place of care at end of life.
5. To continue to expand and develop mutually beneficial partnerships with other organisations.
6. To maintain our effectiveness in moving from idea to implementation in all aspects of what we do.
7. To grow into new areas like dementia care and the scope of our work in long term conditions and accredited complementary therapies.

Part 4 - Our priorities for improvement

4.1. What we achieved in 2015/16

1. We continued to be a trusted provider of NHS funded care across the pathway of care and the spectrum of illnesses that foreshorten life, evidenced by the award of a three year contract by our lead CCGs, further illustrating our developing partnerships.
2. JTH community activity target was set at 95% for the year 2015/2016. In actual terms JTH recorded community activities at 92.32% and in-patient admissions at 7.68%. Whilst community activity fell slightly short of the target, it was an increase of 3.81% on the previous year 2014/2015.
3. Actions to improve this include the implementation of Advanced Care Planning; updating SystmOne patient electronic record system to enable accurate data collection; Implementation of SystmOne to JTH In-Patient Unit enabling all teams within JTH to capture and update patient records in a timely manner.
4. We met our minimal threshold for 95% results for external audits measured in percentage compliance and a minimum standard of 95% compliance for internal audits measured in percentage compliance in most cases.
5. We relaunched and embedded the Macmillan Values Based Standard (MVBS) within our organisation, linked to our agreed Commissioning for Quality and Innovation payments framework (CQUIN) target with our CCG.
6. We moved forward our medical workforce plan, acquiring a full complement of medical staffing including two speciality doctor posts and furthering discussions with partners regarding the recruitment of a consultant in palliative medicine.
7. We consolidated our weekly lunchtime mindfulness sessions.
8. We still hope to acquire a good rating in our first Key Lines of Enquiry (KLOE) assessment, however we are still awaiting the results of our CQC inspection.

9. We maintained our status as 10 for social impact in the NW SE100 index.

10. We are on track with our income target against our five year community investment plan.

11. Increased awareness around falls prevention, increasing audit frequency, and continuing to look for funding opportunities for technology to further reduce falls. One outcome this year has been the implementation of falls prevention information for families and relatives, providing helpful tips on how to stay safe.

12. We are funded for 14 beds on our In-Patient Unit. Sometimes beds become unoccupied due to patients deciding they do not wish to uptake their reserved respite stay, or at times there are no patients requiring specialist palliative care. We averaged 64% bed occupancy during 2015/16, and aim to increase this percentage during 2016/17. Please see below graph for In-Patient Unit occupancy during 2015/16.

In addition to last year’s priorities, we ensured staffing ratios in our In-Patient Unit were in excess of the Royal College of Nursing (RCN) guidelines for adult medical wards and maintained our pledge not to use external agency routinely.

4.2. Performance against 2015/16 CQUIN Target

CQUINs are quality targets set by our commissioners that we aim to achieve as a company over the year. In 2015/16 we agreed the following targets with them:

4.2.1. To Install Wi-Fi across the hospice

Installing Wi-Fi has not been easy as the walls of the building are thick and signal strength is variable however the installation of Wi-Fi was completed on Monday 27th July 2015.

Since the implementation of Wi-Fi at John Taylor Hospice, we purchased smart televisions through a donation from the volunteer group the League of Friends for John Taylor Hospice, which will allow patients to catch up with shows they may have missed. In addition, we have prepared Wi-Fi vouchers for patients and relatives to use while staying at the hospice.

The below information shows the age range and the percentage of users who use the vouchers (visitors and patients). The data provided is between 31st July 2015 and 31st March 2016.
The above graph and table provides information between 31st July and the 17th August 2015.

- 948 visitor Wi-Fi codes were used (83.16%)
- 192 patient Wi-Fi codes were used (16.84%)

We believe that some relatives and visitors are signing into the Wi-Fi using their details for their loved ones, which may explain the lower figures for patient usage.

- 2.1% - Wi-Fi usage was between the age range of 0 and 15,
- 1.75% - Wi-Fi usage was between the age range of 16 and 18,
- 8.68% - Wi-Fi usage was between the age range of 19 and 24,
- 81.6% - Wi-Fi usage was between the age range of 25 and 64,
- 4.73% - Wi-Fi usage was between the age range of 65 and 74,
- 1.05% - Wi-Fi usage was between the age range of 75 and 84,
- 0.09% - Wi-Fi usage was above 85

### 4.2.2. Macmillan Values Based Standard

The hospice has had a very successful year working with the MVBS project. The 8 standards have been promoted by in-house posters, staff Mix & Mingle sessions (please see section 5.9.2), detailed on each handover report and in team meetings across the hospice. The project has been a useful tool as a vocational nudge to best practice. Please see 5.8.5 for the anonymous MVBS questionnaire feedback on the questionnaire that we trialled on our day centre. We now hand out these questionnaires to patients who use or have used our services.
A steering group set up at the start of the year reviews and ensures that any actions highlighted through Every Story Matters sessions and staff suggestions are followed through.

Collaborative events have been attended by staff and ideas shared with other supporters of this project from different areas of healthcare. John Taylor Hospice continues to have an excellent reputation at events in the use and promotion of the standards and others are always interested in the work we are doing.

4.3 What we aim to achieve in 2016/17

We have set out below our 5 main objectives for the 2016/17 period, we have set each objective against one of the 5 domains of the CQC. We are asking ourselves if we are:

**Safe?**
People we care for and staff are supported to make choices and protected from harm, discrimination and neglect.

**Effective?**
People we care for receive effective care which allows them to maintain quality of life.

**Caring?**
People we care for are treated with dignity and respect and patients and their families are empowered to make choices in their care.

**Responsive?**
We offer the care that people need and their concerns are listened to and appropriate actions put in place.

**Well-led?**
Managers promote an open and honest culture in which staff feel empowered to question and where company values are understood.

4.3.1 SAFE - Clinical skills lab

One of our key priorities for 2016/17 is the developments of a skills lab which would facilitate the exploration of the often difficult issues that can arise around communication and decision-making when a patient is dying. Aligned with the National Institute for Health and Care Excellence (NICE) Quality Standards for End of Life Care and building on recent legislation around Advanced Care Planning, the facility would enable teaching to identify the importance of effective communication through clinical intervention scenarios, thus creating realistic learning experiences to confidently deliver evidence-based decision making and compassionate care.

The last few hours or days of life are a challenging time for any professional caregiver. The emotions and fears that patients and families often experience require sensitive and skilled communication and holistic care and support. The nurse, by being a consistent presence, is in a unique and privileged position to provide this essential care as part of a multi-disciplinary approach.

A clinical skills laboratory is specifically designed for teaching and assessing. It would provide learners with the ideal setting to practice the clinical skills of history taking, physical examination, communication, and interpersonal skills.

The lab, representing a realistic clinical environment, would help to assimilate theoretical knowledge into practical skills. Additionally, we would run weekly skills practice sessions that any member of staff could book onto for extra experience.

Including:

- Holistic nurse-led assessment
- Sensitive, open communication
- Handling difficult questions
- Capacity and consent
- Promotion of autonomy and control
- Identifying and respecting expressed wishes and preferences
- Hydration and nutrition
- Advance care planning

We will measure the success of the clinical skills lab through in-depth competencies for our clinical staff, and reflection sessions. We hope to achieve this funding through corporate sponsors, community fundraising or through specific application to a trust/grant bodies.

4.3.2. EFFECTIVE – Advance Care Planning

As our second priority, John Taylor Hospice aims to have Advance Care Planning (ACP) implemented further within both the community and hospice setting by the end of 2016. This will help us to establish early on what the patient’s preferences are.

ACP is a voluntary process of discussion about future care between an individual and their care providers, irrespective of discipline. If the individual wishes, their family and friends may be included. It is recommended that with the individual’s agreement this discussion is documented, regularly reviewed, and communicated to key persons involved in their care.

Advanced Care Planning is becoming increasingly important but can be confusing for health and social care professionals and the public. ACP has always been an intrinsic part of the NHS End of Life Care (EoLC) Programme; the Preferred Priorities for Care (PPC) document is an example of this. Interest is growing, with more literature being published. The enactment of the Mental Capacity Act 2005 has highlighted the need for clarification and a national approach.

The document includes information on:
- Lasting Power of Attorney (LPA)
- Personal welfare decisions
- Healthcare decisions
- Statements of wishes, preferences, beliefs and values

Implementation of ACP will help us to establish early on where the patient’s preferred place of death/care is to allow us to plan in advance their decision.

Below is a graph illustrating what our current Preferred Place of Death (PPD) rate is between April 2015 and March 2016.
There was no documented evidence relating to PPD for 254 patients. Documentation informed: some felt that they were undecided on their preferred place of death; their professional felt it was inappropriate to discuss at the time of assessment. Please see comparison table below.

