

**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 17<sup>th</sup> January 2025**

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)  
 Anna Machin - Governance (AM)

<b>Agenda item</b>	<b>Action</b>	<b>Responsible</b>	<b>Timeline</b>	<b>Ref.</b>
6. CQ&G report	Invite IPU Lead to CQ&G meeting and future Board	Becca Trower	Next meeting cycle	17.01.25/01
	Draft letter of thanks to Community and clinical teams	Dr Carrie Chill	Immediate	17.01.25/02
7. Internal minutes	Report back on data on confidence around prescribing	Becca Trower	April meeting	17.01.25/03

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

The Chair welcomed Committee members to the meeting. Apologies were received from Naomi Collins and Nick Stevens. The meeting was confirmed as quorate.

**2. Review of minutes from 11<sup>th</sup> October 2024 Clinical Quality & Governance Committee meeting, Actions List and update on matters arising**

The minutes of the previous meetings were approved as an accurate record of proceedings, and the matters arising considered as follows:

- Update on drains related risk – it was confirmed that further training and support on this topic had been delivered to ensure a robust approach.
- Risk on consultant on-site time – this is included in the Clinical Risk Register, with an update given in meeting papers.
- Analysis of impact of loss of Hospice at Home service – this is included in the papers.
- Considering appropriate reporting on time from referral to first assessment in the community – this action is completed.
- All remaining actions from previous meetings had been completed.

### **3. Evidence of Excellent Practice Register**

The Committee noted the positive feedback, and that even more information could be captured by the team as they often go above and beyond, but see this as their normal culture (such as one team member attending a patient's funeral on their day off). It was noted that the VOICES survey is an additional source of feedback, and that feedback from complaints is used to 'close the loop' and develop practice.

### **4. NHS consultation**

Becca Trower gave a verbal update with a meeting with local Hospices and the ICB scheduled for mid-February to show a collective view on local Hospice support. Local MPs have advocated for the Hospice including in a recent backbench debate in Parliament. Hospice UK are working to clarify terms and timing of digital and capital funding and the team are exploring internally the projects to apply for. The attention on hospice funding needs has prompted more outreach from the Hospice locally on fundraising (e.g. a door drop), and the family of a patient has also offered some pro bono time to support initiatives. A watching brief will be kept on policy developments.

### **5. Clinical Risk Register**

The Consultant role is a key post currently out to advert, and the timings coincides with similar roles being advertised in other local health settings. Flexible or shared working arrangements would be considered. The Committee emphasised that the current internal cover was only sustainable for a set period of time. The Hospice has a good reputation amongst registrars which should help in recruitment rounds.

With the restructure completed, the data shows that this is not significantly inhibiting the ability to support or admit patients, and the Community team has settled into new working practices as part of this. Assurance was given that the risk of burnout would be monitored but that stretch to this team (as shared previously) currently primarily arose from personal circumstances. It was noted that a paramedic had been recruited into a Specialist Practitioner role as they hold the core competencies (aside from some more limitations around what they can prescribe) and a new IPU Clinical Lead is in place

### **6. Clinical Quality & Governance Report inc Clinical Action Plan**

Becca Trower updated on key programmes of work by the team including re-start of the Highdown Prison project, excellent work undertaken by the Wellbeing Services team, embedding of the Infection Control role, and good momentum within IPU including new joiners and coverage across the Christmas period. The IPU Clinical Lead would be invited to the next Committee and a future Board. The advert is still live for the 0.4 FTE clinical supervisor/facilitator role in Psychological Support Services.

The Committee was asked to note the increased needs of some patients (for example in relation to social work and mental health) leading to some more paired staff visits to support safety. Alex Rudkin presented the statistics on joint visits (32 joint visits i.e. 64 individual staff engagements), noting that some can save time in future by giving more perspective or input in the first visit, but for other patients it is a doubled requirement of time with follow-up visits still being time-consuming. Previously the Hospice at Home team, which no longer exists following the restructure, supported some. This data is valuable for the Community Services Manager

The Committee reflected that it is positive to now reach the milestone of having all referring GPs accessible on EMIS, and received an update on internal knowledge and institutional memory on this system following the departure of Dr Jenny Strawson (Consultant). In relation to the potential scope for electronic prescribing, it was felt that the cost involved was not justified in terms of value for money relative to the number of prescriptions or time-efficiencies that would be made.

Electronic prescribing to be pursued? Could make team more efficient, however expensive for training and ongoing fee which does not necessarily present value for money in relation to the number of prescriptions. Discussed trends behind certain patient incidents e.g. pressure sores.

Trends in the data were reviewed including the rise in the recent period following a fall in referrals the prior quarter, and the Hospice's role in avoiding hospital admissions was emphasised as this reduces pressure on other services.

The Committee commended the well-managed restructure and positive responsiveness around the shift in roles, quality and maintenance of services. This is evidenced in the number of patients and referrals sustained by the Community team (with year-on-year trend data shared) alongside the fact that there were no clinical complaints in the last period (noting two received in the last week, both of which would not be upheld). This shows the teams' continued focus on making a difference to, and caring for, patients. The levels, and morale and ask of the Community team, would be continually monitored. The data is also useful to refer to in upcoming ICB meetings.

On the basis of this information, the Committee would share a letter of thanks to the clinical teams, which would be drafted by Dr Carrie Chill as Chair and circulated to the Committee for comment.

**7. Minutes of internal meetings and audit reports**

The Committee noted the minutes of internal meetings provided for information, in particular the IPU fast-track audit which is an example of good practice. Becca Trower would look further into the variation reported in confidence around prescribing.

**8. Safeguarding Update**

There were no concerns to report.

**9. Any Other Business and Dates of future meetings**

There were no items raised under Any Other Business. The date of the next meeting was confirmed as 2<sup>nd</sup> May 2025 from 10am-12pm.

*The meeting ended at 11.30am.*

Approved.....

Date.....

Ref No.	Recorded By	Date	EXAMPLES OF EXCELLENT PRACTICE - Description
2025/13	CF	17/04/2025	<p>CF, IPU RGN &amp; Tracheostomy lead nurse, wanted to express the outstanding care and management that CNS, Kate Weldon, gave to a patient of ours. He had a fungating wound around his tracheostomy Kate sought advice from the clinical specialist at SGH. Also, from myself as the tracheostomy link nurse for the inpatient unit. The patient and his daughters were anxious about being admitted to the IPU but were beginning to struggle, coping in the community. CNS Kate had the insight to invite me to accompany her on a community visit to the patient. This not only enabled me to assess whether the IPU could indeed deliver an excellent and safe standard of care but I was able to explain, as one of the IPU staff, what it was really like on the IPU. I witnessed the superb care each daughter gave to their father and reassured them that they could continue caring for their father when he was an inpatient. They were so delighted and relieved to know this. The next day the patient was admitted to the IPU. Throughout his stay his daughters looked after their father supported by our team. Kate continued to visit the patient and his daughters even when he was an inpatient. Weeks later the patient had a peaceful death on the IPU surrounded by his daughters. Following his death the daughters visited the hospice and expressed, as well as thanks, a wish for staff to attend their father's funeral. I was not sure whether I could make it as it was my daughter's birthday but I did and I was so pleased to see CNS Kate who had scheduled her visits around the funeral so that she could attend. At the funeral I felt so proud to stand beside Kate Weldon, an excellent caring nurse that definitely went the extra mile to ensure her patient and his family received the highest standard of care and support even at death.</p> <p>CPCT Manager : Thank you, Cathy, for taking the time and thought to provide this outstanding feedback . The situation , although challenging , has demonstrated how cohesively the IPU and CPCT can work together and benefit from each other's expert skills . Having worked with you both I have the experience to say that you are both outstanding , caring and compassionate in everything you do trying to achieve the best outcome for both the patient and those important to them. Highlights how the IPU and CPCT can work together and benefit from each other's expert skills.</p>
2025/12	GT/AR	11/04/2025	<p>The patient CNS staff member went to see today had contacted Dean the volunteer hairdresser – she'd been feeling down and was really miserable about her hair.</p> <p>CNS went back to see them today and he'd been in – both her and her daughter were so delighted with him. They had nothing but wonderful things to say about him. He really brightened up her day.</p> <p>It meant a lot to her.</p>

Ref No.	Recorded By	Date	EXAMPLES OF EXCELLENT PRACTICE - Description
2025/11	AR	02/04/2025	<b><u>Medex feedback in March 2025</u></b> No care concerns x 11 Very happy with the care at St Raphael's
2025/10	AR	02/04/2025	<b><u>Medex feedback in February 2025</u></b> No care concerns x 8 Wife of the deceased thought the care at SRH was so wonderful, amazing, supportive etc. etc. She is so grateful and thankful. Really happy with the care
2025/09	AR	02/04/2025	<b><u>Medex feedback in January 2025</u></b> No care concerns x 6 St Raphael's: Care was fantastic, very, very caring, clean, immaculate, lovely personal touches & views of the garden. Pt was also happy with his care and had made a donation to the hospice while he was there.
2025/08	SJH/AR	14/02/2025	We had a lovely call for our Ebay Team (Ben). Customer was absolutely delighted with her 2012 Olympic Stamp Album and because the price was so reasonable she made a £20 donation to the Hospice yesterday. She was also extremely impressed with Ben as she had said it would be good to see it a bit clearer so Ben uploaded a video to her which sealed the deal.
2025/07	FQ/AR	10/02/2025	Wife of deceased called to inform staff of her husbands funeral. She said thank you to all of you..." for making a terrible time in my life that little bit more bearable, the support and care given to us, I want to thank you all". She said she would let us know when they are having a celebration of his life and will invite all to pop in if they want and when she can she will continue to use the Orangery to give a little support to the Hospice.
2025/06	GTR/AR	05/02/2025	An invaluable experience as a GP trainee! Well organised job, I felt appropriately supervised at all times and felt comfortable to ask questions in a safe and supportive environment. It was nice to have exposure to both the IPU and the community teams in order to develop a better understanding of how they work and the different skills required in both. Really nice to have catch up sessions every couple of months to ensure learning needs were being met Felt really well supervised during the entire placement, may have been nice to complete a WBPA with a consultant in order to receive feedback on areas to work on but other members of the team were able to help facilitate this!

Ref No.	Recorded By	Date	EXAMPLES OF EXCELLENT PRACTICE - Description
2025/05	GTR/AR	05/02/2025	<p>Excellent placement, learnt an incredible amount and the team especially the consultants and registrars have gone above and beyond to make me feel valued and also continue to teach us and support us. Whenever anything was feedback in terms of what we found most useful, everyone would try their best to cater to our needs to make sure we got the most out of the placement.</p> <p>I felt incredibly supported, can't fault my supervisor at all. Feel that all my PDP and educational goals were met.</p> <p>Excellent all round. The hospice and the team are amazing and I will continue to recommend this placement to other GP trainees 😊</p>
2025/04	LJ/AR	21/01/2025	<p>Where can I start! From the very moment that I stepped into St Raphael's Hospice on November 18th 2024 I was amazed at the welcome and reassurance that ALL staff showed to myself and my husband. At that time, it seemed just to be a case of having his medication sorted out but that, unfortunately, was not the case.</p> <p>From the very start with Kate coming to our house and gently telling us the options and subsequently organising the admission with such tact and compassion until his death six days later, his experience and mine was incredible.</p> <p>He was admitted by Sarah who had totally the right approach to him as he had previously vowed he would accept help from no one and he meant it! Her approach to him was perfect - almost as though she knew exactly what to do and say to a man who loathed hospitals and being dependent upon anyone! We are Christians and I believe that the Lord had a hand in all things during his stay at St Raphael's. Sarah got to know quite a bit about us with her gentle questioning and always seemed to be around at the most difficult times in his stay. He deteriorated rapidly and two days before he died Sarah organised for me to be able to a comfort to him by squeezing me beside him in the bed. I know this was a tremendous comfort to him as well as to myself.</p> <p>Of course, it wasn't only Sarah who was involved - all the other staff could not be more compassionate and caring and seemed always to have just the right words for their patients. He was hankering to come home on the 22nd November and one of the nursing staff very casually said "Oh why don't you stay until the weekend as they are changing your meds then you could go home!" Immediately he settled. This I found with all members of staff and feel so privileged that my husband was able to spend his last days at St Raphael's.</p> <p>I can't thank you enough and I know my husband would say the same. You made his passing into God's hands easier and dignified.</p>
2025/03	AR	06/01/2025	<p><b><u>Medex feedback in December 2024</u></b>                      No care concerns x 12                      Care was brilliant, really well looked after</p>
2025/02	AR	06/01/2025	<p><b><u>Medex feedback in November 2024</u></b>                      No care concerns x 9                      Care was A1, brilliant                      SRH: Very professional, caring &amp; supportive</p>
2025/01	AR	06/01/2025	<p><b><u>Medex feedback in October 2024</u></b>                      No care concerns x 16                      SRH was brilliant</p>

Clinical Risk Control Register											
Risk Category	Activity	Top Risk(s)	Initial Likelihood	Initial Severity	Initial Risk Rating	Prevention Controls - reducing likelihood	Mitigation Controls - reducing severity	Final Likelihood	Final Severity	Final Risk Rating	Responsibility?
1	Reduced clinical workforce with loss of 0.6 WTE consultant cover	Reduced clinical capacity - specifically risk of loss of Specialist registrar position due to insufficient availability of consultant supervision which would lead to significant decrease in clinical capacity, morale and reputational damage.	5	3	15	Current consultants GTR and NC can provide telephone support/ emergency on site visits if required for ad hoc days with no consultant presence on a short term/ interim basis (on call payment for SRH consultants now agreed. Could approach colleagues in Princess Alice Hospice, St Helier and Epsom Hospital to enquire about capacity to provide emergency either telephone support or on site cover at time of need. Advertise for replacement - RCP approved JD to maximise attractiveness of post. Exploration of joint site post/ NHS contract ongoing but currently no opportunity	Specialty Doctor one day a week contract now extended for a further six months (Sept 2025). Could offer increased sessions to current staff grade doctors (this would help provide clinical cover but would not address need for clinical supervision). Advert out in early May 2025 for a clinical fellow that will support junior doctor cover	5	2	10	CD/ NC
2	Reduced clinical workforce / hours	Reduced responsiveness to existing caseloads Management of expectations Lower staff morale Reduced staff retention Reputational damage Reduced referrals	5	3	15	Clear messaging to internal and external stakeholders Review of operational guidelines following a period of existing guidelines and reduced staffing model. Regular staff meetings / open door policy	Manage staffing levels across a 7 day service Collaborative working with external colleagues to promote efficiency and reduce risk of patient outliers Prioritise the support that we are responsible for delivering and reduce the amount that we pick up due to a lack of provision within the community.	5	2	10	CD
3	IT PAS System Failure / Cloud Access Down	Inability to access contemporaneous clinical records or run business continuity reports	5	3	15	IT System Management Controls	<ul style="list-style-type: none"> <li>Contactable team OOH (not formal contract)</li> <li>Back up resource -outsourced at times of AL</li> <li>2 x HSCN routers and lines to support fail over</li> <li>Hard copy daily print outs to provide basic continuity</li> </ul> . EMIS mobile has been rolled out for the IPU, medical team and community team in case of system failure. . Medical team can access our EMIS tenant from Princess Alice Hospice IT system. . In an emergency our neighbouring Hospices would allow us access to our EMIS system from either their sites or through remote access. . 2 x Cisco firewalls configured for high availability for EMIS mobile.	4	2	8	IT/CD
4	Breaches of confidentiality involving person identifiable data (PID), including data loss	<ul style="list-style-type: none"> <li>Reputational damage</li> <li>Litigation</li> <li>Fines from ICO</li> <li>Service user distress and safety risk</li> </ul>	3	3	9	<ul style="list-style-type: none"> <li>Protecting Confidential Information Policy</li> <li>All personnel and volunteers trained on Information Governance on induction and annual mandatory training.</li> <li>Data User Agreements in place</li> <li>DPO, ISO, Caldicott Guardian &amp; SIRO in place</li> <li>Suite of Information Security and Governance policy in place</li> <li>Test Phishing emails via IT Dept 3rd party contract.</li> <li>Secure PID communication email channel in place through NHS Net.</li> <li>Regular organisational sweeps in all departments</li> <li>Caldicott Guardian attends regular training and presents at associated fora.</li> <li>Maintenance of shared network drive to ensure file security.</li> <li>IT policy in place to restrict USB storage devices from being used.</li> <li>no local workstations store data, all data is accessed on centralised SAN.</li> </ul>	<ul style="list-style-type: none"> <li>All personnel and volunteers trained on Information Governance on induction and annual mandatory training.</li> <li>Proactive checking in areas such as photocopier/clear desks.</li> <li>Established link with Capsticks solicitor who provides ad hoc advice on data access issues</li> <li>Annual - Information Governance Check list audit / Clinical Record documentation audit</li> </ul>	2	2	4	IT/CD

