St Raphael's Hospice

Meeting of the Clinical Quality & Governance Committee

Held at St Raphael's, London Road, Cheam, Sutton, SM3 9DX with video call access.

At 10:00 on Friday 16th January 2026

Members:	Dr Carrie Chill – Trustee & Committee Chair (CC)
	Alan Cogbill – Trustee & Committee member (AC)
	Bernard Marley – Trustee & Committee member (BM)
	Norman McWhinney – Board Chair & Committee member (NM)
In attendance:	Rebecca Trower – Joint CEO (RT)
	Alex Rudkin – Director of Quality and Governance (AR)
	Dr Naomi Collins – Consultant (NC)
	Rebekah Williams – Registrar (RW)
	Karen Monaghan – Governance (KM)

Agenda item	Action	Responsible	Timeline	Ref.
2.	Executive Committee to design and present Change Management Assurance process to CQ&G for approval	BM/RT	24/04/26	17.10.25/08 (item carried forward)
	Amend October 2025 minutes.	KM	20/01/26	16.01.26/01
4.	Facilitate the inclusion of the Evidence of Excellent Practice Register in all Committee and Board papers.	RT	20/01/26	16.01.26/02
5.	Admissions Meetings updates to be included in future Clinical, Quality & Governance Reports	RT	24/04/26	16.01.26/03
6.	Make amendments to Safeguarding Policy.	AR	28/01/26	16.01.26/04

1. Welcome, apologies for absence and declarations of interest.

The Chair welcomed everyone to the meeting. There were apologies that were accepted from Nick Stevens (NS, Joint CEO).

2. Review of minutes from 17th October 2025 Clinical Quality & Governance Committee meeting, Actions List and update on matters arising

The minutes of the meeting held on 17th October 2025 were reviewed and approved as an accurate record, subject to a minor drafting correction. All actions at that meeting were confirmed as complete or in progress.

The following updates on actions were provided:

- Positive feedback communications: Ongoing inclusion of positive feedback in staff e-newsletters and external channels continues.
- Risk Register: Industrial action and NHS 10-Year Plan impacts have been added.
- 12-hour shift pilot: Outcomes referenced within the Clinical Quality & Governance Report.
- Clinical record documentation audit: Re-audit included in the audit programme and completed.
- Pressure ulcer audit: Included in the audit programme.
- Policy RACI: Agreed this requires further development and will be progressed via a separate meeting.
- Policies requiring Board approval: To be considered as part of the forthcoming Strategy Day.
- Change Management Assurance Process: The Executive Committee has not yet met; BM and RT will meet separately. **Item carried forward.**
- Safeguarding Policy: Included on this agenda.

Action: KM to amend October 2025 minutes.

3. St Raphael's Hospice staffing update

The Committee noted that workforce matters were covered in detail within the Clinical Quality & Governance Report. Overall vacancy levels were currently low, and recent rota and working pattern changes on the IPU were reported as beneficial.

4. Clinical Risk Register

The Committee reviewed the updated Clinical Risk Register and received assurance regarding its ongoing development and use as an active management tool. Trustees noted that the clinical workforce risk score had been reduced, reflecting improved staffing stability, reduced reliance on agency staff, and recent changes to rotas and working patterns within the IPU. The Committee welcomed additional mitigation actions aimed at reducing administrative burden on clinical teams, including the review of clinical administration roles and the exploration of AI-enabled solutions to support clinical documentation and workflow efficiency.

The IT access and system resilience risk remains red-rated, with no material change since the previous review. The Committee acknowledged that while mitigations remain in place, this risk continues to require close monitoring. The addition of junior doctor industrial action to the register was noted, alongside the inclusion of risks associated with the NHS 10-Year Plan. These include potential impacts on funding, workforce availability, and digital capability. Trustees discussed the early-stage nature of mitigation planning in this area and noted the importance of aligning the Modern Service Framework and emerging innovation opportunities to this risk.

The Committee also noted the inclusion of the Terminally Ill Adults / Assisted Dying Bill as an emerging risk. Assurance was provided that this matter has been discussed at Board level, and staff views have been explored. The risk will continue to be monitored as the legislative position evolves. Trustees received an update on the commencement of the CHC Fast Track Project with ICB partners, intended to support patient flow and funding for beds on a pilot basis. The Committee noted this as a positive example of collaborative mitigation in response to system-wide pressures. The Committee received and welcomed the Evidence of Excellent Practice Register and reflected on the importance of capturing and sharing positive practice across the organisation. Members noted examples from the Register, demonstrating the wider contribution of retail and support services to patient and family experience, including sensitive legacy and will-related conversations that resulted in meaningful outcomes for individuals supported by the

hospice.

The Committee recognised that much of this work often occurs outside of formal clinical settings and agreed that greater visibility of such examples strengthens organisational culture and understanding of impact. Examples were discussed from the Psychological Support Team, highlighting exceptional continuity of care for bereaved families and the importance of professional judgement and appropriate boundaries when responding flexibly to individual needs. An example where staff facilitated a wedding ceremony on the IPU shortly before a patient's death was highlighted as a powerful demonstration of person-centred care.

The Committee agreed that stories of excellence should be shared more widely, including with other Board Committees and the full Board, and suggested increased awareness within retail settings of legacy initiatives and signposting opportunities.