<table>
<thead>
<tr>
<th>PPD</th>
<th>2014/15</th>
<th>2015/16</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Home</td>
<td>71%</td>
<td>62%</td>
<td>-9%</td>
</tr>
<tr>
<td>2 Nursing home</td>
<td>75%</td>
<td>79%</td>
<td>+4%</td>
</tr>
<tr>
<td>3 Hospice</td>
<td>72%</td>
<td>80%</td>
<td>+8%</td>
</tr>
<tr>
<td>4 Hospital</td>
<td>100%</td>
<td>100%</td>
<td>0%</td>
</tr>
</tbody>
</table>

JTH realises that crisis can occur within the home setting for patients who choose home as their preferred place of care at end of life. This can result in hospital admission that may be inappropriate. JTH is working hard to provide education and information to loved ones of patients in our care to attempt to reduce this.

Further work to JTH patient electronic data system is ongoing to enable accurate recording of PPC/PPD data to facilitate accurate documentation resulting in accurate measuring for ongoing analysis and reporting to BCC CCG, JTH lead commissioners, on a quarterly basis.

JTH is also implementing Advanced Care Planning alongside Supportive Care Planning, which may also assist in ensuring PPC/PPD.

The ACP document will assist with meeting PPC/PPD for those patients whose life limiting condition indicates they may be unable to do so when their disease progresses. ACP facilitates difficult conversations with patients, empowering patients to make advanced decisions.
JTH are undergoing staff training sessions provided by the consultant in palliative care and nurse consultant. This training will also enable confidence-building for staff to engage in difficult conversations.

JTH In-Patient Unit is currently implementing SystmOne electronic patient records system. This will enable all staff within each department of JTH to update patient records in a timely manner. This priority is also one of our CQUIN targets with our CCGs for 2016/17, this will enhance and support our aim to have an ACP for all patients.

4.3.3. CARING

Our third priority is to ensure all of our clinical staff deliver safe, high quality care to the community we serve. The scale and profile of end of life care has increased significantly recently. The current published government mandate to Health Education England: April 2013 to March 2015: Delivering high quality, effective, compassionate care: Developing the right people with the right skills and the right values that supports improvement initiatives at John Taylor Hospice.

It is the commitment, professionalism and dedication of John Taylor Hospice staff that can make the biggest difference in providing high quality services and care for patients and their families and we recognise that it is important that our staff have the appropriate level of knowledge, skill and ability to be able to provide good care to all patients, as well as support for their families and carers. Person-centred care is a philosophy wherein John Taylor Hospice sees patients as equal partners in the assessment, planning, implementation and evaluation of care to make sure it is most appropriate for their needs. This involves patients and their families being at the heart of all decisions.

John Taylor Hospice services are designed to be user-focused, to promote control, independence and autonomy for the patient, their carers and loved ones, to provide choice and be based on collaborative decision making. Key components of person-centred care include compassion, dignity and respect. These are demonstrated via shared decision making, supportive care and clear communication.

It is with this in mind that we will develop and maintain a whole range of training and support for both clinical and non-clinical staff to ensure that they are able to continually develop and grow in their roles.

The last few hours or days of life are a challenging time for any professional caregiver. The emotions and fears that patients and families often experience require sensitive and skilled communication and holistic care and support.
4.3.4. RESPONSIVE – Introduction of telemedicine

Our fourth aim is to be responsive to our patients’ needs by implementing use of mobile technology as a key enabler for improved quality and more efficient working practices.

Being able to contact the Heart of the Hospice clinical lead Monday to Friday could potentially reduce admissions to A&E if the patient has an option to video or “face-face” conversation with clinical staff.

Contacting patients who are unable to attend the hospice for day care will allow us to understand if any clinical or medical input is required, reinforcing the relationship, to the benefit of both parties.

This may reduce the risk for an urgent home visit in addition to enabling the clinical lead to plan work more effectively.

Patients can appreciate the quick response and long consultations with a clinician, having another channel through which to access care. This is particularly useful for people with reduced mobility.

Additional benefits to the patients can include the ability to attend the day hospice via video messaging. Patients with a keen interest in activities will also be able to communicate with other patients on different days and take part in planned activities.

We aim to implement telemedicine in 2016/17, offering help and support to patients who are interested in this new initiative as way of communicating.

We trialled a video conversation with one of our regular patients within the Heart of the Hospice who agreed to be our first user of this new technology.

First skype call from a patient
Comments we received from the patient during the first Skype video call consisted of:

“If I’m ill and I can’t come in for the day this is really great!”

“Skype is good so we can always talk to each other, maybe just to say hello, no-one would get lonely then.”

“It can even be used to speak to people and family abroad as there is no cost to use it.”

Our Heart of the Hospice clinical lead and membership representative says:

“I think video conversations with patients is a great idea - talking over video message to a patient in their own home allows us to stay connected throughout the week with a personal touch. Being able to see their face will improve my assessment of the conversation which will allow me to give care to the best of my ability. I’m looking forward to trialling the idea.”

We will measure the success of telemedicine through data analysis via our electronic patients records, and through satisfactions surveys provided for patient who use this resource.

4.3.5. WELL-LED – Staff well-being

For our fifth priority, we aim to re-launch our quality circles to staff to identify and improve work-related obstacles as a group. The groups will be led by a member of the Corporate and Commercial Services Team or Membership Representative and will present the findings to ARAC.

Our previous quality circles were a success; we received positive feedback from staff who were included within the discussions. It was highlighted during our recent staff surveys that it would be beneficial to bring the quality circles back to maintain communication across the organisation.

Previous quality circles featured staff in-put around a range of issues including employment equity and fairness and personal development. We will measure the success of quality circles through staff attendance, and feedback provided from staff, actions will then be implemented from the findings.

Part 5 - Review of quality performance

5.1. Patient safety

We take patient safety as our highest priority and have systems and processes in place to ensure our services are safe, caring and compassionate. We monitor quality using a number of metrics and processes.

5.1.1. Our governance systems

Our governance systems are focussed around our Board of Directors and Membership Council as represented below.
Our Board of Directors has a subcommittee that is responsible for assurance, regulation and audit. The committee has two working groups, our Clinical Governance Committee (CGC) and Workplace Safety Committee. ARAC reports to the Board of Directors to give assurance at each meeting. In addition, the Board of Directors has an Audit Subcommittee and a Fundraising and Income Generation Committee which provide assurance on finance and income generation standards.

Our CGC reviews a full range of safety and effectiveness measures. All clinical incidents are examined, audit findings and action plans are reported and all NICE guidance is reviewed.

5.1.2. Safety metrics reviewed

The company regularly reviews a range of safety metrics as part of its governance processes, both clinical and corporate. In terms of clinical safety measures, these include safe staffing levels, reviewed on a daily basis, complaints and compliments, CAS alerts, patient feedback, staff training and appraisals including revalidation, safeguarding and all company risk.

Corporate safety measures include:

- Housekeeping cleanliness audits to ensure a clean and safe environment is maintained.
- Training records to ensure that staff are kept up-to-date and qualified including mandatory training and specialist palliative care training.
- Internal and external audit programmes to monitor and maintain a safe environment for patients and staff that cover:
  - Kitchen audits
  - Medical gas audits
  - Vehicles
  - Environmental/premises including external grounds
  - Patient call bell system reliability
  - Water quality
- Robust Incident and Risk Management - system in place to ensure that incidents and risks are proactively managed at the correct management and Board level.
PLACE audit – annual patient-led audit organised and managed to independently assess our care environment for cleanliness, food and hydration, condition and appearance and maintenance, patient privacy dignity and well-being.

5.2. Safeguarding

Our CQC registered manager ensures that each safeguarding concern raised is reported to the CQC within 24 hours.

The local Mental Capacity Act Project Team has provided training to staff at John Taylor Hospice regarding Safeguarding and Deprivation of Liberty (DOLS).

Our online training provider Marshalls continues to provide us with DOLS, Mental Capacity and Children’s Safeguarding to the existing Adults Safeguarding Training. We ensure all staff and volunteers receive training on safeguarding as part of their induction followed by updates every three years delivered by an accredited external provider in safeguarding of children and adults as well as accredited internal trainers.

5.3. Internal and external audit

John Taylor Hospice has a comprehensive company-wide audit calendar. This allows a designated member of staff from each directorate to be informed when an audit is due, please see appendix 1 for our corporate audit calendar.