Risk Category	Activity	Top Risk(s)	Initial Likelihood	Initial Severity	Initial Risk Rating	Prevention Controls - reducing likelihood	Mitigation Controls - reducing severity	Final Likelihood	Final Severity	Final Risk Rating	Responsibility?
5	Infection spread within hospice	<ul style="list-style-type: none"> <li>Inability to provide full clinical service impacting on both patients, their families and staff.</li> <li>May impact on external stakeholders.</li> <li>May impact reputational damage and potential funding streams</li> </ul>	3	2	6	<ul style="list-style-type: none"> <li>Attention to and compliance with governmental guidance</li> <li>Implementation and maintenance of CLIN52 COVID policy</li> <li>Implementation and maintenance of CLIN08 Infection Control policy</li> <li>IPC Lead in post - overseeing the link nurses on the IPU and Community Team and close working with SWL infection control leads.</li> </ul>	<ul style="list-style-type: none"> <li>Implementation and maintenance of CLIN52 COVID policy</li> <li>Implementation and maintenance of CLIN08 Infection Control policy</li> <li>PPE regular supply available</li> <li>Contingency planning clarified for any identified cases within the Hospice - as per governmental guidance</li> <li>Single room nursing. Increased telephone contact</li> <li>FFP3 mask fit testing ongoing</li> <li>Refresher PPE training and advice and support from PHE Facility for staff to work from home</li> </ul>	2	2	4	CD
6	Extended bed occupancy	<ul style="list-style-type: none"> <li>Delay to discharge due to limited availability of CHC funded beds in the community and patient/family reluctance to transfer.</li> <li>Limits our processing of requests for admission.</li> <li>Potential effect on reputation, income generation and staff morale.</li> <li>Does fluctuate but more of an issue in the autumn/winter.</li> </ul>	3	2	6	<ul style="list-style-type: none"> <li>Maintain relationships with Care Homes/ Sutton and Merton PLACE that have CHC funding.</li> <li>Provision of information to patient and family</li> </ul>	<ul style="list-style-type: none"> <li>Staff proficiency in completing fast track.</li> <li>Screen referrals for potential impact.</li> <li>Dual planning with Hospital requesting admission.</li> <li>Consideration of CHC funded IPU beds in future.</li> <li>Expertise in discussion with patients and family members re discharge planning.</li> </ul>	2	2	4	CD/IPU MDT
7	Clinical Incidents	<ul style="list-style-type: none"> <li>Serious or moderate harm to patient Safety</li> <li>Risk of complaints from patients/families</li> <li>Reputational damage / litigation</li> </ul>	2	3	6	<ul style="list-style-type: none"> <li>Low threshold to reporting</li> <li>Culture embraces reporting of all incidents related to clinical care</li> <li>Hierarchy of investigation</li> <li>Outputs- Learning informs improved procedures and processes</li> <li>Report to Clinical Quality &amp; Governance Committee supports transparency</li> <li>Embrace of the Patient Safety Incident Response Framework (PSIRF) and Plan in OP01 in support of patient safety and learning from incidents</li> </ul>	<ul style="list-style-type: none"> <li>Continued staff training and awareness of new techniques and products.</li> <li>Opportunity to participate in reflection and sharing learning and outcomes.</li> <li>Feedback to complainants regarding change in practice.</li> <li>Encourage an environment of comprehensive reporting to support learning and quality improvement across all departments.</li> <li>Annual clinical audit / QI / research / data monitoring program</li> </ul>	2	2	4	CD & Director of QI
8	Clinical Complaints	<ul style="list-style-type: none"> <li>Local press coverage</li> <li>Potential for public concern</li> <li>Elements of public expectation not being met</li> <li>Loss of confidence in the service</li> <li>Reputational damage</li> </ul>	3	2	6	<ul style="list-style-type: none"> <li>Organisational policy supporting values, behaviours and practices</li> <li>Education and training re communication</li> <li>Adherence to OP05 Feedback and Complaints policy</li> <li>Reported at Clinical Quality and Governance Committee</li> <li>All complaints discussed at hospice team meetings for awareness and learning across the organisation</li> </ul>	<ul style="list-style-type: none"> <li>Reporting culture of any concerns- no blame but responsibility</li> <li>Use of investigative tools for significant incidents.</li> <li>Feedback to complainants regarding change/improvement in practice.</li> <li>All complaints both verbal and written treated with the same level of scrutiny</li> <li>Scoping to establish all clinical staff access to communication skills training</li> <li>Training on care delivery</li> <li>Information shared re: Duty of Candour and scope of the policy</li> <li>Complainants (both verbal and written) are offered the opportunity to meet and discuss concerns with Clinical Director, and maybe offered opportunity to join HUG to help with SRH future learning</li> <li>Complaints documented and register maintained</li> <li>Annual review by EXEC</li> </ul>	2	2	4	CD
9	Insufficient Nursing Resource on the Inpatient Unit.	<ul style="list-style-type: none"> <li>Unable to admit</li> <li>Impact on patients, families and reputation</li> <li>Impact on community team offer of admission</li> </ul>	2	3	6	<ul style="list-style-type: none"> <li>Bank and Agency Nurses available</li> <li>Staff adapting/flexing shifts to cover IPU</li> <li>Monitoring of staffing capacity monthly/weekly/daily</li> <li>Alignment with Agenda for Change pay scales implemented</li> <li>Crisis cover payments in place</li> <li>Active recruitment ongoing</li> </ul>	<ul style="list-style-type: none"> <li>IPU admissions can be reduced to meet staffing capacity</li> <li>Majority of patients are cared for in the community</li> <li>Nursing Associates are being upskilled</li> <li>Acuity score used to help guide admissions v staffing levels</li> <li>All Leave policies amended with improved leave entitlements</li> <li>Utilisation of 10 hour shifts to provide better cover</li> </ul>	1	3	3	CD/IPU Clinical Lead
10	Lone working	<ul style="list-style-type: none"> <li>Staff/volunteers work singularly in the community within referred patients homes.</li> <li>Risk of accident/incident in a patients home and individual risk to staff member.</li> <li>Risk in travel to and from home visits</li> </ul>	3	2	6	<ul style="list-style-type: none"> <li>OP17 Lone worker Policy</li> <li>Community staff are supplied with a mobile phone for contact with the hospice or other healthcare professionals. ACC informed of access and egress.</li> <li>Lone worker alert devices in place.</li> <li>Increase in joint visiting across HCPs</li> </ul>	<ul style="list-style-type: none"> <li>Lone Worker Policy informing steps to follow if a colleague does not return to base at expected time.</li> <li>Clarification and supported training on use of safety devices.</li> <li>EXEC OOH on call in place for contact and advice on further action.</li> <li>If there is perceived or hx of risk staff work in pairs and alert is added to the EPR.</li> <li>Lone Worker Risk assessment and EMIS template updated</li> </ul>	2	1	2	CD/MDT

The axis for Likelihood should be from 1. Very Low – 2. Low – 3. Medium – 4. High – 5. Very High  
 The axis for Severity should be from 1. Light – 2. Serious – 3. Major – 4. Catastrophic – 5. Multi Catastrophic  
 Key  
 Over 13 = red  
 8-13 = amber  
 7 or under = green

Last / next review
April 25/July 25
April 25/July 25
April 25/July 25
April 25/July 25



## ITEM 05

### Clinical Quality and Governance Report

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#### Aim

To update the non-executive members of the Clinical Quality and Governance Committee on a selection of key areas that are integral to the Hospice’s clinical quality and governance agendas.

#### Recommendation

The report be noted.

# Report

## Clinical Services

### Psychological Support Services

- In this quarter, our service has been particularly busy, we noted an increase in referrals from patients, families, and bereavement cases. Consequently, the waiting time for referrals have increased.
- This demand resulted in elevated clinical caseloads and the staff have managed to operate beyond their normal capacity.
- Diana Brombozcsz continued to fully cover management of Bereavement Service with management and clinical supervision of students on placement and Ali Lutz is undertaking training to also become a Clinical Supervisor.
- We have managed to successfully appoint a new staff member at the end of March with starting the new position in April to cover 15 hours to help to manage our Bereavement Service and students' supervision.
- DB also strategically recruited new student counsellors to start in the next quarter.
- The service also delivered bereavement workshops to vulnerable prisoners and Chaplaincy staff at HMP Highdown as an interim part of the Prison Project.

### Social work Summary Jan to March

- High demand remains for the support of the social work team – caseload continues to be overcapacity
- All referrals received are relevant and appropriate for the social work team
- SWT present at every MDT to keep up to date with the needs of the patients and aids us in working directly with CMT and IPUT within the hospice
- Joint working with both the IPU and CMT to use resources appropriately wisely and efficiently – we have open communication with both team , advice support often given when needed
- Complex safeguarding issues raised by the SRH have been referred via statutory services
- More joint home visits completed with the Community team due to increased social complexity and safeguarding
- We have noted increase in numbers of younger families with very young children – continue to support families at end of life with memory and legacy work – this is time intensive and requires significant block of time allocated
- Increase in housing issues – working with patients with the threat of homelessness and living in very poor living conditions
- Seeing more patients and families living with end-of-life poverty – this will continue to increase as benefits allowances will decrease – more companies unable to keep patient employed in

long term sickness and many companies removing 'Death in Service' payments due to cost restraints.

- It continues to be busy, However, Alison and I continue to work very closely with IPU and Community team –we attend every MDT to keep 'in the loop' to be efficient with our time and to gain the best outcome for the patients at this time of their lives.
- And we delivered many Easter Eggs to our patients and families past and present – which were very gratefully received!

Elisa Lunn Specialist Palliative Care Social Worker

### **Wellbeing Services and Compassionate Neighbours**

- The run up to Christmas was extremely busy so perhaps the start of 2025 was slightly quieter. Even so, all of the sessions continue to attract large and modestly increasing numbers.
- We had a Warm and Well Session in January for which we secured a grant from the local NHS and which we delivered in conjunction with Wimbledon Guild.
- We marked the lunar new year with special projects in art and music (with treats of course)
- Morden Primary School's music department entertained a very receptive group of our attendees. Vinyl Matters a Seventies tribute band brought a different kind of music into the centre in February.
- Pancake Day inevitably saw the consumption of more treats and to mark the end of Ramadan we sampled an array of figs, dates and other snacks. It wasn't all about food though.
- Ramadan and EID were marked with another art project recreating ceramic tiles based on Moorish calligraphy with varying degrees of success but with much enthusiasm.
- Finally, March saw the start of a new group designed to support those with a terminal prognosis and is a real co-production inspired and lead by its attendees. The provisional name of this group is the in-betweeners ....
- The Compassionate Neighbours project continues apace. Limited resources have curbed expansion, so the focus has been on delivering a real quality service to those with the highest priority needs.
- Community members and compassionate neighbours are invited to all WBC events. More volunteers have been trained, and more matches have been made.

### **Social Engagement**

Below is a list of events attended/ groups visited in the first quarter:

London Hospice LGBT group  
Sutton Healthwatch AGM  
Merton Befriending Network  
Sutton Secondary Breast Cancer group  
Sutton Carers Death Café (with CAB, Sutton Palliative Care Hub and Poppy's Funerals)  
SANGAM - South Asian seniors  
Central Sutton INT  
Grove Road PPG

**Inpatient Unit**

- Our IPU Clinical Lead, Francis Quinon started in post on 9<sup>th</sup> January and has settled well into his role. Francis has been focusing on bed occupancy in particular.
- The IPU has predominantly been open to 10 beds over the past 3 months which is really encouraging to see.
- Our Senior Band 6 nurses, Penny and Julie, have stepped back into their original Band 6 roles and we are hugely grateful to them for managing the IPU so well whilst there was no IPU Lead in place.
- We now have a number of new bank nurses – both Registered Nurses and HCAs, meaning that there is more availability to cover shifts rather than needing to use agency staff.
- Both our nurses currently undertaking registration training are progressing well – Angela Durrant (Nursing Associate) is due to complete her RN training by the end of the summer, and Ruby Osei (HCA) is now well into her first year of Nursing Associate training.

**Community Palliative Care Team (CPCT)**

- We have one new member of staff –Alexis Fisher who is from a paramedic background and is working 30hrs per week.
- Jackie O’Grady has returned on the bank and is undertaking some HPOC hours for us.
- Michelle Brocklehurst has returned on the bank and has now undertaken a couple of shifts – lovely to see her back.
- Beverley Savioz continues in B6 development post
- Staff have attended training sessions in Conflict Resolution and Non-Medical Prescribing
- We continue to work closely with our NHS teams: Merton EoLC team and Sutton Palliative Care Coordination Hub- all services are feeling under pressure
- Our aim is for improved coordination of care between organisations involved:
  - Improved multidisciplinary working
  - A platform for shared learning
  - Dissemination of policies and best practice

<u>Activity for CPCT) as follows:</u>
<ul style="list-style-type: none"> <li>• <b>8 calls</b> regarding Unregistered patients, mostly from LAS / DN’s/ Urgent care, mostly OOH requesting advice. Large % known to MEoICT or SPCH</li> </ul>
<ul style="list-style-type: none"> <li>• <b>16 Fast Tracks completed</b> (Jan - end of March</li> </ul>
<ul style="list-style-type: none"> <li>• <b>Referrals-</b> 90 referrals received in Jan – steadied out remaining months</li> </ul>
<ul style="list-style-type: none"> <li>• <b>Increase of complaint</b> - dissatisfaction / expectation of service)</li> </ul>
<p><b>Joint visits continue for following reasons</b> - lone risk worker – verbally abusive to health care workers /false allegations / Illicit drug use / Medical support / Staff induction</p> <ul style="list-style-type: none"> <li>• <b>32 joint visits</b> (Sept – Nov) recorded by either CPCT or Medical Team across September, October and November 2024: 27 of which included Hospice staff and 5 included one Hospice staff and an external HCP</li> </ul>
<u>Impact due to cessation of H@H – recorded across the month of November</u>
<ul style="list-style-type: none"> <li>• There was a total of 26 identified episodes when it was felt that H@H input would have been of benefit (Sutton 12/Merton 10/Wandsworth 4). Two patients were identified on 2 different occasions due to change in condition – therefore a total of 24 individuals</li> </ul>
<ul style="list-style-type: none"> <li>• Rationale for H@H Support was: ‘respite or carer crisis’ 14/ CNS or SP support 6/Preferred Place of Death (PPD) support 5/avoidance of hospital admission 1</li> </ul>

<ul style="list-style-type: none"> <li>The classified Phase of Illness for these patients was: Deteriorating 14/ Unstable 7/Dying 4/ Stable 1</li> </ul>
<ul style="list-style-type: none"> <li>The work therefore taken on by the CPCT included the following: Required a F2F visit by CNS or SP 4/ Required a virtual assessment by CNS or SP 1/ Increased emotional support needs for patient and/or those important to them 7 (phone calls or F2F conversations)/Increased telephone calls for triage 9/ Unmet care needs meaning liaising with care agencies or being unable to support 3/ declined referrals and therefore signposting or referring to other services 2.</li> </ul>

## **Education/Training**

### **January**

- The education team supported Advanced Clinical Practice students at City St Georges University with two teaching sessions- one on palliative care trajectories and another on communication. These sessions were requested by the university and formed part of their MSc programme. A study day for our healthcare assistants was held on the 15<sup>th</sup> of January which included team building exercises and infection prevention updates. The attendance was good, and we received great feedback. Karen joined the team of facilitators for Sage & Thyme on 23<sup>rd</sup> January which was attended by SRH staff along with staff from ESHH. The community team attended conflict resolution training which was aimed at staff who visit patients' homes. This session was provided by an external trainer and received excellent feedback.