Action: RT to facilitate the inclusion of the Evidence of Excellent Practice Register in all Committee and Board papers.

5. Clinical Quality & Governance Report; Clinical Action Plan; Quality Account

5.1. Admissions Meeting Review:

The Committee revisited the admissions meeting review and discussed in detail the historic, and then current, tensions between the IPU and Community Teams. Trustees acknowledged that admissions decisions are inherently complex, emotionally charged, and made within the context of constrained resources, and recognised the significant burden placed on staff involved in these discussions.

The Committee noted actions already taken since the previous review, including the earlier timing of admissions meetings, the introduction of a daily IPU situation report providing objective information on staffing, acuity, and bed availability, and improved IPU staffing stability with more consistent bed availability. Members agreed that these changes have contributed to a calmer and more structured admissions process, while recognising that challenges remain.

The Committee discussed the balance between efficiency, learning and advocacy within the admissions process, noting that while reduced attendance may support operational efficiency, it can also limit shared learning and the ability for staff with direct patient knowledge to contribute. Trustees reflected on staff survey feedback indicating that frustrations persist and that previous review discussions were perceived by some as unresolved.

It was agreed that this issue requires continued active oversight. The Committee requested that a short standing update on admissions meetings be included in future Clinical Quality & Governance reports, to provide assurance on progress, emerging risks, and staff experience. Trustees also agreed that staff should be informed that the Committee is aware of, and monitoring, this issue, to reinforce transparency and support.

Action: RT to ensure Admissions Meetings updates are included in future Clinical, Quality & Governance Reports

5.2. Service Developments and Quality Updates:

Trustees were advised of changes within the Psychological Support Service, including adjustments to leadership arrangements following recent staff movements. Assurance was provided that interim arrangements are in place and that a full review of the team structure and future model will be undertaken by the end of March, with the intention of ensuring sustainability, clarity of roles and effective support for patients and families.

The Committee welcomed the recruitment of nine volunteer student bereavement counsellors, all of whom have now completed training. Trustees noted this as a significant achievement that is expected to reduce waiting times and improve access to bereavement support and commended the team for successful engagement with local universities.

Updates were provided on social work provision, noting changes to hours as staff roles evolve, and the potential need to recruit a social work assistant later in the year, should the current

social work assistant move into a substantive counselling role. The Committee also recognised the exceptional contribution of the Wellbeing Team, including recent external recognition through the Sutton Community Equality, Diversity, and Inclusion (EDI) award, which members welcomed as positive external assurance of service quality and values.

The Committee discussed an EDI incident involving racist comments made towards visiting medical students within the Wellbeing Centre. Trustees were assured that the incident was managed promptly and appropriately, including immediate action with the individual concerned, clear reinforcement of behavioural expectations, engagement with HR, and feedback to the medical school Deanery. The Committee noted that while the incident was distressing, it had been managed well and highlighted the importance of ongoing organisational work around EDI.

Trustees also received updates on developments within the IPU environment. Improvements included enhanced medicines management systems, progress towards completion of a multi-faith space designed to meet the needs of diverse communities, and upgrades to staff facilities such as female changing rooms. The Committee welcomed these developments as contributing positively to both patient experience and staff wellbeing.

5.3. Audit, Incidents and Quality Improvement:

Trustees noted that no serious incidents have been reported since the previous meeting and that the organisation continues to demonstrate a strong reporting culture. Data showed a slight increase in non-controlled drug medication incidents, alongside a reduction in patient falls when compared with the previous year. The Committee was reassured that trends are actively monitored and that learning from incidents is used to inform practice improvement.

Updates were provided on audit, quality improvement, and research activity, with members noting the breadth of work underway and the positive contribution of medical trainees to audit and QI projects. Emerging projects include work linked to medicines management and pressure ulcer prevention, aligning with previously agreed priorities.

The Committee acknowledged that not all audit and improvement activities progress at the same pace, given capacity pressures, and supported a pragmatic approach to prioritisation where appropriate. Trustees emphasised the importance of maintaining oversight of the programme, to ensure learning is captured and progress is visible, even where individual projects are paused or deprioritised.

There were no serious incidents reported.

6. Safeguarding Policy Scrutiny

The Committee reviewed the Safeguarding Policy, following the action agreed at the October meeting. Trustees discussed the policy content and were assured that safeguarding arrangements across the organisation remain robust, supported by strong leadership visibility and staff confidence in safeguarding practice. The Committee considered the current approach to safeguarding training, including the use of online refreshers and face-to-face input, and noted confidence that safeguarding awareness remains high, with clear routes for escalation and reporting.

The Committee identified a small number of minor amendments required to the policy. These include correction of typographical errors, clarification of wording in specific sections, and confirmation that reference is made to safeguarding audit activity and the designated safeguarding trustee. Alex Rudkin agreed to make these amendments and update the policy accordingly.

Action: AR to make noted amendments to the Safeguarding Policy.

7. Minutes of internal meetings and audit reports

The Committee reviewed internal meeting minutes and reports. It was agreed to review whether some meetings could be streamlined in frequency or membership, in recognition of capacity pressures. An improvement in response rates to the Voices Report was noted.

8. Departmental Risk Register

Covered under item 5.

9. AOB and Dates of future meetings

Friday 24th April 2026, Friday 10th July 2026, and Friday 25th September 2026.

The meeting ended at 12:00 p.m.

Approved……..

Date……..