5.4. Control of Infection

5.4.1. Hand hygiene

Since implementation of our new clinical hand hygiene audit in January 2014 we have increased our results from 93.8% to 99.70%, receiving 100% after re-auditing staff within the same calendar month.

We have begun to audit all staff within the hospice quarterly to ensure complete compliance. Staff members and visitors (who are willing to undertake the audit) will be audited in 5 categories:

1. In-Patient Unit – Clinical
2. In-Patient Unit – Non Clinical
3. Community - Clinical
4. Non Clinical
5. Visitors
This will provide all JTH staff and participating visitors with knowledge and information and an insight into the importance JTH applies to IPC and patient safety. The Corporate Hand Hygiene Audit will be undertaken quarterly.

5.4.2. C-Diff incident

The company regularly reviews infections at its CGC and ARAC however during early 2015 JTH saw four separate cases of the infection C-Difficile in the IPU. All four specimens were analysed by the Heart of England NHS Foundation Trust (HEFT) microbiology department to look for similarities in order to eliminate “outbreak”. A major outbreak depends not only on the number of people affected but also on the pathogenicity of the causative organism and its potential for spread in a community or beyond one ward or department. An outbreak may be defined as: An incident affecting two or more people thought to have a common exposure to a potential source, in which they experience similar illness or proven infection. Microbiology results confirmed ribotyping results were different, therefore we did not have an outbreak.

On 16th June 2015, HEFT microbiologists confirmed that there was no evidence of cross contamination and on 8th July 2015 Cross City Clinical Commissioning Group conformed that the Serious Incidents reported to them by JTH had been closed.

HEFT applauded JTH on the management of C-Diff on the In-Patient Unit. We have undertaken our annual external infection control inspection audit by HEFT since the infection, wherein JTH scored an excellent 98% compliance.

The following actions were implemented:

- Development of restrictive antibiotic guidelines that use narrow-spectrum agents alone or in combination for empirical and definitive treatment where appropriate.
- Adopted antimicrobial stewardship: systems and processes for effective antimicrobial medicine: NICE guidance [NG15] Published date: August 2015.
- JTH clinical pharmacists now undertake a daily review of drug charts to check application of our current antibiotic guidelines and where there is a breach in compliance liaise immediately with the medic on duty and the nurse in charge to review the care of the patient to resume concordance.
- An Antibiotic Use Audit, to be owned by the Pharmacy Team, has been added to medicines audit calendar.
- The modern matron and executive director of Corporate and Commercial Services have consolidated learning within the JTH domestic team to maintain the systems in place for deep cleaning.
- Exception reporting on breaches in infection control is reported directly to the Board with ARAC delegated to oversee action planning.
- To use Mix & Mingles at least once a year to celebrate infection control.

In addition, JTH trialled an innovative piece of equipment called Xenex. Xenex provides pulsating light which effectively destroys the DNA of spores within the air and upon surfaces that it can reach during a 5 minutes cycle of use. Another significant factor relating to this product is its ability to extinguish malodour.

The trial began on 7th July 2015 and full training was provided to the service improvement manager and domestic staff.

Ongoing trials continue in other facilities both here in UK and Stateside. JTH will consider acquiring Xenex through funding pending results of other trials/confirmation of data.

5.5. Incident reporting

5.5.1. Serious incidents

NHS England, Serious Incident Framework (March 2015) defines a serious incident as:
Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in:

- Unexpected or avoidable death of one or more people. This includes
  - suicide/self-inflicted death; and
  - homicide by a person in receipt of mental health care within the recent past;
- Unexpected or avoidable injury to one or more people that has resulted in serious harm;
- Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent:
  - the death of the service user; or
  - serious harm;
- Actual or alleged abuse; sexual abuse, physical or psychological ill treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminatory and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where:
  - healthcare did not take appropriate action/intervention to safeguard against such abuse occurring; or
  - where abuse occurred during the provision of NHS-funded care.

This includes abuse that resulted in (or was identified through) a Serious Case Review (SCR), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally-led investigation, where delivery of NHS-funded care caused/contributed towards the incident (see Part One; sections 1.3 and 1.5 for further information).

John Taylor Hospice has not had a serious incident in the 2015/16 period.

5.5.2. Non-serious incidents

We encourage our staff to report any incident, even if no harm has actually occurred, so that we can be active at prevention, not just responding to events that have happened. We keep detailed records, reviewing every incident and report as well as continually improving our reporting and review process.

Between April 2015 and March 2016 there were a total of 171 reports, 57% of which involved no harm to anyone at all and 37% were insignificant in their effect but monitoring these helps us keep a “preventative lookout”.

An “insignificant” incident is one where the personal impact is that a person may require simple first aid.

A “minor” incident is one where a person may require medical treatment for up to 2 days.

A “moderate” incident is one that may involve semi-permanent injury.

We also understand the types of incidents we have and, as expected, most of them relate to clinical matters or safeguarding, reflecting the nature of the patients we care for.
Clinical and safeguarding includes all matters of directly delivering care to our patients and ensuring their safety and liberties.

Corporate incidents includes such aspects as equipment, security at the hospice, health and safety.

Financial and information technology includes incidents relating to these functions.

We use information about incidents, the cases, actions and processes involved, as part of our “evidence-base” so that our constant improvements in patient care and safety are based on staff’s rational understanding of the practices and systems that make up our services. Having collected several years of information we can now have a real level of what to expect in terms of incident reports.

This chart shows the number of reports each month as well as the maximum and minimum number of reports we would expect most of the time, in fact for 95% of the time.

This means that for 19 out of every 20 months we expect there to be between 7 and 21 reports each month, we calculated that using the same the kind of statistical analysis that underpins all clinical evidence.

So, as well as investigating every individual report, we can also investigate any sudden deviations away from our expectations, like the peak in November 2015 where there were 26 reports.

Most noticeable in that month is that there were 10 falls reported whereas we normally have 3 a month on average. Closer investigation showed that these were related to one patient for whom staff encouraged their independence as well as taking safety precautions. This was reflected in the fact that of those 10 falls, 9 did not lead to any harm at all and one lead to simple first aid being given yet the patient’s independence and mobility benefitted enormously.

We make thorough use of information to continually monitor and improve our patient’s care and safety as well as our staff’s professional knowledge and decision making.
5.5.3. Never event

We record any Never Events through our incident reporting system which flags up any incident as a Never Event at the outset.

Never events are serious, largely preventable, patient safety incidents that should not occur if the correct preventative measures have been implemented. There are 25 explicit events considered as Never Events by the NHS such as wrong site surgery or wrong route administration of medication. Incidents are considered to be Never Events if there is evidence that the event has occurred in the past and is a known source of risk or if there is guidance which if followed would prevent a Never Event. Not all Never Events necessarily result in severe harm or death.

John Taylor Hospice has had no Never Event during the 2015/16 period.

5.5.4. Medication errors

We have a detailed programme of medicine management audits as part of the organisation’s commitment to providing highest quality clinical services and reducing risks of harm to our patients with a high success rate.

The In-Patient Unit has daily expertise from the specialist clinical pharmacists, in addition to providing medicine management training to staff.

Our medicines management technician ensures that patients have timely access to medicines.

As well as more frequent regular audits we have a programme of annual medicines management audits which include the Hospice UK audit tools for:

- General Medicines Audit Tool
- Controlled Drugs Audit Tool
- Self-Administration of Medicines Audit Tool
- Medical Gases Audit Tool
- Self-Assessment of the Controlled Drugs Accountable Officer Audit Tool

The below table illustrates the total number of medicine related incidents that have occurred in the 2015/16 period.

**Medicine Related Incidents**

![Bar chart showing medicine related incidents by month]

In-house Incident outcomes include: reflection session; table top exercises; Route Cause Analysis; medicine management training; medication administration competencies; medic led teaching sessions; external training; educational sessions held by our pharmacy team. All of which have an indirect positive outcome for patients, ensuring safe practice through reflection and enabling staff to learn from their mistakes.
5.6. VTEs and UTIs

5.6.1. Venous thromboembolisms (VTEs)

We have experienced consultant, GP and speciality doctors who are able to assess if a patient is vulnerable to venous thromboembolism on admission and able to nurse the patient if they are receiving treatment. During the 2015/16 period we have had one patient with a VTE. Our medical staff followed the correct procedure and safely admitted the patient to hospital for an ultrasound. In addition, we report to the Safety Thermometer on a monthly basis for our VTEs.

The NHS Safety Thermometer provides a quick and simple method for surveying patient harms and analysing results so that we can measure and monitor local improvement and harm-free care (external) over time.

Please see Safety Thermometer graph below.