### **February**

- Non-medical prescribing update was provided to support community staff who have this extended role. Kevin Hobson, the NMP Lead, facilitated the update alongside the education team. A study day for the nursing staff on the in-patient unit was held on 13<sup>th</sup> February. Topics included tracheostomy care, male catheterisation, infection prevention and medicines administration. The team facilitated education sessions around common symptoms in end-of-life care and sensitive communication for prison officers and members of a prison chaplaincy team. These sessions were provided at a local prison and form part of a larger project aiming to connect with hard-to-reach groups.

### **March**

- Two members of our nursing team are undertaking nurse training as part of an apprenticeship scheme. The education team are required to meet with the individuals and their personal tutors on a regular basis. These meetings took place in March, along with a meeting with an external examiner to give feedback about the apprenticeship scheme from an employer's perspective. A local care home attended training at the hospice in verification of expected death. This is an extended role for registered nurses which is useful in community settings. Further sessions are scheduled for May. Maura completed training to become a Freedom to Speak Up Guardian.

## **Medical Team**

1. Medical cover has been identified as a risk. The consultant vacancy remains unfilled, though we have benefitted recently from a 7 week locum (Mar-April 2025) provided by Dr Katie Taylor. Becca Trower, Carrie Chill, Gaby Tamura Rose and Naomi Collins met to discuss options. There has been minimal interest in the consultant post, so the plan is to temporarily pull the advert at the end of April. The possibility of creating a 4 day a week clinical fellow role (for 6-12 months whilst consultant vacancy remains) is being actively considered. Naomi and Gaby will continue to cover 'on call' on their days off when we have no consultant in the Hospice.
2. We have two new psychiatric trainees joining the team in April/ May 2025. Both will work one day a week on a Wednesday.

## **Research**

3. Outcome of CHELseall study awaited – recruitment has now been completed for this nationwide study into hydration at the end of life.
4. Recruitment to the POST survey (into opinion about terminology) ongoing.
5. St Raphael's have registered interest in contributing to a national study examining the metabolites present in urine specimens towards the end of life.

## **Education**

Gaby Tamura Rose has addressed work experience students interested in a medical career and provided palliative care teaching for GP trainees. Naomi Collins gave a talk to GPs on symptom control at the end of life and continues with a Masters in Medical Leadership, City of London University.

## **Office Space**

An outpatient room has been created, and outpatient reviews started. This has necessitated an office move for the consultants and junior medical team.

## **CQC and Organisational Assurance**

The CQC last inspected the Hospice in [November 2019](#) and awarded a Good rating. The report is available via the Hospice website.

Much has changed since our last inspection, and we are keen to showcase all the developments we have made.

A depository for evidence of excellence is included as an Agenda item for the CQ&G Sub.

We expect our KLOE work will support our evidence base to demonstrate compliance. Achieving an 'Outstanding' rating at our next inspection and maintaining it in the future remains our ambition.

## **Governance Meetings**

The Hospice's 'Governance' meetings feed into the work of all the sub-committees of the Hospice's Board of Trustees. Presently, there are 6 clinically focused forums that currently feed into the CQ&G Committee.

The Health & Safety Committee feeds into the F&R Committee.

The Staff Consultative Group is suspended and the Training & Development Committee feeds into the HR Committee.

Governance Meetings - Clinical	Date last held	Date of Last Minutes Reviewed at CQ&G Sub	Next meeting
Clinical Audit and Activity Data	Apr'24	Apr'24	May'25
Clinical HODs	Apr'25	Feb'25	May'25
Medical Business	Apr'25	Apr'25	May'25
Drugs & Therapeutics	Apr'25	Feb'25	Aug'25
Outcome Measurement Group	Dec'22 (no min)	May'22	Pended
Infection Control	Feb'25	Feb'25	Jul'25
Prescribers	Nov'24	Nov'24	Mar'25

## **Incidents / Accidents / Near Misses**

- Each incident is reviewed by the line manager (HOD) and all incidents receive final approval from a member of the Executive team. Clinical review has been incorporated into the business of the Clinical Heads of Department Meeting that meets every 6 weeks. Those that are non-clinical are reviewed at H&S Committee. Representatives are expected to cascade review information back to their teams and an incident feedback facility is programmed into the DATIX report for the reporter. Data is presented later in this report and engagement with the system continues to be healthy, from both clinical and non-clinical departments.
- An annual report for incidents has been included as a future planning priority in 2023/24's Quality Account and is part of the Management Plan objectives for 2024/25 to demonstrate the range of incidents / accidents recorded across the Hospice and to provide a useful reference point for the learning taken.
- Quarterly submission to Hospice UK's Quality Metrics project began in July 2017 and are on-going with the latest submission made in April 2025. The submission categories cover pressure sores, patient medication incidents and incidents of patient falls.

## **Quality Account**

The Hospice published its **Quality Account** for 2023/2024 to its website on 4<sup>th</sup> July 2024 and URL notification sent to the NHS. It is available [here](#) and copy is made available within the Hospice.

## **EMIS**

The EMIS system has been in place since May 2023.

The project team includes Clinical Admin (Kelly & Dawn) who provide users with additional practical support, along with John Groom, Heather Siddall, Tracy Christmas, Alex Rudkin and Dr Gaby Tamura-Rose. The group meets only periodically now as the system is embedded. The implementation of electronic prescribing in the community is not part of current planning.

EMIS facilitates the data capture that supports the care planned and delivered alongside the data output that feeds into SWLICB activity review meetings.

Use of EMIS mobile provides both connectivity contingency and facilitate community engagement. Shared record access is in place with all GP practices in Sutton & Merton and the community hubs of Sutton and CLCH (Merton/Wandsworth).

## **Clinical Audit, Quality Improvement, Monitoring and Research**

Proactive audit of the prescription charts remains a weekly undertaking for our clinical Pharmacist and results are routinely shared via the Live Care system and reported to the D&TC. The management of controlled drugs (CDs) audit is an annual audit undertaken by the Ashton's Pharmacist and our Clinical Director who is our Accountable Officer for CDs.

An IPU led-audit based upon the clinical pharmacist audit of the prescription charts has been included in the 2025/26 clinical audit program in order to better identify and associate learning opportunity based upon the clinical pharmacist findings

Review of progress with the clinical audit program and opportunity to feedback results is provided at CHoDS and via the Clinical Audit and Activity Data forum (CAAD). Its next meeting is scheduled for May2025. A Clinical Audit and Quality Improvement Project Presentation Forum that provides platform for project leads to present results of their project to a wider audience was last held in November 2024 with presentations delivered on CSCI Audit; Fast Track on the IPU and IPU Admissions Audit (presentations included in papers). The forum usually occupies a lunch-time slot and is open to the clinical teams and those with an interest in topic.

Progress of the Audit/Research Programme 2025/26 - spanning clinical audit, quality improvement, research and data monitoring - is set out from page 11. At the start of 2025/26 we set out 25 projects for pursuit. New topics in 2025/26 include Admission Meeting, Discharge Summary and Medicare nurse call system responsiveness alongside Complementary Therapy Feedback. Ownership is delegated across the clinical team and Quality office and the medical team projects have Dr Tamura-Rose as medical audit and research overseer.

## Data Dashboards

The population of clinical data dashboards that inform the service areas of the IPU, Well-being Centre, Community and Psychological Support Services teams is expected to be re-commenced in 2025/26 subject to priorities highlighted at the CAAD meetings. An index of tracked data that has been periodically presented and communicated to the clinical team is held.

Report Reference	Title	Lead	Created	Function	Primary Aud.	Exec / CCG Interest	Freq
20/001	UCR Monitoring	TC	Jan-20	To improve UCR data capture	CPCT	Yes	Weekly
20/002	NOK Details	AH	Jan-20	To improve NoK data capture	Psy / Bereavement/ Qual / Donor Support	No	Monthly
20/003	Community Team Visit Responsiveness	LB	Jan-20	To support responsiveness evidence	CPCT	Yes	Quarterly
20/004	Sharing Information Consent	TC	2018	To monitor and improve Sharing Information Consent data capture	CPCT	No	Monthly
20/005	Safeguarding Monitoring	EL	Feb-20	To highlight patients with safeguarding concerns and track follow up	CPCT	No	Monthly
20/006	Referrals Monitoring	LB	Mar-20	To monitor and improve Referrals data capture	CPCT	No	Monthly
20/007	Referral to RIP Monitoring	LB	Mar-20	To monitor time between referral and death	CPCT	No	Monthly
20/008	Active Caseloads	NS/RT	May-20	To monitor active caseload levels	Exec	Yes	Weekly
20/009	Daily Activity Data - capacity tracker support	NS/RT	May-20	To monitor activity recorded on Crosscare	Exec	Yes	Daily
20/010	Referrals by Postcode	DN	Jun-20	To monitor referrals by postcode	Fundraising & Exec	Yes	Monthly
21/001	PPoD vs Actual PoD Monitoring	RT	Apr21	To monitor PPoD achievement rates	Exec	Yes	Quarterly
21/002	IPU Waiting Times / Requests for Admission	RT	Feb-22	To demonstrate the servicing of admission requests and profile waiting times for admission	Exec	Yes	Quarterly

## Clinical Quality & Governance Management Plan Objectives 2024/25

DATE	Number	Complete / on-going	Into 25/26	Pended
27-09-2024	28	3 / 21	1	3
10-01-2025	28	8 / 16	1	3
24/04/2025	28	20 / 0	3	5

### Goals Completed

	Goal
3.1	Develop provision for psychiatry trainee support for Hospice Dr GTR approached several Psychiatry trainees interested in visiting the Hospice as part of their "special interest"
3.2	Produce and maintain an audit/monitoring/research project schedule 2024/25
3.3	Maintain student bereavement counsellor placements at 8
3.4	Maintain delivery of Trauma Specific Work (EMDR).
3.5	Develop the Bereavement Pathway Project
3.6	Evaluate the Patient Safety Incident Response Framework and position the Hospice accordingly
3.7	Support the design, implementation, training, use, integrity and output of the EMIS system Ensure input templates are fit for purpose
3.8	Maintain an establishment that services the safe delivery of care for a 10 bed IPU
3.9	Expand Provision of Bereavement Support Work to High down Prison as well as specialist palliative care psychotherapy to residents end of life.
3.10	Maintain a robust approach to Infection Control across clinical and non-clinical services - IPC link healthcare professionals supported to continue leading on audits - Closer working between Facilities, Housekeeping and clinical services
3.13	Developing a Complementary Therapy survey with the Comms Team
3.14	To maintain the development of joint-working across the clinical areas
3.15	Continued development of Locality Team Lead Roles and responsibilities via Job Descriptions review to ensure currency Education opportunities Coaching opportunities Support/ feedback from line manager
3.16	Development of education programme to include- mandatory and statutory education requirements Facilitating access to CPD based on individual and service needs Support the development of extended roles for HCA and registered staff. For example, second checker role and audit.
3.17	Increase SRH presence in the Merton Borough/Sutton / Wandsworth via appropriate referrals - Collaboration with MEoLCT/ Sutton PCH Daily referrals meeting TC to work with HPOC lead maximising opportunity Continue to encourage self-referral for patients discharged from the Hospice clinical service Closer working with referrers to improve quality of referral information provided
3.18	Sustain provision of a 10 bed IPU including the family suite appropriately staffed A more responsive and active IPU

	<b>Goal</b>
<b>3.19</b>	<p>Developing and supporting band 6s to lead the ward in while there is a IPU clinical lead vacancy</p> <p>All band 6s to allocated specific roles and responsibilities to support running of the ward</p> <p>Discussing in-house management course for band 6s with no previous training.</p> <p>IPU clinical lead vacant post appointed to</p>
<b>3.21</b>	<p>Develop the compassionate community's model</p> <p>Learn from other Hospice organisations that have developed this model</p> <p>Work in collaboration with the Wellbeing Centre to communicate and inform about CC</p> <p>Recruit volunteers to support CN</p> <p>Potential to work collaboratively with other voluntary sector organisations such as Age UK, Sutton/Merton Carer Centres.</p>
<b>3.22</b>	<p>Embed our CT services into the Living Well program in order to reach more people. That means taking part into the Pampering sessions every six weeks.</p> <p>Offer complementary therapies in the Den.</p> <p>Attend the needs of the IPU by offering 'aromastick' inhalers and short treatments with the assistance of volunteers.</p> <p>For example: develop a "prepare to sleep" program for patients and carers in IPU with the help of a nurse and an HCA champion.</p> <p>Recruit more volunteer therapists via advert in social media (liaison with Comms)</p> <p>Liaise with other therapists</p>
<b>3.23</b>	<p>Wellbeing : Double our morning and afternoon sessions on Tuesdays, Wednesdays and Thursdays using both The Den and The Wellbeing Centre.</p> <p>Increase the range of services to include additional art sessions, light exercise classes, tech support, scam awareness and more social sessions (card/bridge/board games/quizzes).</p> <p>Try to get outside more: regular Walk and Talks, utilising the outside space for sessions when the weather allows and starting regular gardening sessions in raised beds.</p> <p>Reinstate carers lunches</p> <p>Continue to run trips to galleries/theatre/museums</p>

## Audit / QI /Research 2025/26

### Overview

23 projects scheduled in 2025/2026

### **2025/26 Listing**

Project Ref.	Title	HQIP Prioritisation	Lead	Status
2025/26 -01	IPU & Community - VOICES survey of bereaved next of kin 3-6months post bereavement	• Priority 2 Internal 'must do' audit	Quality Office - J Cope / A Rudkin	Ongoing – Last published in February 2025 Report for Apr 24 – Sep 24 due in May 2025
2025/26 -02	IPU - Patient Satisfaction	• Priority 2 Internal 'must do' audit	IPU – F Quinon Quality Office - J Cope / A Rudkin	Ongoing - 2025 report for publication in Mar 2026
2025/26 -03	IPU – Infection Control: Environment & Hand-washing Audit	Priority 1 External 'must do' audit	IPU – D Akatea-Lewis / C Foster Community - J Smith Quality Office - J Cope / A Rudkin	Ongoing - Quarterly production of graphical compliance for IPU display across Handwashing, Staff, Mattress, Environment and Sharps.
2025/26 -04	IPU - Medicines Management Audit	• Priority 2 Internal 'must do' audit	Ashton's Clinical Pharmacist	Ongoing Last published in April 2025
2025/26 -05	IPU - Re- Audit against Audit NICE Guidance NG31 Care of Dying Adults at the End of Life	Priority 1 External 'must do' audit	Dr Naomi Collins	2024 audit report drafted and under Consultant review Data collection for 2025 re-audit tba
2025/26 -06	Controlled Drugs Annual Audit	Priority 1 External 'must do' audit	R Trower	Ongoing Last published in April 2025

Project Ref.	Title	HQIP Prioritisation	Lead	Status
2025/26 -07	Admission Meeting – Process Review	• Priority 4 Clinician interest audit	Dr Charlotte / Theo – Medical Team	Project to be planned
2025/26 -08	Outcome measures (Step 2- CSNAT)	• Priority 2 Internal ‘must do’ audit	Implementation Group Dr NC / TC	Project to be planned
2025/26 -09	Psychological Support Services Questionnaire	• Priority 4 Clinician interest audit	Psychological services DB	Jul-Dec 2024 rpt expected in Apr/May 2025 Ongoing
2025/26 -10	Activity Monitoring Data UCR NOK CPCT Responsiveness Sharing Information Safeguarding Referrals Referrals to RIP Active Caseloads Daily Activity Data - capacity tracker Referrals by Postcode PPOD	• Priority 3 Specialty Priority	Quality Office+ CAAD	For revival via CAAD in 2025/26
2025/26 -11	IPU & Community & Psychological Support Services - Activity Data Dashboards Development	• Priority 2 Internal ‘must do’ audit	Quality Office + CAAD	Ongoing
2025/26 -12	Incidents	• Priority 2 Internal ‘must do’ audit	Quality Office + CHODs	Ongoing NEW annual report expected pre-June 2025
2025/26 -13	Falls	• Priority 2 Internal ‘must do’ audit	Quality Office + CHODs Mtg	Ongoing - April 2024 - March 2025 chart last produced in April 2025

Project Ref.	Title	HQIP Prioritisation	Lead	Status
2025/26 -14	Complaints	• Priority 2 Internal 'must do' audit	Quality Office + Exec	Ongoing – 2024/5 complaints review to be held and reported in May 2025
2025/26 -15	Safeguarding Documentation	• Priority 3 Specialty Priority	Elisa Lunn Quality Office	Ongoing - 2024 annual report published in April 2025
2025/26 -16	Clinical Records Documentation	• Priority 2 Internal 'must do' audit	R Trower	Last Reported in Dec 2022. Re-audit in 2025/2026
2025/26 -17	Referral to the IPU Re-Audit	• Priority 3 Specialty Priority	TBA	Timeline and Lead tba with Medical Team
2025/26 -18	Caldicott - IG Sweep	• Priority 2 Internal 'must do' audit	Dr G Tamura-Rose	Annual Data collection Tool revised in May 2024.
2025/26 – 19	Advance Care Planning Re-audit	• Priority 2 Internal 'must do' audit	Dr G Tamura-Rose Tracy Christmas	Data collection underway in July 2024 Project to incorporate 2025 comparative data. Timeline tba.
2025/26 - 20	Discharge Summary audit	• Priority 3 Specialty Priority	Dr K Taylor	Data Collection Underway
2025/26 – 21	Clinical Pharmacist Prescription Chart Error	• Priority 2 Internal 'must do' audit	F Quinon / Quality Office	Project under planning
2025/26 - 22	Medicare – call bell responsiveness	• Priority 2 Internal 'must do' audit	F Quinon / Quality Office	Project under planning
2025/26-23	Patient 'label' research project - the PhD project for a Pall Care SpR in Our Ladies Hospice in Ireland, Dr Any Taylor. Prof Andrew Davies is the overall Principal Investigator and Dr Charlotte Leach, Pall Care Consultant at Royal Surrey County Hospital, is UK lead.	Research participation	Dr N Collins	Data collection started in November 2023 (whole project nationally to recruit 383 patients across 7 sites).

## Clinical Risk Management

**Clinical Unexpected Incidents** : Overview of incident data for January – December 2025 is shown below:-

2025	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2025	2024	2023
Admissions to IPU	16	16	20										52	211	207
Discharges	4	6	6										16	33	
RIPS on IPU	7	13	13										33	169	
Beds	10	10	10												
Bed Occupied Days	244	235	223												
Bed Available Days	310	280	310												
Bed Occupancy (10 beds)	78.71%	83.93%	71.94%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	0.00%	0.00%	0.00%			
CD Medication Incident	1	2	1										4	22	42
CD Medication Near Miss	0	0	0										0	2	1
Non-CD Medication Incident	0	2	2										4	8	23
Non-CD Medication Near Miss	0	0	0										0	0	0
Pressure Sore on Admission	3	7	2										12	34	30
Pressure Sore during Admission	0	0	3										3	27	16
Moisture Associated Skin Damage ON	0	0	0										0	2	1
Moisture Associated Skin Damage	0	0	0										0	2	1
Sharps/Splash	1	0	0										1	0	3
Infection (Near Miss)	0	0	0										0	0	0
Infection	0	0	0										0	1	3
Unexpected Transfer	0	0	0										0	0	0
Near Miss(non-medication & non-IG)	0	0	0										0	0	0
Staffing	0	0	0										0	2	0
Behaviour (staff) : non-complaint	0	0	0										0	0	0
IG	0	0	0										0	8	15
IG near miss	0	0	0										0	0	3
Manual Handling	0	1	0										1	1	0
Slips, trips, falls	1	1	3										5	32	14
Falls near miss	0	0	1										1	0	6
Verbal Violence (Pt)	0	1	1										2	1	1
Verbal Violence Rel)	0	0	0										0	2	
Physical Violence (Pt)	0	0	0										0	1	2
Physical Violence Rel)	0	0	0										0	1	
Bump	0	0	0										0	1	0
Burn/Scald	0	0	0										0	1	1
Equipment	0	0	0										0	1	2
Equipment (near miss)	0	0	0										0	0	2
Doctor On Call	0	0	0										0	0	1
EXEC Out of Hours Call	0	0	1										1	21	5
OTHER -	1	1	2										4	15	11
MAD Alerts (re SRH)	0	0	0										0	0	2
* Incidents reported to Community –	0	1	2										3	3	7
* MAD Alerts (incl. in Community:non-	0	0	0										0	0	3
<b>Total 2025 *excluded</b>	<b>7</b>	<b>15</b>	<b>16</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>38</b>		
<b>Total 2024 *excluded</b>	<b>16</b>	<b>11</b>	<b>9</b>	<b>18</b>	<b>24</b>	<b>17</b>	<b>25</b>	<b>17</b>	<b>19</b>	<b>14</b>	<b>9</b>	<b>6</b>		<b>185</b>	
<b>Total 2023 *excluded</b>	<b>26</b>	<b>8</b>	<b>31</b>	<b>7</b>	<b>24</b>	<b>12</b>	<b>4</b>	<b>15</b>	<b>20</b>	<b>13</b>	<b>23</b>	<b>9</b>			<b>192</b>

## Incident Key

<b>Medication Incidents</b>	
<b>Level 0</b>	Error prevented by staff or patient surveillance
<b>Level 1</b>	Error occurred with no adverse effect to patient
<b>Level 2</b>	Error occurred: increased monitoring of patient required, but no change in clinical status noted
<b>Level 3</b>	Error occurred: some change in clinical status noted and/or investigations required: no ultimate harm to patient
<b>Level 4</b>	Error occurred: additional treatment required or increased length of patient stay e.g. Naloxone required for opioid overdose
<b>Level 5</b>	Error resulted in permanent harm to patient
<b>Level 6</b>	Error resulted in patient death
<b>Reference</b>	Wilson DG et al (1998) in Naylor R, Medication Errors, Radcliffe medical press, Oxford, 2002.

<b>Falls</b>	<b>Include all slips, trips and falls (inpatient unit only).</b> (e.g. if a patient is found on the floor, lowered themselves onto the floor, slipped from a chair, rolled out of bed, etc)
<b>No harm</b>	Impact prevented – any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people receiving care. Impact not prevented – any patient safety incident that ran to completion but no harm occurred.
<b>Low harm</b>	Harm requiring first-aid level treatment, or extra observation only (e.g. bruises, grazes). Any patient safety incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving care.
<b>Moderate harm</b>	Harm requiring hospital treatment or a prolonged length of stay but from which a full recovery is expected (e.g. fractured clavicle, laceration requiring suturing). Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm, to one or more persons receiving care.
<b>Severe harm</b>	Harm causing permanent disability (e.g. brain injury, hip fractures where the patient is unlikely to regain their former level of independence). Any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving care.
<b>Death</b>	Where death is directly attributable to the fall. Any patient safety incident that directly resulted in the death of one or more persons receiving care.
<b>References</b>	- National Patient Safety Agency 2010 Slips trips and falls data update NPSA: 23 June 2010. - NPSA Seven Steps to Patient Safety.

<i>Clinical Significance</i>	Jan	Feb	Mar	Jan-Mar	Apr	May	Jun	Apr-Jun	Jul	Aug	Sep	Jul-Sep	Oct	Nov	Dec	Oct-Dec	2025	2024	2023
Admissions to IPU	16	16	20	52	0	0	0	0	0	0	0	0	0	0	0	0	52	211	207
Bed Occupied Days	244	235	223		0	0	0		0	0	0		0	0	0				
Bed Available Days	310	280	310		0	0	0		0	0	0		0	0	0				
Bed Occupancy	78.71%	83.93%	71.94%		#DIV/0!	#DIV/0!	#DIV/0!		#DIV/0!	#DIV/0!	#DIV/0!		0.00%	0.00%	0.00%				
Fall No Harm	1	1	3	5				0				0				0	5	26	11
Fall Low Harm	0	0	1	1				0				0				0	1	6	3
Fall Moderate Harm	0	0	0	0				0				0				0	0	0	0
Med Level 0	0	2	0	2				0				0				0	2	9	32
Med Level 1	1	2	3	6				0				0				0	6	23	34
Med Level 2	0	0	0	0				0				0				0	0	0	0
Med Level 3	0	0	0	0				0				0				0	0	0	0
Minor (No Harm or Low Harm)	2	3	4	9				0				0				0	9	56	62
Moderate (Moderate Harm)	0	0	0	0				0				0				0	0	0	0
Serious (serious Harm)	0	0	0	0				0				0				0	0	0	0
Pressure Ulcers	3	7	5	15				0				0				0	15	65	50
Totals 2023	7	15	16	38	0	0	0	0	0	0	0	0	0	0	0	0	38		
Totals 2024	16	11	9	36	18	24	17	59	25	17	19	61	14	9	6	29		185	
Totals 2023	26	8	31	65	7	24	12	43	4	15	20	39	13	23	9	45			192

**Clinical Complaints**

- There have been 3 clinical complaints received in and between January and March 2025.

**Complaints Overview**

2025 - Complaints	CPCT / Care	CPCT / Comms	CPCT Care & Comms	IPU Care	IPU Comms	IPU Care & Comms	Counselling Comms	Bereavement Comms	Reception Comms	Volunteer Services Comms	Fundraising /Shop Comms	HR	Total	UPHELD in Whole or Part
January			1				1						2	1
February								1					1	1
March										1			1	1
April														
May														
June														
July														
August														
September														
October														
November														
December														
2025			1				1	1		1			4	3
2024	0	1	0	0	0	0	0	0	0	1	17	0	19	17
2023	1	4	0	1	4	0	0	1	1	0	10	0	22	20
2022	3	0	0	2	3	0	0	0	0	0	0	0	8	6
2021	4	5	0	1	1	1	0	0	0	1	0	0	13	12
2020	4	1	0	2	3	1	0	1	0	0	1	2	15	14

**Clinical Complaints: January – March 2025**

ID	FROM	DATE RECEIVED	DETAILS OF COMPLAINT	MAIN CLASS	ACTION TAKEN SUMMARY	UPHELD IN PART OR WHOLE
2025/03	Relative to patient	12/03/2025	Complaint was raised by a family of patient in the IPU about the staff in the reception making unsavoury comments about their use of the galley kitchen. Insulting comments were heard by the patient's daughter that they treat the hospice " like the NHS" that they should not be using the kitchen's coffee and tea as it was intended only for the staff. The family member further stated that the 2 staff member by the reception were also hurling insults to the rest of the relatives visiting the IPU. The daughters of the patient were so distressed by this incident.	Reception Comms	FQ spoke with the daughters of the patient and apologised and assured them that we will not inhibit them from using the galley and that they are welcome to use these facilities to help them through their difficult times. FQalso assured them that we will look into this and make sure that no such thing will happen again and that learning will be made and improvements will be in place going forward. Statement from Volunteer manager explaining incident - reflection on what was said and that there was a misunderstanding regarding who can use the Galley Kitchen. Staff who were present are now aware. Family have received an apology from the IPU staff on behalf of the reception staff. Email to go out to all reception staff to remind them that visitors have access to the kitchen and also to be aware of what is spoken about at reception.	Upheld
2025/02	Client	16/01/2025	Client made verbal complaint over telephone to CD re the bereavement counselling accessed at St Raphael's being unsatisfactory to her need. She stated that the counselling was not good enough and she didn't feel she should have to question a therapeutic relationship.	Counselling Services	CD advised that she understood that at the beginning of her last counselling session, our counsellor discussed the use of boundaries and mutual respect for one another. However, during the session, the client raised her voice and swore at the counsellor, leaving her feeling intimidated. Client confirmed to CD that she swore but that it was not directed at our counsellor. Whether this was her intention or not, CD expressed that we will not tolerate abuse and therefore feel unable to continue with counselling provision. CD offered to help client to seek external counselling but this was declined.	Not Upheld

2025/01	Daughter	02/01/2025	Patient' daughter called Reception to voice a complaint about her mother's care. CD advised and made contact with daughter.	CPCT Care	<p>CD liaised with the clinical team in conducting her investigation and responded to the complainant providing rationale for the clinical decisions taken and the evidence that supports those decisions. Responding in detail to the points raised under Hospice values of Safety, Teamwork and Support, Respect and Accountability, Person-centred care and Excellence and Leadership she explained:-</p> <p><b>Safety</b> – the use of morphine was not premature in our clinical opinion and the dose was low, titrated up slowly over a number of days as is recommended according to the PANG guidelines. It can sometimes be a difficult balance between managing pain and preventing side effects such as nausea/vomiting and fatigue, and some people tolerate it better than others. The morphine was discontinued ten days after commencing it due to your mother presenting with side effects at that time.</p> <p><b>Teamwork and Support:</b> I'm sorry that you feel your family received minimal support. We have limited resource and are predominantly charity funded. Although we would like to offer more support to those we care for and those important to them, we are only able to work within the resource that we have, something which we find equally frustrating. It is disappointing that you found our care to be insincere and inadequate.</p> <p><b>Respect and Accountability</b> – as above, I'm sorry that you felt a lack of support and have been left feeling abandoned. We will be in touch to offer you bereavement support – should you wish to speak to one of our team in the meantime, please do feel free to contact me.</p> <p><b>Person-Centred Care-</b> I'm afraid we are unable to comment on the care or discharge process provided at St George's Hospital. However, I can assure you that our team spoke with the Hospital Palliative Care Team at St George's to highlight that your wish was for your mother's discharge home as soon as possible.</p> <p><b>Excellence and Leadership</b> – I am sorry that you feel the care that we provided to your mother did not meet the standards expected from a leading palliative care service. We always strive to provide a high standard of care to the best of our ability and clearly our care of your mother did not meet your expectations.</p>	Upheld in part
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**Constructive feedback: January – March 2025**