![Safety Thermometer Graph](image)

A ‘Harm’ can be classed as one of the following:

- Worst old PU (Pressure ulcer developed less than 72 hours of admission)
- Worst new PU (Pressure ulcer developed more than 72 hours of admission)
- Fall (A fall that caused low harm or worse)
- Catheter (A patient who has a catheter in-situ)
- VTE Treat (A patient who has a new DVT, PE or other)

In the above graph December 2015, March 2016 and April 2016 are below 100% Harm free, the total number of patients within the 3 months were 5. The 5 patients with a Harm all developed pressure ulcers more than 72 hours prior to admission which means they were not developed at the hospice.

5.6.2. Urinary tract infections (UTIs)

All staff are aware of the importance of meticulous infection control measures particularly hand hygiene and catheter care due to the increased risk of developing infection.
The In-Patient Unit recorded a total of 18 patients diagnosed with a UTI between April 2015 and March 2016. Details of UTIs are submitted to the safety thermometer on a monthly snapshot basis. This is a mandatory requirement.

- 5 of the 18 patients had a catheter in place on admission
- 7 of the 18 patients were admitted with a UTI
- 6 of the 18 patients developed UTIs whilst at JTH

Actions in place to reduce UTIs can be seen below.

- Personal hygiene needs met
- Increased fluids (if patient is able)
- Catheter care
- Hand hygiene
- Appropriate screening
- Antimicrobial stewardship

5.7. Patient feedback

5.7.1. Concerns and complaints

We provide complaints data to the Health and Social Care Information Centre (soon to be NHS Digital in July 2016).

The clinical and operational aspects of the complaint continue to be dealt with by our executive clinical director, though there are no further actions the CIC can take at present.

We have a clear, unambiguous flow chart and process for complaints and concerns, we aim to include Complaints and Concerns into our already robust QPOP (Queries for Pathways Outcomes and Performance Overview) database by the end of 2016.

We have had no written complaints in the 2015/16 period.

John Taylor Hospice receives positive comments from Facebook, Twitter and Patient Opinion in addition to personalised cards given to us from patients, families and loved ones.

5.7.2. Patient Opinion

Patient Opinion [www.patientopinion.org.uk](http://www.patientopinion.org.uk) is an independent website where people are invited to ‘review’ health services. Some of our recent messages have included those shown in the screen shots below:

> Posted by Diagi9 (as a staff member posting for a patient/service user), 2 months ago

The whole of the John Taylor Hospice go above and beyond. The team have done so much for me during my stay there, I don’t even know where to start.

They all made myself, my wife and all of my family feel so welcome and so at ease from the start.

I don’t have a bad word to say about anyone there - so caring, so kind, so thoughtful, so gentle.
We have a very lively Facebook page with patients and families commenting on many of the posts. There is also a review section where the majority of the reviews we have received have been five stars, our overall star rating is 4.9/5.

We have received a total of 1,093 comments on our Facebook page with 89.3% of those being complementary of the services we provide for our patients, the other 11.5% of overall comments were neutral. We have not received any negative comments during this period.
5.7.4. Every Story Matters

We actively gather stories from our patients, their relatives and loved ones about the care we have provided and what worked and what, for them, we missed. Even when the overall experience was positive we look for improvements to care and address identified gaps to improve our service overall. The improvements we can make, based on these stories, are used to compile a plan of actions, below are recent examples:-

<table>
<thead>
<tr>
<th>Issue</th>
<th>Action Taken</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Use of jargon</td>
<td>Staff will be made aware when using jargon, our Brand Team will review the welcome pack.</td>
<td>A review of jargon has been completed, we will continue to be mindful of the public when producing literature.</td>
</tr>
<tr>
<td>2 Patients wanting to wear their own pyjamas</td>
<td>Staff awareness improved, more questions will be asked when asking patient and family what their preferences are regarding clothing and other items.</td>
<td>A more personalised assessment will take place with patient to understand what their preferences are, in addition, a new communication link role team has been created on the In-Patient Unit.</td>
</tr>
<tr>
<td>3 Young children visiting hospice</td>
<td>More information is now in Visitors’ Room; improved space/toys/equipment provided; art trail in the garden; creating memories for adults and children; package in reception, raising awareness: child and adults display; art memory boxes; websites; children’s forums.</td>
<td>Support to younger visitors to the hospice has been increased, we have received donations of a PS4 and an Xbox 360. We have also recently refurbished our children’s play therapy room for children who will be seen by our child counsellor.</td>
</tr>
<tr>
<td>4 Digital aid for older children</td>
<td>I-pads are now available on reception. Wi-Fi has now been installed across the IPU for public access, reception will distribute the Wi-Fi cards when appropriate.</td>
<td>More information can be seen in 4.2.1 regarding the Wi-Fi installation. I-pads are now available for patients who wish to use them while staying at the hospice.</td>
</tr>
<tr>
<td>5 Preferred name used for consistency and familiarity</td>
<td>Front of House staff are now made aware of patients’ preferred name, the IPU ward clerk will now inform the reception team of patients’ preferred first name.</td>
<td>A handover now takes place between the Front of House and IPU administrators to improve communication throughout the day.</td>
</tr>
</tbody>
</table>

All above actions have since been implemented. Every Story Matters helps John Taylor Hospice improve its care both to the patients who use our services and also to their families who are equally important.

5.7.5. Patient satisfaction surveys - Macmillan Values Based Standard

John Taylor Hospice continues to use the MVBS throughout its departments. One recent enhancement to the MVBS was the implementation of a new questionnaire.

The patient satisfaction questionnaire was launched on Wednesday 24th February 2016. Our aim is to analyse feedback from patients who use or have used our services and to understand where as a hospice we can improve using MVBS.

Patients who complete the questionnaire are assured that their feedback is completely anonymous, however if they feel they would like to be identified, they are free to include their name.

We have tailored the questions to suit any patient who uses our services (within the hospice and the patient’s own home) and the MVBS.
The patient also has an opportunity to comment about the service(s) they received at JTH or to make a suggestion on how we could improve our care. Patient feedback can be seen below.

For the purpose of collecting data we have coupled each of the patient’s answers to a number which provides an indicator regarding how our patients have responded.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

As explained above, the MVBS questionnaire was launched on the 24th February. We therefore decided to collect data from the Heart of the Hospice for the last few days of the month to give us a benchmark.

Patients in the Heart of the Hospice were asked if they could fill in a new questionnaire based around the MVBS and during the 3 patient days 21 patients obliged.

### Average Score - Per Question

1. **I would feel able to complain**: Average score 4.6
2. **If I wanted to make a complaint, I would know who to complain to**: Average score 4.6
3. **I never feel ignored**: Average score 4.6
4. **Staff deal with my concerns appropriately**: Average score 4.6
5. **I feel listened to by staff who fully understand my concerns**: Average score 4.6
6. **I am given the opportunity to discuss personal concerns in private**: Average score 4.6
7. **I am given the opportunity to inform staff of my specific requirements**: Average score 4.6
8. **I am always addressed by my preferred name**: Average score 4.6
9. **I feel hospice staff are welcoming**: Average score 4.6

### Average score for the questionnaire.

- 0 out of 21 patients scored between 1 and 2 (0%)
- 0 out of 21 patients scored between 2 and 3 (0%)
- 1 out of 21 patients scored between 3 and 4 (4.76%)
- 10 out of 21 patients scored between 4 and 5 (47.62%)
- 10 out of 21 patients scored 5 (47.62%)

### Total score for the questionnaire.

- 1 out of 9 patients scored between 4.4 and 4.5 (11.11%)
- 0 out of 9 patients scored between 4.5 and 4.6 (0%)
- 2 out of 9 patients scored between 4.6 and 4.7 (22.22%)
- 5 out of 9 patients scored between 4.7 and 4.8 (55.56%)
- 1 out of 9 patients scored between 4.8 and 4.9 (11.11%)
- 0 out of 9 patients scored between 4.9 and 5.0 (0%)

During the initial trial of the MVBS questionnaire, it was highlighted that we need to work on information relating to complaints and who to complain to. The next stage of this work is to
create and distribute an easy-to-follow leaflet to hand out to all patients who use our service to explain who to talk to regarding any concerns they may have.

5.8. Research

John Taylor Hospice is committed to involvement and development of research and has recently established an internal research forum. The following are examples of research during 2015/16.

5.8.1. Benjamin’s Brothers

Benjamin’s Brothers provides a community-led information, engagement and support service that breaks down the barriers in the African Caribbean communities relating to prostate health issues. It is both a clinical and non-clinical service - a specific project aimed at improving life chances to men from the African Caribbean communities who are three times more likely to die from prostate cancer and die at a younger age. It is a fresh approach to providing information and support to those that need it most. The project has an information basis, using health activists and staff to spread the message throughout Birmingham and the wider West Midlands. It has been designed to encourage individuals, and particularly those from the African Caribbean communities, to get themselves ‘checked out’ – by visiting their GPs and getting themselves tested with the Prostate-Specific Antigen (PSA), Digital Rectal Examination (DRE) or both.

The project also has a dedicated prostate cancer nurse specialist, working in partnership with Prostate Cancer UK, who provides one-to-one support to patients and families making sure they receive the right care, information and guidance at what can be a very difficult time. The project nurse also links directly into Multi-Disciplinary Teams, GP practices, hospitals and health centres, providing support and training to staff. Working with primary and secondary care allows the project to access individuals that may be at risk so they can be supported to be tested and then follow up with advice and guidance should they have a positive diagnosis.

The main outcomes of the project are to:

- Increase the awareness of prostate cancer, its risks and treatments throughout Birmingham and the wider West Midlands by attending community events, GP practices, health engagement activities and public/statutory meetings,
- Generate a greater understanding of prostate cancer amongst local community groups, enabling them to engage with their client groups to share knowledge and where to seek further assistance,
- Improve the health and well-being of men diagnosed with prostate cancer, providing holistic consultations and ongoing support,
- Empower patients in supported self-management and cancer survivorship,
- Standardise links and pathways for men diagnosed with prostate cancer, integrating primary and secondary care, allowing for improved shared care,
- Enhance GP knowledge of specialist care at a local level, and
- Create outreach support groups for black and minority ethnic groups and provide city-wide engagement through health activists.

There is no reason for men to die of prostate cancer. This project aims to help brothers become uncles, daughters to have grandfathers and sons to outlive their parents.

5.8.2. Acupuncture

A member of our physiotherapy team provides an acupuncture service for patients who use John Taylor Hospice.

A recent research paper he undertook was submitted and has been accepted by the World Cancer Congress. It will be published in the Acupuncture in Physiotherapy journal spring edition.

The research paper shows that side effects such as hot flushes and night sweating symptoms from medication prescribed for patients with breast cancer can be managed with acupuncture.
A presentation will be provided at the Palais des Congrès de Paris on 31st October – 3 November 2016.

5.9. Workforce

5.9.1. Revalidation at JTH

Revalidation for medical staff is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice. Revalidation aims to give extra confidence to patients that their doctor is being regularly checked by their employer and the General Medical Council (GMC).

The CIC’s associate medical director and responsible medical officer confirm that all JTH doctors have had their revalidation interview and no issues have arisen.

In addition, nurse revalidation took effect from April 2016 building on existing renewal requirements by introducing new elements which encourage nurses and midwives to reflect on their code of practice and demonstrate that they are ‘living’ the standards set out within it.

John Taylor hospice ensures that all nursing staff have access to:

- Revalidation presentations
- RCN formal revalidation training
- A dedicated training and personal and professional development co-ordinator who maintains records of individual training accomplishments of all staff in preparation to Registered General Nurse (RGN) revalidation
- Opportunities to reflect on their role to demonstrate they are ‘living’ the standards and to encourage a culture of sharing and improvement
- Weekly reflective discussion pertinent to clinical practice
- Computers and resources to encourage they are up to date in professional practice and continual professional development
- Dedicated clinical managers who examine supporting evidence within RGN portfolios to fulfil the requirements of revalidation, and sign off completed NMC revalidation applications
- Annual appraisal
- Practice related feedback
At JTH we are committed to career development and clinical specialisms, we have in our workforce a nurse consultant, a respiratory nurse specialist and a neurological nurse specialist. We hope in the future to continue to recruit specialist clinicians.

5.9.2. Workforce engagement

In anticipation of the upcoming quality circles explained in the Well-Led section of this report in 4.3.5, we hold several events for staff including our successful Mix & Mingle sessions.

Each month staff are invited for Croissant & Conserve, Afternoon Tea or a Buffet Lunch where we provide slideshows from departments within the organisation to showcase success and to expand on news provided by our weekly JTH News.

Slideshows are emailed to all staff following each session to keep everyone who was not able to attend informed.

The hospice Brand and Media Team also produces a weekly internal newsletter JTH News which is sent to staff and volunteers by email with a copy also being displayed in a staff area of the hospice.

It features:

- **Key Messages** – Information about the company as a whole, announcements, new appointments etc.
- **Fundraising** – Events, campaigns, fundraising initiatives from the Community Investment Crew
- **Brand News** – Updates on media stories, PR and advertising campaigns, award nominations and wins

### Part 6 - External scrutiny

The company welcomes external scrutiny of its services and is part of a peer review network using Macmillan Cancer Care’s external review of patient experience standards.

Of the 10,000 patient contacts in 15/16, over 92% were where ‘people call home’.

Our performance indicators continue to show a significant increase in the volume of work in people’s homes. For example, Hospice at Home delivered 27.1% more contacts in 15/16 compared with the same period last year.

The success of e-rostering for day case and in-patient activity was extended to Hospice at Home in 15/16.

Continuous measurement and quality control to support internal and external scrutiny is achieved through:

- One integrated audit calendar across clinical, corporate and financial aspects of our services. Our Board is informed of the audit results as are our commissioners.
- We run patient satisfaction surveys, subscribe to the Patient Opinion website and run ‘Every Story Matters’ sessions to hear patients’ views.
- Our Company Plan is measured using a business balanced scorecard which informs the AGM annually.

6.1. External data reporting

John Taylor Hospice provides data to the Health and Social Care Information Centre (soon to be NHS Digital in July 2016) and Unify2. Please see the varied list below which can be explained in more detail within the glossary:
• Monthly Delayed Transfers of Care
• Complaints
• Safety Thermometer
• Information Governance Toolkit
• PLACE
• Central Alert System (CAS)
  • John Taylor Hospice review all CAS alerts and respond to them in a timely manner. We have a range of clinical professionals who respond and act on all alerts received by the hospice. Alerts usually involve pharmaceuticals/clinical equipment/estates.
  • John Taylor Hospice has not breached any indicated final response times.

All our care activities are logged electronically on our secure patient record, SystmOne. We report on a quarterly basis to the NHS commissioners and also monthly to our own Board on all activities delivered.

6.2. Birmingham CrossCity Clinical Commissioning Group

Birmingham CrossCity Clinical Commissioning Group visits John Taylor Hospice on a quarterly basis to review our clinical quality. We have a good relationship with our commissioners and work above our contract for the needs of our patients.

John Taylor Hospice has delivered two CQUINS in 2015/16 for Birmingham CrossCity Commissioners Group: Macmillan Values Based Standard and Wi-Fi, as reported earlier.

We have received confirmation that the two CQUINS for 2016/17 are:

1. Advance Care Planning – Details of which can be found in 4.3.2.
2. OACC - Outcome Assessment and Complexity Collaborative

OACC is an outcome measure which captures ‘change in health status’ as a consequence of health care or interventions.

The term ‘health status’ is used here in its broadest sense and it relates to both patient and family (in keeping with the patient and family perspective of palliative care). Health status may not improve but it may be maintained rather than allowed to decline. For example, quality of life may be maintained at a level for weeks or days longer than without palliative care interventions or pain may be controlled better or families may be more supported and less burdened.

It is important to recognise that experience of care is not the same as outcomes of care. Experiences are likely to be better if outcomes are better but they relate more closely to how individuals are respected, listened to and heard. Both outcome and experience measures are important but this booklet concentrates predominantly on outcome measures.

We will report to our lead CCG on a quarterly basis on our progress with these two CQUINS and will provide feedback in our 2016/17 Quality Account.

6.3. PLACE audit

Every patient should be cared for with compassion and dignity in a clean, safe environment and where standards fall short, they should be able to draw it to attention and hold the service to account. So April 2013 saw the introduction of PLACE which is the new system for assessing the quality of the patient environment in hospitals, hospices and day treatment centres providing NHS funded care.
John Taylor Hospice is above average in four of the five categories. We fell short of the national average in dementia by 2.19%. Since this audit result, we have been working hard with our corporate partners to create two dementia-friendly rooms and have enhanced our entrance to the building with clear and easy-to-see signage.

John Taylor Hospice is currently awaiting results from our 2016 PLACE audit which took place in April 2016.