ID	FROM	DATE RECEIVED	DETAILS OF CONSTRUCTIVE FEEDBACK	ACTION TAKEN SUMMARY
2025/04	DN Lead	17/02/2025	<p>During the Merton Huddle - a forum for sharing practice with community service there was verbal feedback followed by an email from DN lead initially requesting information regarding working models on</p> <p>NMP - anticipatory prescribing Virtual assessment</p> <p>CPCT Manager replied outlining the policies for above to receive an email response highlighting further concerns regarding the hospice community service including response , communication and model of working</p> <p>DN Lead : I wanted to address the email I received, as it lacked clarity regarding the situation, which is why I felt it necessary to discuss it further during our meeting yesterday.</p> <p>Regarding the virtual assessments and NMP, I want to clarify that, as a prescriber myself, I am fully aware of the prescribing framework that we, as prescribers, are required to adhere to. However, in this particular case, given that the patient was in pain in addition to, a complex family dynamic, I did not believe a FaceTime call was the appropriate approach. I still stand by this decision, as I felt it placed the nurses in an uncomfortable and unfair position.</p> <p>It is also important to note that the patient was only open to the DN Team for a brief period. I'm not entirely sure what transpired, but I am aware that the patient's wife had informed the nurses that she had been expecting a call from the Hospice days before contact was made.</p> <p>Furthermore, the decision to initiate a syringe driver was made by the Hospice, not at the request of the DN Team and given that the busy holiday period was upon us, it would have been helpful to have the medications on the chart for this reason. There needs to be exceptions and foresight to anticipate the deterioration and not a crisis when the deterioration occurs especially over long bank holiday periods. When the nurses were on site and voiced concerns about the patient's pain and assessments, it became evident that there was a gap in communication. When calling the Hospice for action, it is crucial that nurses concerns are acknowledged and addressed in a way that works well for everyone.</p> <p>As the day team lead, I cannot speak on behalf of the night nurses team regarding the setup of the syringe driver. However, I can confirm that a task was sent to the night nurses for this purpose.</p> <p>There is also a recurring issue in that the DN teams are not kept informed about changes implemented by the Hospice, nor are these changes properly explained when nurses reach out to query. This has become a significant issue, as many of the teams in Merton share a similar experience of feeling unheard when communicating with the Hospice or raising concerns about patients. This has led to increased frustration and distress, especially when managing end-of-life patients requiring complex care.</p> <p>I also wanted to acknowledge your point about the Pan London MAAR chart policy – no one is denying the importance of that. However, it is becoming increasingly clear that there needs to be much better collaborative working between the DN teams and the Hospice. Unfortunately, this collaboration is currently lacking, which is contributing to the ongoing challenges we face.</p> <p>Both services are under immense pressure right now, with high demand, and limited time and capacity. I believe that with a more cohesive and coordinated approach, we could alleviate some of the strain on our teams and ensure the highest standard of care for patients in their final days. Thank you.</p>	<p>CPCT Manager : I am sorry you feel this way, as stated it was feedback and I received no reply to the email requesting clarity</p> <p>All health care partners are under an incredible pressure, and we have to consider how we can be time efficient to cover both boroughs, especially at weekends . I would also agree that no nurse should be placed in an uncomfortable position however the nurse also has a duty to report they are uncomfortable with the decision at the time of the event. The CNS / NMP is very experienced, and her notes demonstrate a detailed virtual assessment and clinical decision making to be able to prescribe the CSCI MAAR .</p> <p>We contacted the wife on the Dec 20th , within 24hrs of discharge, and booked a routine 1 st assessment . This was escalated to a response visit on the 24th following a triage call from the daughter. Despite 33% cut in staff due to lack of NHS funding , we have continued to have a response rate of seeing 42% of referrals within 7 days . Following the redundancies we have reviewed and changed our model of working to allow response visits such as this, however this sadly means we have less input with those patients that are more stable . Unless there is a significant amount of increased funding from the NHS our staffing will not change.</p> <p>As per my earlier email I have shared the NMP's caution and learning . S/c PRN's are available until CSCI MAAR can be obtained . The CNS returned to complete the fast track to obtain POC for the BH period .We requested nights sits but CHC declined</p> <p>We have two CNS/P each day 8-6 on telephone triage and access to consultants if needed . We would strongly urge you phone in to discuss any concerns or questions . We also now have EMIs sharing . The Merton Huddle has been formed to try and improve collaboration and support for each other in these increasingly challenging times. Maybe communication is something you wish to place on the agenda and discuss for the next huddle ?</p> <p>I hope this has now concluded the points that we both needed to raise.</p> <p>BW</p>

ID	FROM	DATE RECEIVED	DETAILS OF CONSTRUCTIVE FEEDBACK	ACTION TAKEN SUMMARY
2025/03	Wife of patient	27/01/2025	Telephone call received from wife of community patient 1830 following his death. She recognised the responsiveness of our service however she would have liked us to have worked more preventatively, anticipating his needs and planning to prevent crisis rather than reacting to a crisis. I have shared our enquires email address and she will provide her suggestions for improvement in writing.	CPCT Manager has shared our enquires email address and she will provide her suggestions for improvement in writing. No correspondence received.
2025/02	SRH CPCT	10/01/2025	10.01.2025 Email of concern sent to Merton Rapid Response team, MRRRT line manager regarding the management of bladder scanning and catheterisation for patients in the final days of life at home. A recent case highlighted the possible need for a clearer pathway for those patients who are end of life to ensure that they receive the appropriate care while avoiding unnecessary hospital admissions.	No reply other than that they are reviewing the service specification
2025/01	Daughter of patient	10/01/2025	EMIS 2242 Call returned to daughter and wife following message from ACC By HPOC. Daughter trying to find out who is responsible for her Dad's palliative care support. She understands the referral to the hospice was rejected but unsure why. Her Dad has been seen once by SPCH but since then there has been little contact. Daughter said she is unable to get hold of them/calls are not returned. Daughter advised her Dad struggles with his breathing, becomes SOBOE. She and her Mum would like to put ACP/DNACPR in place. Her Dad has not had a review by the GP recently. Main issue is care- his wife provides all care and she is finding this very hard. She is currently off her job at Epsom & SHH- may need to take unpaid leave. Family do not wish for NH placement. HPOC apologised for any confusion and explained how we and SPCH work together in the community. HPOC explained why the referral was rejected. HPOC advised will ask for SPCH to make contact and arrange a visit to review. HPOC explained funded/social services/private funded care. HPOC advised unfortunately the hospice has no care services. HPOC will update family once I have spoken to SPCH team. HPOC will highlight to manager given confusion in who was leading care.	SPCH contacted by SRH HPOC and informed of family concern Patient is not known and currently doesn't meet hospice referral criteria No further action required

### Records – Access Requests

Between January and March 2025, we have had no access to record requests.

	DSARs	Access To Health Records	Sharing	Care Cost Summary
2025	0	0	0	0
2024	4	1	4	2
2023	0	0	3	5
2022	0	5(*2)	1	3(*2 included)
2021	0	5	4	
2020	0	3	4	
2019	1	4	0	

### CQC Notifications

Between January and March 2025, there has been 1 serious injury notifications made to the CQC concerning pressure sore grade 3 on Admission.

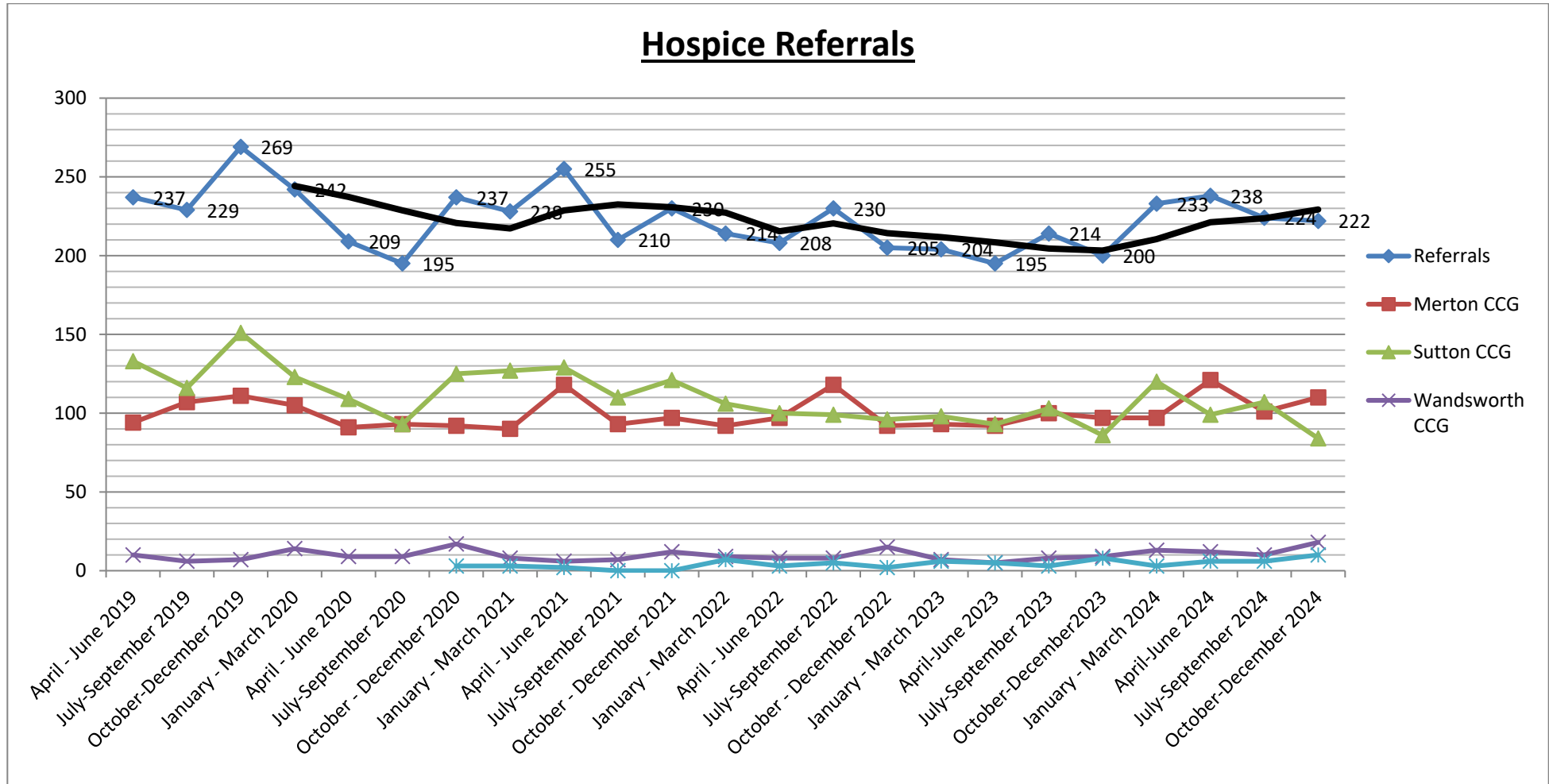
Between January and March 2025 there have been 0 safeguarding notifications made to the CQC

	Serious Injury	Safeguarding
2025 Jan - Mar	1	0
2024	30	8
2023	21	13
2022	9	21
2021	10	19

There have been no safeguarding notification raised against St Raphael's in 2025.

**Clinical Commissioning Group (CCG) Data**

Submission of Activity data for the preceding quarterly period is routinely supplied to the SWL CCG prior to our contract review meetings.



The authors of this paper are Mrs R Trower- Clinical Director, Dr N Collins – Lead Palliative Care Consultant and Mr A Rudkin - Director of Quality with inputs from clinical heads.

Meeting: <b>Clinical HODs Meeting</b>			
Date: 24.02.25		Time: 13.30	
Chair : Rebecca Trower		Minutes: Lynn Jackson	
Present: Tracy Christmas TC, Maura Flint MF, Dr Naomi Collins NC, Dr Gaby Tamura-Rose GTR, Sara Mosalam SM, Alex Rudkin AR, Francis Quinon FQ, Diana Bromboszcz DB, Dr Shahlaa Walsh SW			
<b>Apologies:</b> Tracy Christmas			
Agenda item	Discussion	Actions & by whom	Anticipated date for completion
<b>Review of previous minutes</b>	Accurate		
<b>Matters Arising</b>			
Topic			
Infection Prevention	Last IP&C of 2024 held on 12 <sup>th</sup> November. Next mtg scheduled for 25th February 2025. Minutes at <a href="N:\Minutes of Meetings\Infection Control Committee\2024\2024-11-12\2024-11-12 SRH Infection Control Committee Minutes.pdf">N:\Minutes of Meetings\Infection Control Committee\2024\2024-11-12\2024-11-12 SRH Infection Control Committee Minutes.pdf</a>  Clinical staff to have Hep B vaccine	SM & Jacky HR to email staff reminders	
Medical Devices	Catheter stands are incompatible with bags.  7 Syringe Drivers on the ward. 3 in repair.	FQ/SM to review & order new ones where necessary  FQ & Pete M to do an equipment audit/inventory	
Medicine Management	FQ reported to CHODS that he witnessed a medication error it has been been datixed & actioned with reflection education given to the nurses involved		

<p>Incidents &amp; Accidents</p>	<table border="1" data-bbox="375 347 1034 571"> <thead> <tr> <th>IPU</th> <th>Nov 24</th> <th>Dec 24</th> <th>Jan 25</th> </tr> </thead> <tbody> <tr> <td>Admissions</td> <td>15</td> <td>15</td> <td>16</td> </tr> <tr> <td>Discharges</td> <td>2</td> <td>4</td> <td>4</td> </tr> <tr> <td>RIPs</td> <td>10</td> <td>15</td> <td>7</td> </tr> <tr> <td>Occupancy</td> <td>66.13%</td> <td>75.16%</td> <td>78.71%</td> </tr> </tbody> </table> <p><b>January 2025</b> Pressure ulcers (incl. MASD) during admission (n=3), pressure ulcers (incl. MASD) on admission (n=0), patient falls (n=1), CD medication incidents (n=1), sharps incident (n-1) constitute 86% of reported clinical incident numbers in January 2025 which is the lowest reported numbers in a January since 2021. <u>Outcome from incidents include:-</u></p> <ul style="list-style-type: none"> <li>- Reminder email to staff for stringent checks of medications received from admitted patients following storage/count of zolpidem.</li> <li>- Increased stringency in ensuring safety when checking patient clothing re potential sharps.</li> <li>- Revision to clin admin process regarding ensuring calls are not missed from the triage calls list</li> </ul> <p>There were no incidents associated with medium or severe harm in January 2025.</p>	IPU	Nov 24	Dec 24	Jan 25	Admissions	15	15	16	Discharges	2	4	4	RIPs	10	15	7	Occupancy	66.13%	75.16%	78.71%		
IPU	Nov 24	Dec 24	Jan 25																				
Admissions	15	15	16																				
Discharges	2	4	4																				
RIPs	10	15	7																				
Occupancy	66.13%	75.16%	78.71%																				
<p>Complaints &amp; Compliments</p>	<p>Two clinical complaints received in January 2025:-</p> <ol style="list-style-type: none"> <li>1. From daughter of patient re care received in community. Detailed explanations provided by CD, Community Team Manager and consultant in palliative medicine. Acknowledged provision of leaflet on medicines used for symptom control would have been beneficial to daughter.</li> <li>2. From client re bereavement counselling experience. CD explained that abuse will not be tolerated and offered support in seeking alternative counselling.</li> </ol>																						
<p>Health &amp; Safety</p>	<p>H&amp;S Workplace Audit checklist undertaken by Facilities commenced in January 2025. Re-audit across Retail/Capitol House by end of April 2025. H&amp;S RAs to show evidence of review within a two year period – AR thanked staff for completion of these. Fire Policy – no substantive change Outstanding water risk points actioned in 2024/25. Outstanding fire door works in non-patient areas to be incorporated into 2025/26 budget.</p>																						

	<p>Recent incident of relative fall on the IPU was reviewed and staff reminded of being mindful of vulnerable visitors.</p>		
<p>New/Revised Policies/ Guidelines</p>	<p>Most recent policy publications include:-</p> <p><b>HR17 Training &amp; Development Policy</b> <a href="#">N:\Policy Manual\HR\HR17 Training &amp; Development Policy.pdf</a> v3.3 issued 30/01/2025 (Appendix A added re external payments, cancellation and refund to SRH courses)</p> <p><b>OP01 Incident &amp; Near Miss Reporting Policy</b> <a href="#">N:\Policy Manual\OP\OP01 Incident &amp; Near Miss Reporting Policy.pdf</a> v5.0 issued 31/01/2025 (takes into account PSIRF requirements and enhances expected investigative process that supports learning)</p> <p><b>OP01a Managing and Supporting Staff Following a Medication Error</b> <a href="#">N:\Policy Manual\OP\OP01a Managing and Supporting Staff Following a Medication Error.pdf</a> v3.0 issued 31/01/2025 (adds consideration to possible second checking of CD administration with RN for low/moderate harm errors; removes references to RCA and inserts references to the Patient Safety Response Plan's expected responses to incidents as set out in Table 2 of Appendix 4 of OP01 Incident &amp; Near Miss Reporting Policy)</p> <p><b>CLIN15 Deprivation of Liberty Guidelines</b> <a href="#">N:\Policy Manual\CLIN\CLIN15 Deprivation of Liberty Guidelines.pdf</a> v1.9 issued 07-02-2025 (no substantive changes)</p> <p><b>OP48 Wellbeing Centre Operational Policy</b> <a href="#">N:\Policy Manual\OP\OP48 Wellbeing Centre Operational Policy.pdf</a> v6.1 issued 18-02-2025 (Section 8 expanded to clarify the calling of an ambulance for certain symptoms)</p> <p><b>CLIN08 Infection Control Policy</b> <a href="#">N:\Policy Manual\CLIN\CLIN08 Infection Control Policy.pdf</a> v6.3 issued 18-02-2025 (minor adjustments throughout plus removal of reference to alcohol hand rub at 9.7 and 22.9)</p> <p><b>CLIN52 Managing COVID-19</b> <a href="#">N:\Policy Manual\CLIN\CLIN52 Managing COVID-19.pdf</a> v41 issued 18-02-2025 (minor edits throughout)</p>		

Documentation/ EMIS	<ul style="list-style-type: none"> <li>• <b>Data sharing</b> IG for CLCHT &amp; ESTH community hubs in place with ICB as at 26/11/2024. Practical 'switch on' achieved by Hubs via CLCHT &amp; ESTH in December 2024. Full data sharing in place across GPs and Hubs.</li> <li>• <b>EMIS working group</b> meeting 25 February 2025 (Members: John Groom, Alex Rudkin, Dr Gaby Tamura-Rose, Heather Siddall, Tracy Christmas, Francis Quinon, Kelly Groom, Dawn Miller) Reminder to ensure as far as is practically possible that face to face and telephone contacts are recorded on EMIS by selection of associated triggers. Reference to telephone calls in textual entry without a corresponding telephone trigger unfortunately is not reportable and will under-report contacts.</li> </ul> <p>DR GTR will present her Weekend Activity report to enhance ""CNS commissioning bid"</p>		
Audit/Research	<p><u>Data Collection</u></p> <ol style="list-style-type: none"> <li>1. Care of Dying Adults at End of Life re-audit</li> <li>2. DNACPR on the IPU re-audit</li> <li>3. Safeguarding 2024</li> <li>4. Advance Care Planning re-audit</li> </ol> <p><u>Yet to commence</u></p> <ol style="list-style-type: none"> <li>1. IPU PUs &amp; Patient Handling RA re-audit</li> <li>2. IPU Mouthcare RA re-audit</li> <li>3. CDs Annual Audit</li> <li>4. Clinical Records Documentation</li> <li>5. Caldicott – IG sweep 2024/2025</li> </ol> <p>Currently under review/revision is the IPU Satisfaction Survey following a low completion in 2024 and a spotlight on food service in 2025/</p>		
Education/Training Reflective Forums	<p>BLS Training Guildford course – September 25 VOED training for care home providers Training given by MF &amp; KC to 19 attendees at HMP Highdown – Good evaluation feedback given Presentation given to St George's Masters Students</p>		
Recruitment/ Staffing	<p>Hoping to welcome Dr Katie Taylor, locum consultant, to work three days a week (Tuesday, Wednesday and Fridays) for 6-8 weeks from late February/ March. Two new GP trainees have joined us this month - farewell and thanks to Rayah and Priya – hello and welcome to Dr Jasmine Patel (Monday and Wednesday) and Dr Theodora (Theo) Moss (Wednesday and Thursday mornings). They will be with us for 6 months.</p>		

	<p>CPCT have a new member of staff – Alexis Fisher</p> <p>Interviews are to be held for Band 5 nurses &amp; Head of Peoples Services.</p>		
CQC/PIR			
<b>AOB</b>			
	<p><b>13:30-14:00 “Mesothelioma and Claims” talk by Lorna Webster – Partner at Hodge, Jones &amp; Allen deferred to Feb 2025 meeting</b></p> <p>Dr GTR – informed CHODS of PAH complex patients</p> <p>Patient PDP – to be reminded that she is a well known staff member</p>		

**Date next meeting:**

**Monday, April 7, 2025 1:30:00 PM**

**Monday, May 19, 2025 1:30:00 PM**

**Monday, June 30, 2025 1:30:00 PM**

**Monday, August 11, 2025 1:30:00 PM**

**Monday, September 22, 2025 1:30:00 PM**

**Monday, November 3, 2025 1:30:00 PM**

**Monday, December 15, 2025 1:30:00 PM**

**Monday, January 26, 2026 1:30:00 PM**

**Monday, March 9, 2026 1:30:00 PM**

**Meeting ID: 856 3859 2795**

**Passcode: 976968**

**MINUTES OF THE**  
**DRUGS & THERAPEUTICS COMMITTEE**  
**Held on 26<sup>th</sup> February 2025**  
**in St Bedes / Zoom**

**Attending**

(Dr NC) Dr Naomi Collins - Hospice Palliative Care Consultant (Chair) (TC) Tracy Christmas – Community Services Manager, NMP (MM) Mario Manzo – Clinical Pharmacist, Ashtons	(KH) Kevin Hobson - CNS NMP (MF) Maura Flint – Practice Educator (KC) Karen Cook – Practice Educator (AR) Alex Rudkin – Director of Quality and Governance / Mins
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**ITEM 1: Welcome**

1.1 Dr NC extended welcome.

**ITEM 2: Apologies for Absence**

(PH) Philomena Hutchinson – IPU Senior Nurse; (JS) Jill Smith - CNS NMP; (RT) Rebecca Trower – Clinical Director; (Dr GT-R) Dr Gaby Tamura-Rose – Hospice Palliative Care Consultant; (HT) Hai To – Sutton CCG Care Home Pharmacist;

**ITEM 3: Pharmacist Update**

3.1 MM delivered Ashton’s Clinical Pharmacist reports for Q3 2024 that included [Pharmacist Activity Report](#), [St Raphaels Hospice - ABI Report Dec24](#), [MM Report.xlsx](#), [Hospice benchmarking ANON Q3 2024](#), [Hospice CD Pricing Jan25.xlsx](#), [Water for Injection \(12 months\) - Dec23-Nov24.xlsx](#), [Hospice Drug Spend Analysis Q3 2024 \(anon\).xlsx](#) and [Suggestions for cost effective prescribing in Palliative Care V1 \(October 2024\)](#)

There were no outstanding service issues with communications and responsiveness reported as satisfactory.

Administration errors and missing signatures were discussed. Views were mixed as to the significance associated with the errors given the quantities of medications administered routinely. The Hospice compares favourably with other Hospices with reported numbers. It was felt that there may be an unrealistic administrative burden to expect all pharmacist documentation errors be reported via DATIX. However, administration errors (documentation omissions) identified by the clinical pharmacist should be raised with the NIC in order that there is traceability that can feed into learning and improvement and that missed steps in the checking process can be addressed.

MM/FQ

There were no red items in review of Jul-Sep Medicines Management Audit; MHRA warning folder in place in clinic room.

Ashtons are requested to check the ordering of non – stock items in order that high price items are clearly understood pre-ordering. Prescribers are also encouraged to check the cost of new non-stock medications either via the BNF or Ashton’s on-line ordering before prescribing.

It was agreed that the stock list should be reviewed in line with cost-effective prescribing

NC, FQ,  
MM

Pharmacy e-newsletter can be subscribed to by individual practitioners at the Hospice. AR will circulate.

AR

#### **ITEM 4: Minutes of the Last Meeting**

Minutes of the last meeting held on 7<sup>th</sup> August 2024 were agreed.

#### **ITEM 5: Matters Arising**

- Re-design of the clinic room has been pended
- Changes to the flow chart for community prescribing at end of life were communicated - **(Ocreotide added as second line after Hyoscine Butylbromide/Buscopan as anti-secretory medication for high volume vomiting – under Intestinal obstruction on page 3 – Nausea/Vomiting ; under Respiratory Secretions on page 4, choice between Hyoscine Butylbromide (Buscopan) and Glycopyrronium with BNF pricing included).**
- No issues with medication ordering. Incorporated into periodic review at Medical Business.
- Abstral Audit actions considered by Medical Team will be reviewed and update provided at the next meeting..
- Unnecessary retention of delivery ice packs discontinued.
- Completion of allergy box on prescription charts much improved.

NC

#### **ITEM 6: Supplies of Hyoscine Butylbromide injection and cost**

No issues

**ITEM 7: The growing use of Naltrexone in oncology - ? perception and ? difficulties with subsequent pain management**

Deferred to when Ashtons and HT are present

**ITEM 8: Update on medication policy review**

CLIN57a Flow Chart for Community prescribing at the end of life [N:\Policy Manual\CLIN\CLIN57a Flow Chart for Community prescribing at the end of life.pdf](#) v4 issued 16/08/2024 (Oxycodone added as second line after Hyoscine Butylbromide/Buscopan as anti-secretory medication for high volume vomiting – under Intestinal obstruction on page 3 – Nausea/Vomiting ; under Respiratory Secretions on page 4, choice between Hyoscine Butylbromide (Buscopan) and Glycopyrronium with BNF pricing included)

CLIN58 Use of the MAAR Chart for subcutaneous and intramuscular medication in the community [N:\Policy Manual\CLIN\CLIN58 Use of the MAAR Chart for subcutaneous and intramuscular medication in the community.pdf](#) v2.1 issued 10/12/2024 (reference to revised pan-London policy and procedure version 5 incorporated – no other change)

CLINSOP09 Safe and Secure Management of NHS Prescription Stationery [N:\Policy Manual\CLINSOP\CLINSOP09 Safe and Secure Management of NHS Prescription Stationery \(FP10 prescription forms\).pdf](#) v2.2 issued 07/01/2025 (addition at 11.2 re Clinical Admin completion and sending to SWLICB of leaver form on behalf of NMP)

CLIN58 Use of the MAAR Chart for subcutaneous and intramuscular medication in the community [CLIN58 Use of the MAAR Chart for subcutaneous and intramuscular medication in the community](#) v2.2 issued 26/02/2025 (links to policy and procedure updated)

**ITEM 9: Serious Medication Incidents**

There have been no medication incidents reported between 7<sup>th</sup> August 2024 and 26<sup>th</sup> February 2025 resulting in moderates or serious harm. NC advised of one significant incorrect drug administration of pregabalin rather than gabapentin that resulted in no harm.

**ITEM 10: Update on CAS/MHRA Alerts**

10.1 All CAS/MHRA alerts are logged on our register at [N:\Governance\Central Alerting System\Register of Alerts](#).

**ITEM 11: Any other business**

- Medicines Management and NMP education days diaried.
- NMP team now numbers 7 with the latest qualified member being CNS Heather Syddall

## ITEM 12: Future Dates

12.1 Dates for future meetings in 2025 are :-

Date & Time	Event	Venue/Virtual
Wed 23 <sup>rd</sup> April 11.30-1pm	Drugs and Therapeutic Committee	St Bede's & Virtual
Wed 16 <sup>th</sup> July 11.30-1pm	Drugs and Therapeutic Committee	St Bede's & Virtual
Wed 29 <sup>th</sup> October 11.30- 1pm	Drugs and Therapeutic Committee	St Bede's & Virtual

<b>DRAFT Minutes Medical Business Meeting</b>			
<b>9<sup>th</sup> April 2025</b>			
<b>In attendance</b>	Busi Da Silva	Speciality Dr	BDS
	Chris Roughley	Speciality Dr	CR
	Katie Taylor	Locum Consultant	KT
	Naomi Collins	Consultant	NC
	Theo Moss	GP VTS	TM
	Gaby Tamura-Rose	Consultant	GTR
	Ambreen Akhtar	Specialty Dr	AA
	Jasmine Patel	GP VTS	JP
<b>Apologies</b>	Shahlaa Walsh	SpR	SW
<b>Minutes of the last meeting</b>	Last meeting 05.03.25 – minutes reviewed		
<b>Team wellbeing</b>	All shared, thank you		
<b>Rota / staffing</b>	<p>GTR and NC meeting with Dr Rajendran today, SpR Old Age Psychiatry, interested in placement at StRH. Also another psychiatric trainee coming next week.</p> <p>SW rotating to IPU in July/ August</p> <p>JP and TM to rotate from IPU to CPCT on Wednesdays from start of May (remaining on IPU on Monday/ Thursday am respectively).</p> <p>CR attending funeral 14/05/25</p>		
<b>Clinical challenges</b>	Discussion around difficulties in discharging patients from IPU setting		
<b>Drug Issues/ Budget</b>	<p>Next drugs and therapeutics meeting is 23/04/25, 11.30-1pm in St Bede's– all encouraged to attend</p> <p>Abstral – following on from last MBM -CR will look into possible solutions to safe prescribing of Abstral prn and feedback</p> <p>Following discussion last MBM – TM talked to Penny James about prescribing strength/ dose. Discussion held and decision made safest option is not to specify strength at all but only dose to be administered to avoid confusion.</p> <p>Discussion about requesting supply of high cost items eg IV Levetiracetam from hospitals when patients transferred over ?needs further discussion with pharmacy colleagues/ hospital pall care teams to implement</p>		<p><b>CR</b></p> <p><b>ALL</b></p>

<b>Infection control</b>	Following on from last MBM – NC to clarify with SM re policy for wearing of gowns and PPI when patient on antibiotics for routine infections.	<b>NC</b>
<b>Education</b>	GTR talking to education around possibility of hosting work experience day for potential medical students	<b>GTR</b>
<b>Datix</b>	<p>Nil recently for medical team – well done! 😊</p> <p>TM passed on positive feedback about hospice discharge summary from GP colleague 😊</p> <p>Pharmacist, Mario, found no problems with drug charts during his review this week 😊</p>	
<b>Audit &amp; Research</b>	<p>In patient recruited to POST study -= AA will chase completed proforma</p> <p>KT – discharge summary audit underway</p> <p>CR – considering QIP looking at discharge experience from IPU</p> <p>GTR and CR taking part in research into prescribing for patients who are recreational drug users – other participants welcome</p> <p>NC – at start of new audit year, just a reminder that everyone expected to complete at least one audit during coming 12 months</p>	
<b>Deep Dive</b>	<ol style="list-style-type: none"> <li>1. Admissions meeting – just started. KT – new comments page to help capture any feedback/ issues as they arise. Medical staff not involved in the admissions meeting to either be in CPCT meeting or head straight to IPU to start patient reviews (if needed urgently), paperwork, drug chart checking etc ahead of 09:30 handover.</li> <li>2. Hospice values – all staff and volunteers surveyed end of 2024 regarding hospice values. 6 themes emerged the first five of which were not new – safety, teamwork, honesty and integrity, respect, person-centred; the new one being compassion. It is felt that these are true for almost any organisation and perhaps we should have less values and more personalised for us/ the hospice. Please be thinking/ feel free to suggest.</li> </ol>	<p>ALL</p> <p>ALL</p>