6.4. Care Quality Commission

Our CQC registered officer keeps constantly updated evidence of how we meet the care standards of the Care Quality Commission. John Taylor Hospice is aligning evidence to new CQC Key Lines of Enquiry regarding safety, effectiveness, caring, responsive to people’s needs and being well-led. CQC inspection November 2013 positively reported that JTH:

✓ Treating people with respect and involving them in their care
✓ Providing care, treatment and support that meets people’s needs
✓ Caring for people safely and protecting them from harm
✓ Staffing
✓ Quality and suitability of management

The evidence that we meet care standards is gathered from all the teams in the company and is kept in a constant state of readiness for scrutiny by our regulators which ensures that the care we provide is continually checked as meeting the standards. We continue to wait for the upcoming CQC report.
Part 7 - Statements from our stakeholders

7.1. Clinical Commissioning Group

John Taylor Hospice
Quality Account 2015/16
Statement of Assurance from Birmingham CrossCity CCG June 2016

1.1 As coordinating commissioner Birmingham CrossCity Clinical Commissioning Group (BCC CCG) has welcomed the opportunity to provide this statement for the John Taylor Hospice (JTH) quality account for 2015/16. The review of this quality account has been undertaken in accordance with the Department of Health guidance and Monitor’s requirements, and the statement of assurance has been developed in consultation with neighbouring CCGs, NHS England (West Midlands) and the Birmingham CrossCity CCG Health Panel.

1.2 It was encouraging to read that overall the majority of improvement priorities for 2015/16 had been achieved. Where priorities were not achieved, e.g. activity in people’s homes, more detail on what actions will be undertaken to address this in the coming year would be useful.

1.3 The five strategic objectives identified for 2016/17 have a detailed rationale for their implementation and actions set out to deliver each objective. What is unclear is how the achievement of each objective will be measured.
1.3.1 The definition used for serious incidents is incorrect and requires updating in line with the latest national criteria. (Serious Incident Framework, Supporting learning to prevent recurrence, 2015).

1.4 The quality account is comprehensive in terms of the 2015/16 data, the 2015/16 CQUIN performance and provides details of the other innovative work undertaken such as advance care planning, the ‘Clinical Skills Lab’ and Telemedicine.

1.5 It is positive to see the inclusion of information on equality and diversity both in terms of staff, and in relation to dignity in life and death.

1.6 Use of technology and social media and how it is being used to increase patient and public information, highlighting activities that are occurring within the hospice is well described.

1.7 It is positive to see how the hospice is promoting prevention of disease by setting up “Benjamin’s Brothers”. The hospice should now look at how they can work with others in the local community to get this message across e.g. local health visiting teams and children’s centres that have access to young men in this population who have recently become fathers. It would also be useful for the hospice to collaborate with national organisations to further this.

1.8 Central Alerting System (CAS) alerts are briefly mentioned, but there is no detail to give assurance that medicine related CAS alerts are acted upon.

1.9 Whilst the quality account details a variety of different medicines-related audits that are in place and seem appropriate. However, it would have been enhanced if information had been included on the outcomes of the audits and how this impacted onto patient safety.

1.10 Under the Control of Infection section the hand hygiene graph labels appear to be incorrect (details performance in 2016/17) – should this be 2015/16?

1.11 It would enhance readers understanding if further explanation was provided on what the Xenex equipment purchased following the Clostridium difficile incident in 2015 is used for.

1.12 Generally, the quality account is well presented, reader friendly and accessible. Some areas would benefit from improved labelling such as the pictures, tabling and graphs used and ensuring that graphs are located near to the text they relate to (for example the graph on in-patient unit occupancy comes at the end of the section on 2015/16 achievements, but does not appear to be linked to the text).
7.2. Healthwatch Birmingham

Sent by Email

Comment from Healthwatch Birmingham regarding the John Taylor Hospice Quality Account 2015/16

25 May 2016

John Taylor Hospice

Thank you for sending us a draft copy of John Taylor Hospice (JTH) Quality Account 2015/16.

At Healthwatch Birmingham we are passionate about putting patients, public, service users and carers (PPSUc) at the heart of service improvement in health and social care in the City of Birmingham. In line with our new strategy, we are focused on helping drive continuous improvement in patient and public involvement (PPI) and patient experience. We also seek to champion health equity so that PPSuC consistently receive care that meets their individual and collective needs. We have therefore focused our comments on aspects of the Quality Account that are particularly relevant to these issues.

2015/16

We are pleased to hear that JTH has progressed with a variety of initiatives over 2015/16. For example, it is good to learn that JTH has made progress in embedding the Macmillan Value Based Standard, has completed the installation of WiFi, and has ensured staffing ratios in the In-Patient Unit were in excess of Royal College of Nursing guidelines. We hope the organisation is able to continue to maintain and build on these achievements in the coming year.

It is disappointing that JTH did not meet its target for activity at home in 2015/16, achieving 92.32 per cent. We would ask for last year’s target to be included in the ‘What we achieved in 2015/16’ section so the extent to which this target has not been met is clear. We would also appreciate last year’s figure to be included (if available) to allow for comparison.

Quality priorities 2016/17

JTH has identified a number of Quality Priorities for 2016/17 that have the potential to improve patient experience and make care responsive to an individual’s needs. We support JTH’s goal to further implement Advance Care Planning within both community and hospice settings to enable greater responsiveness to patient preferences. However, we would appreciate more clarity on how JTH will monitor its progress against this goal. The draft Quality Account implies that this will be monitored through the Preferred Place of Death (PPD) rate, but it would be useful for this to be made explicit. With respect to the PPD rate, we would also value last year’s performance to be included in the Quality Account (if available) to allow for comparison.

We are interested to learn about JTH’s intention to develop a Clinical Skills Laboratory. This sound like it has the potential to be an excellent resource to help staff develop practical skills in delivering holistic and sensitive patient care. It is also positive that the hospice intends to build and maintain a range of training for its staff to assist in the delivery of person-centred care in the coming year.
addition to this, we also note that JTH also intends to improve its responsiveness to patient needs through implementing the use of mobile technology in 2016/17. The Quality Account demonstrates a strong rationale for the specific benefits this equipment could have for patients at JTH, particularly with respect to improving the experience of people with reduced mobility. We look forward to finding out more about how this technology has been used to improve patient care and experience in next year’s Quality Account.

Patient feedback

The Quality Account shows JTH uses a variety of methods to monitor patient experience. This includes: comments on the patient opinion website, feedback from social media, patient stories and a patient survey. It is heartening to see the positive feedback that JTH has received over the course of the year. For example, the Quality Account shows that JTH has received an overall rating of 4.9/5 on Facebook, and that the service has not received any negative comments on the site during 2015/16 (with all 1,063 comments being either complimentary or neutral). It is also excellent to see the organisation is using the stories gathered from “Every Story Matters” to identify and make improvements, and we appreciate JTH providing examples of this in the Quality Account.

We are happy to see JTH launched the Macmillan Value Based Standard questionnaire in February 2016, and has provided benchmark data from 21 respondents as part of the Quality Account. This shows patient responses to be largely positive, with all of the nine questions showing an average score of over 4.4 out of 5. It is good that JTH has used the survey to identify the need for work on information relating to complaints, and that this has led to the development of an easy-to-follow leaflet to hand out to patients. We look forward to seeing more data from this survey in next year’s account, alongside more examples of how the survey has been used to identify areas of improvement. A common challenge with patient surveys is making them accessible to all patients, so we would value any information in next year’s account on how JTH has made sure that all patients feel equally able to take part.

Thank you again for giving us the opportunity to review the Trust’s Quality Accounts.

Yours Sincerely

[Signature]

Andy Cave
Chief Executive Officer
7.3. John Taylor Hospice response to external statements

Since receiving the above statements we have amended the report in accordance with their suggestions, please see below:

**HW:** It is disappointing that JTH did not meet its target for activity at home in 2015/16, achieving 92.32 per cent. We would ask for last year’s target to be included in the ‘what we achieved in 2015/16’ section so the extent to which this target has not been met is clear. We would also appreciate last year’s figure to be included (if available) to allow for comparison.

**JTH:** JTH Community activity target was set at 95% for the year 2015/2016. In actual terms JTH recorded community activities at 92.32% and in-patient admissions at 7.68%. Whilst community activity fell slightly short of the target, it was an increase of 3.81% on the previous year 2014/2015.

Actions to improve this include the implementation of Advanced Care Planning; updating SystmOne patient electronic record system to enable accurate data collection; implementation of SystmOne to JTH In-Patient Unit enabling all teams within JTH to capture and update patient records in a timely manner.

**HW:** With respect to the PPD rate, we would also value last year’s performance to be included in the Quality Account (if available) to allow for comparison.

**JTH:** “We did not have records of 254 patients’ preferred place of death, some felt that they were undecided on their preferred place of death, or their professional felt it was inappropriate to discuss at the time of assessment, please see comparison table below.