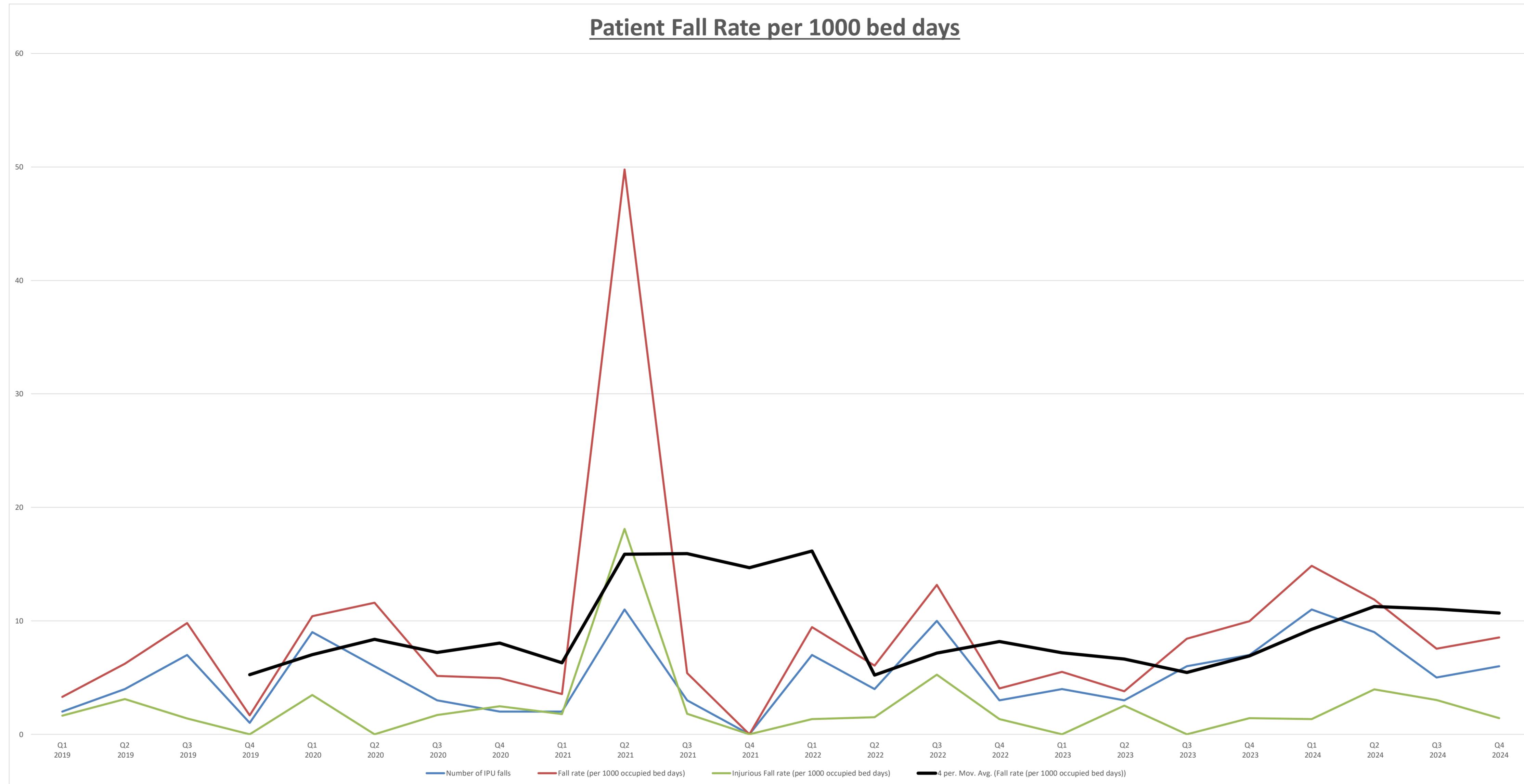
<b>AOB</b>	<p>GTR – Any complex/ unusual patient to be handed over verbally to on call team, especially if neither are from STRH. Resus policy being reviewed and, in the process, come to light historic names for offices/ departments such as TCC and ACC need updating.</p> <p>Location of AED needs highlighting and consider moving from ward office to reception?</p> <p>TM, JOP and KT have been reviewing/ amending the medical handover sheet – to add column for research/ EDD and date of family meeting; to remove unnecessary historic details but retain those helpful for discharge summary/ on call dr</p> <p>GTR – remember to keep saving old copies</p>	BDS
<b>Date of next meeting</b>	<b>07/05/2025</b>	

Patient	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024
IPU Admissions	42	56	52	57	63	41	34	36	59	16	41	44	61	54	48	57	53	50	47	55	57	47	52	52
IPU Occupancy %	87	84	83	82	68	84	86	75	77	33	79	86	82	72	83	82	80	86	78	77	81	83	72	78
IPU Occupied Bed Days	604	643	713	596	864	517	584	403	563	221	556	640	742	661	760	742	727	793	713	703	741	759	663	702
Number of non-IPU patients who fell				1															1					
Number of non-IPU patient falls	1			1															1					
Number of IPU patients who fell	2	3	4	1	7	6	3	1	2	2	3	0	2	4	6	2	2	3	5	6	5	5	4	4
Number of IPU falls	2	4	7	1	9	6	3	2	2	11	3	0	7	4	10	3	4	3	6	7	11	9	5	6
IPU Sustained injury	1	2	1	3			1	1	1	4	1	0	1	1	4	1	0	2	0	1	1	3	2	1
IPU Sustained injury %	50%	50%	14%	0%	33%	0%	33%	50%	50%	36%	33%	0%	14%	25%	40%	33%	0%	67%	0%	14%	9%	33%	40%	17%
Fall rate (per 1000 occupied bed days)	3.31	6.22	9.82	1.68	10.42	11.61	5.14	4.96	3.55	49.77	5.40	0.00	9.43	6.05	13.16	4.04	5.50	3.78	8.42	9.96	14.84	11.86	7.54	8.55
Injurious Fall rate (per 1000 occupied bed days)	1.66	3.11	1.40	0.00	3.47	0.00	1.71	2.48	1.78	18.10	1.80	0.00	1.35	1.51	5.26	1.35	0.00	2.52	0.00	1.42	1.35	3.95	3.02	1.42

Patient	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
IPU Occupied Bed Days	2556	2368	1980	2905	2936	2865
No. of IPU falls	14	20	16	24	20	31
IPU Falls Sustained injury	4	5	6	7	3	7
IPU Fall rate (per 1000 occupied bed days)	5.48	8.45	8.08	8.26	6.81	10.82
Injurious IPU Fall rate (per 1000 occupied bed days)	1.56	2.11	3.03	2.41	1.02	2.44

**2024/25 Review**  
**Patient falls** (31 across 18 patients) lie above historical range (2023/24 (20 across 16 patients); 2022/23 (24 across 14 patients)) largely due to two spike quarters in the year Q1 & Q2 2024/25 c.f. one spike quarter Q3 in 2022/23 and one spike quarter in Q2 2021/22  
 IPU fall rate (10.82) is the highest it has been since 2019/20 (5.48) and injurious fall rate (2.44) is the 2nd highest in the past 6 years.  
 Reporting of falls via DATIX began in November 2021 and staff are commended for their attention to reporting and embrace of development and learning consequential to reported events. Patient fall events in 2024/25 led to investigations into sensor mat trigger operating effectively, sensor checking, increased frequency of monitoring, one to one monitoring, reiterations of use of call bell.  
 Injurious falls were low harm and included cut to elbow, bruise to shoulder, broken skin to knee, cut to forehead, bruise to buttock.  
**Non-patients falls** in 2024/25 (5) is lower than 2023/24 (10) & 2022/23 (8) and injurious falls in 2024/25 (40%) are lower than in 2023/24 (70%) and 2022/23 (50%).  
 Proportionally, staff falls are at 40% in 2024/25 c.f. 30% in 2023/24 and 50% in 2022/23; volunteer falls are at 20% in 2024/25 c.f. 30% in 2023/24 & 25% in 2022/23; visitor falls are at 40% in 2024/25 c.f. 40% in 2023/24 & 25% in 2022/23. Visitor falls are exclusively relatives on the Hospice IPU in 2024/25.  
 One relative fall event led to further vigilance being highlighted to staff regarding patient visitor risk.  
 One staff fall event led to further vigilance over exposed wires. Injurious falls were low harm and included first aid to knee, first aid, provision of clean clothing and advice owing to an underlying health condition.

Non-patient	Apr - Jun 2019	Jul - Sep 2019	Oct - Dec 2019	Jan - Mar 2020	Apr - Jun 2020	Jul - Sep 2020	Oct - Dec 2020	Jan - Mar 2021	Apr - Jun 2021	Jul - Sep 2021	Oct - Dec 2021	Jan - Mar 2022	Apr - Jun 2022	Jul - Sep 2022	Oct - Dec 2022	Jan - Mar 2023	Apr - Jun 2023	Jul - Sep 2023	Oct - Dec 2023	Jan - Mar 2024	Apr - Jun 2024	Jul - Sep 2024	Oct - Dec 2024	Jan - Mar 2025
Staff Falls	1			1	1			1		4		2	3		1		1	1	1	1	2			
Volunteer Falls											1	1		1		1				3		1		
Contractor Falls																				0				
Visitor Falls			1	1										1	1		1	1		2				2
Sustained injury				1	1			1		3	1	2	2	2	0	0	0	1	1	5	1	0	0	1
Totals	1	0	1	2	1	0	0	1	0	4	1	3	3	2	2	1	1	2	1	6	2	1	0	2



**MINUTES OF THE  
INFECTION CONTROL COMMITTEE**

**Held at 1pm on 25<sup>th</sup> February 2024  
at St Bede's Conference Centre and via Zoom**

<b>Attendance</b>	
(Dr JS) Dr J Stephenson, Consultant Microbiologist -ESTH, SSAH (Chair) (MF) M Flint – Palliative Care Educator	(CF) C Foster - IPU IC Link RN (Dr GT-R) Gabrielle Tamura-Rose – Consultant in Palliative Care
(AR) A Rudkin – Director of Quality and Improvement	(SM) Sara Mosalam – Infection Control Lead
(JC) J Cope – Quality Support (Minutes)	(PM) Peter Morris – Facilities Manager
(FQ) Francis Quinon – Clinical Lead, IPU	
<b>Apologies</b>	
(PD-P) P Di-Palma – Housekeeping	(MS) M Sorrell – Community rep
(AD) A Durrant – IPU rep	(RT) R Trower – Clinical Director
(MP) M Prior – Clinical Nurse Specialist	(Dr NC) Dr N Collins – Palliative Care Consultant
(TC) T Christmas – Community Team Manager	

**ITEM 1: Welcome**

**Action**

Dr JS extended welcome to all present.

**ITEM 2: Apologies**

Apologies as listed above

**ITEM 3: Minutes of the last meeting held on 12 November 2024**

3.1 These were accepted as an accurate record. Dr JS recommended changing one word in the minutes. Page 4 Item 9.1 - changing "outbreaks" to "isolates" - as a reader might interpret this as clinical outbreaks. Dr JS commended JC for taking and drafting the minutes.

**ITEM 4: Matters Arising**

4.1 Nil raised

## **ITEM 5: COVID-19 Update**

- 5.1 **Staffing:** Currently minimal impact.
- 5.2 **Testing :** Nil new.
- 5.3 **PPE :** SM informed the meeting that the standard for staff Fit testing is for review every two years for each staff member. SM advised that currently there is only one trained staff member for staff Fit testing and that there will be a Fit testing session held on April 2<sup>nd</sup> for five staff members.
- 5.4 **POLICY :** Dr JS told the meeting that COVID is less pathogenic these days and the symptoms less severe. AR suggested that COVID be removed as an agenda item and Dr JS agreed. COVID is currently less of an issue than Flu A which does not have a specific agenda item. The matter of Fit testing can remain as part of the IPC training/ education item.

## **ITEM 6: IP&C Annual Report**

- 6.1 SM showed the meeting her annual report and it was commended by all present. SM commended JC for his assistance.

## **ITEM 7: IPC training/education**

- 7.1 MF announced that the link nurses would be given Fit testing training and the training would then be cascaded to other staff. SM told the meeting that St Raphael's participated in the FCA study days that took place on 15<sup>th</sup> January for doctors and 13<sup>th</sup> February for nurses. The goal was to increase awareness for the IC standard. Dr JS commended the efforts made with regards to training.

## **ITEM 8: IPC Incidents / Sharps Injuries / Body Fluid Exposures / Audit**

- 8.1 AR informed the meeting that there was an incident where a staff member was pricked by a toothpick while checking a patient's clothing, but there have been no clinical sharps incidents. CF told the meeting that safety needles are used for insulin injections except for NovoRapid. The hospice will obtain safety needles for NovoRapid soon though. Quarterly graphical reporting produced by JC reflects the data. Set out below are the figures for the 4th quarter (October- December) of 2024 with available figures for the 3rd quarter 2024 (July-September) 2024 also included. This is followed by a written summary specifically for the 4th quarter of 2024. AR and SM commended JC for compiling the data.

**SM**

<b>IPC Criterion</b>	<b>Jul-Sep 2024</b>	<b>Oct-Dec 2024</b>
Staff Hand Hygiene	<b>98%</b>	<b>97%</b>
St Bede's Environmental	<b>NA</b>	<b>NA</b>
Wellbeing Centre Environmental	<b>98%</b>	<b>NA</b>
Men's Den Environmental	<b>100%</b>	<b>NA</b>
IPU Environmental	<b>90%</b>	<b>95%</b>
IPU Staff Spot Check	<b>97%</b>	<b>96%</b>
Sharps	<b>89%</b>	<b>99%</b>
Urinary Catheter Insertion	<b>97%</b>	<b>96%</b>
Waste Management	<b>81%</b>	<b>100%</b>
Mattress Cover	<b>100%</b>	<b>100%</b>
Mattress	<b>100%</b>	<b>100%</b>

- 8.2.1 Overall compliance for staff hand hygiene is 97%. Overall compliance is decreased very slightly but is still high.
- 8.2.2 The Sharps Audit showed 99% compliance overall which is a significant improvement on 89% from the July-September audit. Areas that have shown improvement include keeping sharps' trays clean and tidy and making sure that sharps bins do not contain items other than sharps, ensuring bins are free from protruding sharps, and that the temporary closure mechanism is not in use.
- 8.2.3 IPU staff spot checks showed a 96% compliance. The only instances of non-compliance were mostly from one doctor not being compliant with being bare below the elbows, tying her hair back, not keeping nails short and free of polish and removing jewellery. The only other instances of non-compliance were single instances of staff members not being compliant regarding having an ID badge visible and not wearing jewellery.
- 8.2.4 The IPU Environmental Audit showed an overall compliance of 95% which is an improvement on the previous audit period. The areas which still brought down the overall compliance were: desks and surfaces being clean and free of dust (67%) and the carpets/floors being clean and free of stains (67%)
- 8.2.5 Waste Management showed 100% overall compliance which is an improvement. However, the data cohort was smaller during this audit period.
- 8.2.6 The Urinary Catheter Insertion audit shows overall compliance of 96%. The one criterion that reduces overall compliance is the standard that the draining bag be dated and changed by day 8. This has achieved 80% compliance whereas the other criteria show perfect compliance.
- 8.2.7 The Mattress and Mattress Cover audit shows perfect compliance.

## ITEM 9 : Alert Organisms Surveillance

- 9.1 Dr JS reported that Candida Auris is a worldwide issue, comparable to MRSA. It is resistant to anti-fungals and has increased in hospitals and in tertiary care. Although it can sit on a host's skin and not do any harm, if it gets inside the body it is a health hazard. FQ said that the hospice does a deep clean after a patient leaves a bed space. Sometimes organisms are not flagged up when patients enter the hospice, especially if they come in from the community. Terminal cleaning is needed. Dr JS asked if the hospice routinely screens for MRSA and AR replied that that is not a routine screening. Dr JS said that a referring hospice should always inform St Raphael's about what bugs a patient could possibly be carrying.

## ITEM 10 : Water Assessment and testing update

- 9.1 PM has succeeded Steve Cresswell as Facilities Manager and reported that a robust tap flushing routine is in place. There have been no new outbreaks of Legionella in the water. Water safety is a standing item at the H&S Committee. There is a monthly testing of the taps and the chemicals and the pumps. Housekeeping flush taps four times a week. Facilities flush them on an ad hoc basis. Dr JS commended PM and advised him to keep monitoring and recording.

## ITEM 11 : Any Other Business

- 10.1 SM mentioned a case of an infectious patient who did not want the door closed due to their claustrophobia. Dr JS advised that there is a need to be pragmatic. Measles is contagious and can be spread through the air. A doctor has caught measles by standing in the doorway of a patient's bedroom. COVID and diarrhea are less infectious. Diarrhea is not spread through the air. [Dr GT-R entered the meeting] CF asked if masks were needed when a patient entered the hospice with a resistant bug and Dr JS replied that masks are procedure based. CF said that masks are worn when there is a patient who has undergone a tracheostomy and Dr JS agreed that masks are sometimes necessary and that it is a case by case basis.

## ITEM 11 : Date of next ICC meeting

Date	Event	Venue/Time
TBA	<b>IP&amp;C Meeting</b>	TBA

# St Raphael's

Your Local Hospice



# VOICES QUESTIONNAIRE

## 2023-2024

Compiled by: Quality Office

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## **INTRODUCTION**

The staff and volunteers of St Raphael's Hospice place great value on the views and experience of their patients, their relatives and carers. They wish to ensure that the care that they give is as helpful as possible for the patients and the people close to them. To do this, they seek to inform themselves as to how they can improve the way they look after people.

The National Survey of Bereaved People (VOICES, Views of Informal Carers – Evaluation of Services) collects information on bereaved people's views on the quality of care provided to a friend or relative in the last 3 months of life. The survey was commissioned by the Department of Health in the NHS in 2011. Nationally, VOICES data provides information to inform policy requirements, including the End of Life Care Strategy, that promote high quality care for all adults at the end of life.

The information given in response to the survey will support us to improve people's experiences of care at the end of life.