<table>
<thead>
<tr>
<th>PPD</th>
<th>2014/15</th>
<th>2015/16</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Home</td>
<td>71%</td>
<td>62%</td>
<td>-9%</td>
</tr>
<tr>
<td>2 Nursing home</td>
<td>75%</td>
<td>79%</td>
<td>+4%</td>
</tr>
<tr>
<td>3 Hospice</td>
<td>72%</td>
<td>80%</td>
<td>+8%</td>
</tr>
<tr>
<td>4 Hospital</td>
<td>100%</td>
<td>100%</td>
<td>0%</td>
</tr>
</tbody>
</table>

JTH realises that crisis can occur with patients who choose home as their preferred place of care at end of life. This can result in hospital admission that may be inappropriate. JTH is working hard to provide education and information to loved ones of patients in our care to attempt to reduce this.

Further work to JTH patient electronic data system is ongoing to enable accurate recording of PPC/PPD data to facilitate accurate documentation resulting in accurate measuring for ongoing analysis and reporting to BCC CCG, JTH lead commissioners, on a quarterly basis.

JTH is also implementing Advanced Care Planning alongside Supportive Care Planning, which may also assist in ensuring PPC/PPD.

**HW:** We support JTH’s goal to further implement Advance Care Planning within both community and hospice settings to enable greater responsiveness to patient preferences. However, we would appreciate more clarity on how JTH will monitor its progress against this goal. The draft Quality Account implies that this will be monitored through the Preferred Place of Death (PPD) rate, but it would be useful for this to be made explicit. *Following on from the previous point*
**JTH:** The ACP document will assist with meeting PPC/PPD for those patients whose condition indicates they may be unable to do so when their disease progresses. ACP facilitates difficult conversations with patients, empowering patient to make advanced decisions.

JTH is undergoing staff training sessions provided by the consultant in palliative care and nurse consultant. This training will also enable confidence building for staff to engage in difficult conversations.

JTH In-Patient Unit is currently implementing SystmOne electronic patient records system. This will enable all staff within each department of JTH to update patient records in a timely manner.

This priority is also one of our CQUIN targets with our CCGs for 2016/17, this will enhance and support our aim to have an ACP for all patients.

**HW:** Amend Health Watch in 7.2 page 29 to Healthwatch Birmingham when you include our response.

**JTH:** This has now been changed.

**BCCG:** It was encouraging to read that overall the majority of improvement priorities for 2015/16 had been achieved. Where priorities were not achieved, e.g. activity in people’s homes, more detail on what actions will be undertaken to address this in the coming year would be useful.

**JTH:** JTH Community activity target was set at 95% for the year 2015/2016. In actual terms JTH recorded community activities at 92.32% and in-patient admissions at 7.68%. Whilst community activity fell slightly short of the target, it was an increase of 3.81% on the previous year 2014/2015.

Actions to improve this include the implementation of Advanced Care Planning; updating SystmOne patient electronic record system to enable accurate data collection; Implementation of SystmOne to JTH In-Patient Unit enabling all teams within JTH to capture and update patient records in a timely manner.

**BCCG:** The definition used for serious incidents is incorrect and requires updating in line with the latest national criteria. (Serious Incident Framework, Supporting learning to prevent recurrence, 2015).

**JTH:** NHS England, Serious Incident Framework defines a serious incident as:

Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in:

- Unexpected or avoidable death of one or more people. This includes
  - suicide/self-inflicted death; and
  - homicide by a person in receipt of mental health care within the recent past;
- Unexpected or avoidable injury to one or more people that has resulted in serious harm;
- Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent:
  - the death of the service user; or
  - serious harm;
Actual or alleged abuse; sexual abuse, physical or psychological ill treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where:
- healthcare did not take appropriate action/intervention to safeguard against such abuse occurring; or
- where abuse occurred during the provision of NHS-funded care.

This includes abuse that resulted in (or was identified through) a Serious Case Review (SCR), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally-led investigation, where delivery of NHS funded care caused/contributed towards the incident (see Part One; sections 1.3 and 1.5 for further information).

**BCCG:** Central Alerting System (CAS) alerts are briefly mentioned, but there is no detail to give assurance that medicine related CAS alerts are acted upon.

**JTH:** John Taylor Hospice provides data to the Health and Social Care Information Centre (soon to be NHS Digital in July 2016) and Unify2. Please see the varied list below which can be explained in more detail within the glossary:
- Monthly Delayed Transfers of Care
- Complaints
- Safety Thermometer
- Information Governance Toolkit
- PLACE
- Central Alert System (CAS)
  - John Taylor Hospice reviews all CAS alerts and responds to them in a timely manner. We have a range of clinical professionals who respond and act on all alerts received by the hospice. Alerts usually involve pharmaceuticals/clinical equipment/estates.

John Taylor Hospice has not breached any final response times indicated.

**BCCG:** Under the Control of Infection section the hand hygiene graph labels appear to be incorrect (details performance in 2016/17) – should this be 2015/16?

**JTH:** This has now been changed.

**BCCG:** It would enhance readers understanding if further explanation was provided on what the Xenex equipment purchased following the Clostidium difficile incident in 2015 is used for.

**JTH:** “In addition, JTH trialled an innovative piece of equipment called Xenex. Xenex provides pulsating light which effectively destroys the DNA of spores within the air and upon surfaces that it can reach during a 5 minutes cycle of use. Another significant factor relating to this product is its ability to extinguish malodour. The trial began on 7th July 2015 and full training was provided to the service improvement manager and domestic staff. Ongoing trials continue in other facilities both here in UK and Stateside. JTH will consider acquiring Xenex through funding pending results of other trials/confirmation of data.
BCCG: It is positive to see how the hospice is promoting prevention of disease by setting up “Benjamin’s Brothers”. The hospice should now look at how they can work with others in the local community to get this message across e.g. local health visiting teams and children’s centres that have access to young men in this population who have recently become fathers. It would also be useful for the hospice to collaborate with national organisations to further this.

JTH: The organisation welcomes this positive comment and has initiated a series of meetings with public health colleagues in Birmingham.

BCCG: The five strategic objectives identified for 2016/17 have a detailed rationale for their implementation and actions set out to deliver each objective. What is unclear is how the achievement of each objective will be measured.

CSL: We will measure the success of the clinical skills lab through in-depth competencies for our clinical staff and reflection sessions.

Tele: We will measure the success of telemedicine through data analysis through our electronic patients records and through satisfactions surveys provided for patient who use this resource.

QC: We will measure the success of quality circles through staff attendance and feedback provided from staff, actions will then be implemented from the findings.

BCCG: Whilst the quality account details a variety of different medicines-related audits that are in place and seem appropriate. However, it would have been enhanced if information had been included on the outcomes of the audits and how this impacted onto patient safety.

JTH: In-house incident outcomes include: reflection session; table top exercises; Route Cause Analysis; medicine management training; medication administration competencies; medic led teaching sessions; external training; educational sessions held by our pharmacy team. All of which have an indirect positive outcome for patients, ensuring safe practice through reflection and enabling staff to learn from their mistakes.
Appendices

Appendix 1 – Audit Calendar

Examples of audits undertaken at JTH:
- Statutory financial audit of the CIC and charity
- Patient bathrooms
- Patient areas
- Clinical rooms
- Company Hand Hygiene Audit
- Hand Hygiene Audit
- Sharps
- Protective clothing
- Catheter audit
- Appropriate use of pressure relieving equipment
- Pressure prevention
- Falls prevention
- Controlled drugs
- Self-administration of medicines
- Missed dose
- Use of PODS
- Non-Medical Prescribing Audit
- Pain assessment and analgesic effectiveness
- Nutrition Audit
- Medical gases
- Documentation Audit
- Information Governance Toolkit
- Discharge Information Audit
- Information governance spot checks
- COSHH
- Door security access system
- First aid box checks
- Front of house panic alarm
- Telephone stats
- External Kitchen Audits
- Internal kitchen fridge/freezer checks
- Kitchen procedures and record keeping
- Medical gases
- Waste Audit
- Waste Pre-Acceptance Audit
- Water flushing regime
- Water temperature checks
- Fire marshal zone check sheet
- PLACE
- Monitory Housekeeping Audit
- Building inspection
- CCTV Audit
- Environmental Audit
- Post on load generator test
Glossary

ACP

Advance Care Planning (ACP) is a voluntary process of discussion about future care between an individual and their care providers, irrespective of discipline. If the individual wishes, their family and friends may be included. It is recommended that with the individual’s agreement this discussion is documented, regularly reviewed and communicated to key persons involved in their care.

ARAC

The Audit, Risk and Assurance Committee (ARAC) is our Board subcommittee which focuses on the overall quality of the organisation.

CCG

Clinical commissioning groups (CCGs) are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.

Central Alert System

The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others including independent providers of health and social care.

Alerts available on the CAS website include safety alerts, drug alerts, Dear Doctor letters and Medical Device Alerts.

Community Interested Company

A CIC is a special type of limited company which exists to benefit the community rather than private shareholders. As such, it makes a legal promise stating that the company’s assets will only be used for its social objectives, setting limits to the money it can pay to shareholders.

Complaints

The NHS complaints procedure is the statutorily based mechanism for dealing with complaints about NHS care and treatment and all NHS organisations in England are required to operate the procedure. This annual collection is a count of written complaints made by (or on behalf of) patients, received between 1 April 2013 and 31 March 2014 and also includes experimental information on upheld complaints.

CGC

Clinical governance Committee (CGC) is a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

COSHH

Control of Substances Hazardous to Health (COSHH) covers substances that are hazardous to health. Substances can take many forms and include:

- chemicals
- products containing chemicals
- fumes
- dusts
- vapours
- mists
- nanotechnology
- gases and asphyxiating gases and
• biological agents (germs). If the packaging has any of the hazard symbols then it is classed as a hazardous substance.
• germs that cause diseases such as leptospirosis or legionnaires’ disease and germs used in laboratories.

CQC
Care Quality Commission, more can be seen in the KLOE section in the glossary below.

CQUIN
Its full name is a “Commissioning for Quality and Innovation payments framework” and was set up by NHS England as a way of encouraging care providers to share and continually improve how care is delivered and to be open about overall improvement in healthcare. CQUINS take the form of agreements between care providers and their NHS commissioners for the care provider organisation to make changes that have a direct improvement on the quality of patient care for which the care providers receives payment when those changes are fully made.

DOLs
The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

Delayed Transfers of Care
A Delayed Transfer of Care is experienced by an in-patient in a hospital who is ready to move on to the next stage of care but is prevented from doing so for one or more reasons. The arrangements for transfer to a more appropriate care setting (either within the NHS or in discharge from NHS care) will vary according to the needs of each patient but can be complex and sometimes lead to delays. We record any such delays and report them to our commissioners.

DRE
A digital rectal exam (DRE) is a screening test for both men and women. It allows a doctor to check the lower rectum, pelvis, and lower belly for cancer and other health problems, including prostate cancer in men, rectal cancer or cancer in the lower colon of men and women.

Duty of Candour
This became a regulatory requirement in November 2015 to ensure that care providers are open and transparent with the “relevant people” when certain incidents occur in relation to care and treatment. It is a direct response to the Francis Inquiry report into Mid Staffordshire NHS Foundation that defines the duty of candour as ensuring that:

...any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it...

EoLC
End of life care (EoLC) is the care experienced by people who have an incurable illness and are approaching death. Good EoLC enables people to live in as much comfort as possible until they die and to make choices about their care.

GMC
The General Medical Council (GMC) is a public body that maintains the official register of medical practitioners within the United Kingdom. Its chief responsibility is ‘to protect, promote and maintain the health and safety of the public’ by controlling entry to the register and suspending or removing members when necessary. It also sets the standards for medical schools
in the UK. It is a criminal offence to make a false claim of membership. The GMC is supported by fees paid by its members and it became a registered charity in 2001.

Information Governance Toolkit

The IG Toolkit is an online system which allows organisations to assess themselves or be assessed against Information Governance policies and standards. It also allows members of the public to view participating organisations’ IG Toolkit assessments. Read more

HEFT

Heart of England NHS Foundation Trust (Heft) includes Birmingham Heartlands Hospital, Solihull Hospital and Community Services, Good Hope Hospital in Sutton Coldfield and the Birmingham Chest Clinic.

JTH

John Taylor Hospice

League of Friends

The League of Friends for John Taylor Hospice is a Birmingham-based charity made up of volunteers working to raise funds for hospice patients and carers.

Key Lines of Enquiry (KLOEs)

The CQC has established a review process in which adult care services are inspected around five key questions which inspectors use to help establish whether a service is providing the high standard of care expected of them. The five key questions are as follows. Is a service:

- Safe?
- Effective?
- Caring?
- Responsive?
- Well-led?

LPA

A Lasting Power of Attorney (LPA) is a legal tool that allows you to appoint someone to make certain decisions on your behalf. The appointed person can manage your finances for you in the future if you reach a point where you are no longer able to make decisions for yourself.

Macmillan Values Based Standard – MVBS

In 2009 Macmillan Cancer Support commissioned work to research and develop a standard for cancer care services, expressing human rights principles as specific behaviours. The Macmillan Values Based Standard has been developed through an 18 month engagement process with over 300 healthcare staff and people living with and affected by cancer across the country. In Improving Outcomes: A Strategy for Cancer Care the government has confirmed its support for the Macmillan Values Based Standard, recognising that the application of human rights to the delivery of cancer care focuses on ‘what matters’ to patients and has the potential to create more equitable care outcomes by changing the nature of the relationship between patients and professionals.

NICE

The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care.

Performance Indicators
These are measures of how efficiently a care provider is providing the services for which it is commissioned. They include basic quantitative indicators like the number of people who will be provided care each year and how frequently we see them, to more qualitative things like how quickly we respond to a patient being referred to us and how fully we understand and meet the needs of our patients. Performance Indicators are typically used in the business contracts between care organisations and commissioners so tend to have an emphasis on being “measureable”. Performance Indicators are different but closely related to “Quality Indicators”.

PSA
Prostate-specific antigen or PSA, is a protein produced by cells of the prostate gland. The PSA test measures the level of PSA in a man’s blood. For this test, a blood sample is sent to a laboratory for analysis. The results are usually reported as nanograms of PSA per millilitre (ng/mL) of blood.

Safety Thermometer
The NHS Safety Thermometer provides a quick and simple method for surveying patient harms and analysing results in order to measure and monitor local improvement and harm free care over time.

From April 2015 data collected using the NHS Safety Thermometer is included in the NHS Standard Contract under Schedule 6B.

Serious Incidents
The NHS defines a serious incident as one which resulted in one or more of the following:

- The unexpected or avoidable death or severe harm of one or more patients, staff or members of the public.
- A Never Event – See ‘Never Event’.
- A situation that prevents an organisation’s ability to continue to deliver healthcare including data loss, property damage or incidents in programmes like screening and immunisation where harm potentially may extend to a large population.
- Allegations or incidents of physical abuse and sexual assault or abuse.
- A loss of confidence in the service, adverse media coverage or public concern about healthcare or an organisation.

Never Events
Never Events are serious, largely preventable patient safety incidents that should not occur if the correct preventative measures have been implemented. There are 25 explicit events considered as Never Events by the NHS such as wrong site surgery or wrong route administration of medication. Incidents are considered to be Never Events if there is evidence that the event has occurred in the past and is a known source of risk or if there is guidance which if followed would prevent a Never Event. Not all Never Events necessarily result in severe harm or death.

PODs
Patients’ own drugs.

PLACE
Every patient should be cared for with compassion and dignity in a clean, safe environment and where standards fall short, they should be able to draw it to the attention and hold the service to account. April 2013 saw the introduction of PLACE which is the new system for assessing the quality of the patient environment in hospitals, hospices and day treatment centres providing NHS funded care.
**PPC**
Preferred Priorities for Care.

**PPD**
A Patient’s Preferred Place of Death.

**QPOP**
QPOP (Queries for Pathways Outcomes and Performance Overview) database. QPOP is driven by a data model that links local activity information with bespoke data tables.

**NW SE100**
NatWest SE100 Index is a national register of social enterprises which are evaluated in terms of impact, growth and resilience. Updated annually, it encourages social enterprises to benchmark performance against peers nationally, regionally and by sector.

**RCN**
The Royal College of Nursing represents nurses and nursing, promotes excellence in practice and shapes health policies.

**RGN**
Registered General Nurse is a nurse who has completed a three-year training course in all aspects of nursing care to enable the nurse to be registered with the Nursing and Midwifery Council (NMC).

**Urinary Tract Infection**
A urinary tract infection (UTI) is also known as acute cystitis or bladder infection. It is an infection that affects part of the urinary tract.

**Venous Thromboembolism**
Venous thromboembolism (VTE) is a condition that includes both deep vein thrombosis and pulmonary embolism. A deep vein thrombosis is the formation of a blood clot in a deep vein and the most serious complication is that the clot could dislodge and travel to the lungs, becoming a pulmonary embolism.

**Xenex**
Xenex provides pulsating light which effectively destroys the DNA of spores within the air and upon surfaces that it can reach during a 5 minutes cycle of use. Another significant factor relating to this product is its ability to extinguish malodour.