The VOICES questionnaire asks about the care and support both the patient and carer received in the last months of the patient's life and whether their needs were fully met. Most of the questions can be answered by simply ticking the most appropriate box.

## **AIMS**

- To assess carer/relative opinion.
- To highlight areas for improvement or further evaluation.
- To identify action taken or to be taken consequential to feedback received.

## **METHODOLOGY**

The questionnaire used in this survey is taken from the National Survey of Bereaved People (VOICES) questionnaire. The next of kin / main carer of those Hospice patients that died during the period 1<sup>st</sup> October 2023 to 31<sup>st</sup> March 2024 were sent questionnaires 4-6 months post-bereavement. They were invited to complete the questionnaire under no obligation, and return completed surveys in pre-paid envelopes. This is a comparative audit report comparing the 2023/24 dataset with earlier audit from 2023.

## **Executive Summary**

- a) The number of returned questionnaires was 31% in 2023/24 (c.f. 29% in 2023, 25% in 2022/23, 26% in 2022, 27% in 2021/22, 25% in 2021, 37% in 2020/21, 26% in 2020, 28% in 2019/20, 25% in 2019, 29% in 2018/19 ;34% in 2018; 32% in 2017/18; 28% in 2017).
- b) Responses to the questions on the care and environment provided in the inpatient ward (IPU) are overwhelmingly positive, with all respondents agreeing that help with personal care and nursing care met their requirements and all agreeing that the environment respected the patients' privacy (see page 11).
- c) Definite assertion of the adequacy of inpatient emotional support increased to 91% in 2023/24 from 2023's 74% (page 12) and definitive assertion of the adequacy of inpatient religious/spiritual support has increased to 80% from 2023's 69%.
- d) Inpatient support regarding financial concerns or other practical problems was considered to be of somewhat greater need – 6 respondents (21%) in 2023/24 (c.f. 14% in 2023). That need was considered to have been definitely met by 4 (67% in 2023/24 c.f. 67% in 2023).
- e) Definite assertion that symptoms other than pain in the IPU had been relieved has decreased to 83% in 2023/24 (c.f. 88% in 2023). 96% recorded either definitely or to some extent in 2023/24 (c.f. 100% in 2023). 4% answered “No” (c.f. 0% in 2023).
- f) Support regarding family concerns of inpatients was considered to be of greater need – 69% in 2023/24 (c.f. 41% in 2023). That need was considered to have been definitely met by 85% in 2023/24 (c.f. 78% in 2023).
- g) Inpatient pain relieved completely, ‘all of the time’ has increased to 79% in 2023/24 (c.f. 59% 2023), ‘some of the time’ has decreased to 21% in 2023/24 (c.f. 27% in 2023) and ‘partially’ has maintained at 0% in 2023/24 (c.f. 0% in 2023) (Page 13).
- h) A shift in the number of family members to being always kept informed from usually being kept informed of the inpatients' condition - 79% in 2023/24 (c.f. 68% in 2023) being always kept informed. 18% considered family members were usually kept informed (c.f. 27% in 2023). 4% considered family members were only sometimes informed (c.f. 5% in 2023).
- i) The percentage of respondents who considered the language used by doctors and nurses on the IPU to explain the condition to be ‘very easy’ to understand increased to 89% in 2023/24 (c.f. 64% in 2023) (Page 14) with a decrease in ‘fairly easy to understand’ responses to 11% in 2023/24 (c.f. 32% in 2023). 0% reported that they ‘never spoke’ to staff about the inpatient's condition (c.f. 0% in 2023). 0% reported that doctors and nurses “did not explain” the inpatient's condition (c.f. 5% in 2023).

- j) The number of respondents that felt that decisions were made about the inpatients' care/treatment that they wouldn't have wanted has decreased to 7% in 2023/24 (c.f. 9% in 2023). (page 14)
- k) Doctors and nurses 'always treating inpatients with respect and dignity' achieved the same for doctors and slightly lower for nurses – 93% for nurses and 100% for doctors (c.f. 95% for nurses and 100% for doctors in 2023).
- l) Definite assertion by the nok of inpatients that the Hospice worked well with GPs and other external services has increased to 59% in 2023/24 (c.f. 36% in 2023). 7% replied that the Hospice had worked well with the GPs 'to some extent,' (c.f. 36% in 2023). 4% of respondents (c.f. 0% in 2023) felt that they didn't work well together and 30% in 2023/24 didn't know (c.f. 27% in 2023).
- m) A greater proportion of respondents regarded that being able to stay overnight in the Hospice was important – 68% (c.f. 41% in 2023) (page 16, Question 11).
- n) 'Definitely received sufficient emotional support from the hospice team' whilst an inpatient has maintained at 86% in 2023/24 (c.f. 86% in 2023) (page 16), with decreased emotional support not being required – 3% in 2023/24 (c.f. 5% in 2023). Taken together the adequacy of emotional support as either definite, to some extent or not required has maintained in 2023/24 at 100% on the IPU.
- o) Respondents were asked to rate care given to inpatients by doctors and nurses and the responses in 2023/24 show a shift to 'Exceptional' up from 'Excellent, Good and Fair.' 76% considered doctor care to be 'Exceptional' (c.f. 64% in 2023), 24% considered it to be 'Excellent' (c.f. 27% in 2023) and 0% considered it to be 'Good' (c.f. 5% in 2023) and 0% considered it 'Fair' (c.f. 5% in 2023) and 0% recorded 'Don't Know' (c.f. 0% in 2023). Taking 'exceptional' and 'excellent' together rates in 2023/24 for doctor care have increased to 100% (c.f. 90% in 2023). Responses relating to nursing care show a shift to 'Exceptional' from 'Excellent': 86% rating nursing care as 'Exceptional' (c.f. 77% in 2023) and 10% as 'Excellent' (c.f. 18% in 2023) and 0% as 'Good' (c.f. 5% in 2023) and 0% as 'Fair' (c.f. 0% in 2023) and 3% as 'Poor' (c.f. 0% in 2023) (Page 17). Taking 'exceptional' and 'excellent' together, rates in 2023/24 for nursing care have increased to 96% (c.f. 95% in 2023).
- p) Regarding the food provided on the IPU in 2023/24, there was an increase in 'Exceptional' responses: 24% rated the food as 'Exceptional' in 2023/24 (c.f. 21% in 2023), 35% 'Excellent' (c.f. 21% in 2023), 24% 'Good' (c.f. 50% in 2023), 6% 'Fair' (c.f. 0% in 2023), 0% 'Poor' (c.f. 0% in 2023) (Page 18) and 12% recorded 'Don't know' (c.f. 7% in 2023).

- Combining ‘exceptional’ and ‘excellent’ ratings there has been a large increase in 2023/24 – 59% (c.f. 42% in 2023), with the shift notably being towards ‘Excellent’ at 35% (c.f. 21% in 2023) away from ‘Good.’
- q) 97% of respondents rated the patient bedroom as ‘Excellent’ which is an increase from 86% in 2023. The en-suite bathrooms were rated ‘Excellent’ by 90% in 2023/24 (c.f. 77% in 2023) (Page 19) which is an increase.
  - r) Satisfaction with the Community Services should be regarded with a degree of caution as it is difficult to isolate St Raphael’s impact amongst what may be a multitude of care providers. Responsiveness of visit has maintained at 84% in 2023/24 (c.f. 84% in 2023); ‘Yes definitely’ answers for emotional support have increased – 79% (c.f. 69% in 2023); Religious or spiritual support have increased marginally to 50% (c.f. 48% in 2023), but that question has a smaller data cohort, since fewer respondents consider religious/spiritual support to be necessary.
  - s) A lower proportion felt that the patient required help with urgent problems during the evenings, between 5pm and 11pm, – 62% in 2023/24 (c.f. 67% in 2023) and of those, an increased proportion – 70% (c.f. 50% in 2023) felt definitely that enough support had been received. (page 22)
  - t) A lower proportion felt that the patient required help with urgent problems during the night (7pm – 9am) – 56% in 2023/24 (c.f. 63% in 2023) and of those, a higher proportion – 67% (c.f. 54% in 2023) felt definitely that enough support had been received.
  - u) The same portion of respondents considered that the patient’s pain had been completely relieved all of the time by the CPCT – “Completely all the time” 50% (c.f. 50% in 2023), “Completely some of the time” 38% (c.f. 31% in 2023), and “Partially” 12% (c.f. 19% in 2023) and “Not relieved at all” 0% (c.f. 0% in 2023).
  - v) A slightly higher proportion in 2023/24 – 87% (c.f. 86% in 2023) stated that they and their family received enough help and support from the Hospice CPCT.
  - w) The way in which the CPCT team explained the patient’s condition, treatment or tests shifted: ‘Very easy’ to understand increased to 83% in 2023/24 (c.f. 72% in 2023) and ‘fairly easy’ decreased to 17% (c.f. 23% in 2023).
  - x) Care received from the CPCT altogether saw an increase to 68% rating it as ‘Exceptional’ in 2023/24 (c.f. 60% in 2023), 0% rated it as ‘Poor’ (c.f. 5% in 2023) (Page 25). Overall regard for care as a whole provided by the CPCT shows a slight increase on 2023/24 with either ‘Exceptional’, ‘Excellent’ or ‘Good’ yielding 97% in 2023/24 (c.f. 95% in 2023).

- y) CPCT involving family/carers in decisions about the patients' treatment has increased to 97% in 2023/24 (c.f. 88% in 2023).
- z) Patients' explicit statement on their preferred place of death once again indicates that it is usually their home or the Hospice: Home – 67% (c.f. 49% in 2023) Hospice – 26% (c.f. 46% in 2023).
- aa) 87% of respondents in 2023/24 believed the patient died in the right place (c.f. 87% in 2023) (page 28).
- bb) 63% felt the patient achieved their preferred place of death in 2023/24 (c.f. 69% in 2023) (page 26).
- cc) Bereavement support for those whose loved ones died in the Hospice was considered definitely enough by 100% in 2023/24 – an increase from 2023's 91% (page 29).
- dd) 88% felt able to talk to someone from the Hospice as soon as they wanted about their bereavement (c.f. 62% in 2023) which shows a large increase. 0% wanted it sooner (c.f. 14% in 2023) and 12% were unsure (c.f. 24% in 2023).
- ee) Following receipt of the bereavement leaflet – an increased proportion - 82% found it either definitely helpful or helpful to some degree (c.f. 76% in 2023). 13% did not receive the leaflet (c.f. 17% in 2023).
- ff) The proportion of respondents that considered contact from the bereavement team was either definitely helpful or helpful to some degree has increased to 83% in 2023/24 (c.f. 75% in 2023). 0% felt the contact was unhelpful (c.f. 2% in 2023). Responses stating that contact wasn't received decreased to 13% (c.f. 16% in 2023).
- gg) In November 2023 an 'Outstanding' rating was included in the survey. There were 45 respondents for that time period and two did not record answers. Of the 43 respondents who recorded answers for that time period, 33 (77%) rated the hospice as 'Outstanding,' 7 (16%) rated the hospice as 'Very Good', 2 (5%) rated the hospice as 'Good', 0 (0%) rated the hospice as 'neither good nor poor,' 1 (2%) rated the hospice as 'Poor,' 0 (0%) rated it as 'Very Poor,' and 0 (0%) did not know the answer to this question. Taken together, 'Outstanding' and 'Very Good' responses were awarded in 93% of responses.

#### [Audit Periods Overview](#)

Click the link to view the table with the percentage scores and trends for all reported audit periods:

## **What can we learn?**

- a) The survey return rate really bears no relationship to whether the survey is sent out in month 6 or month 4 following patient death. To continue the routine and monthly mailing of VOICES questionnaires in A3 format and ensure mailing is undertaken between 4-6 months post patient death.

## **What will we do or change?**

- a) Without additional resources (such as survey follow-up by t/c, email, post or implementation of an alternative/complementary route for survey returns) targeted toward improving the survey return rate, the return rate sits within an acceptable level 25%-35%. However, we will strive to improve the return rate.

Under consideration are:

- b) Exploring if VOICES survey follow-up is merited/viable and can be combined with any routine contact undertaken by the bereavement journey coordinator: **ACTION : A Rudkin / R Trower**
- c) Reconcile record of bereavement literature provision in EMIS with Q36 : **ACTION : J Cope / A Rudkin**
- d) Review the operation and opening hours of the Orangery : **ACTION : Exec**
- e) Make record on EMIS of VOICES Survey sent : **ACTION : J Cope / A Rudkin**

## MAIN BODY

In October 2023 – March 2024, there were 55 questionnaires returned, providing a return rate of 31% (c.f. 29% in 2023, 25% in 2022-2023, 26% in 2022, 27% in 2021-2022, 25% in 2021, 37% in 2020-2021, 26% in 2020, 28% c.f. in 2019-2020, 25% in 2019, 29% in 2018-2019, 34% in 2018, 32% in 2017/18 & 28% in 2017)

### Demographics:

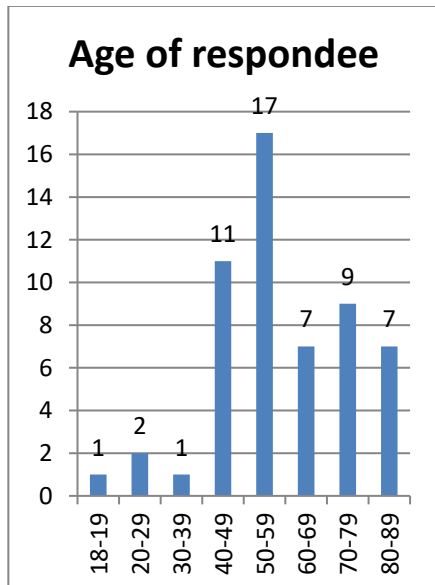
#### Gender of Respondent

Period	Male	Female	n/r
2023-24	16 (29%)	39 (71%)	0
2023	15 (31%)	34 (69%)	0
2022-23	9 (21%)	33 (79%)	2
2022	9 (30%)	21 (70%)	2
2021-22	13 (27%)	35 (73%)	0
2021	20 (41%)	29 (59%)	0
2020-21	21 (28%)	53 (72%)	2
2020	18 (32%)	39 (68%)	2
2019-20	19 (33%)	38 (67%)	1
2019	18 (36%)	32 (64%)	0
2018-19	19 (28%)	49 (72%)	1
2018	22 (31%)	50 (69%)	0
2017-18	16 (24%)	51 (76%)	0
2017	17 (35%)	31 (65%)	3

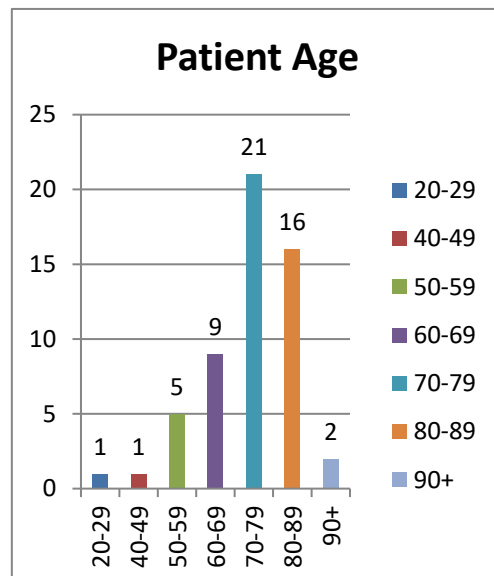
#### Gender of Patient

Period	Male	Female	n/r
2023-24	26 (47%)	29 (53%)	0
2023	28 (57%)	21 (43%)	0
2022-23	25 (60%)	17 (40%)	2
2022	19 (59%)	13 (41%)	0
2021-22	22 (49%)	23 (51%)	3
2021	26 (53%)	23 (47%)	0
2020-21	42 (58%)	31 (42%)	3
2020	27 (49%)	28 (51%)	4
2019-20	26 (46%)	31 (54%)	1
2019	23 (48%)	25 (52%)	2
2018-19	37 (54%)	31 (46%)	1
2018	38 (54%)	33 (46%)	1
2017-18	33 (49%)	34 (51%)	0
2017	23 (48%)	25 (52%)	3

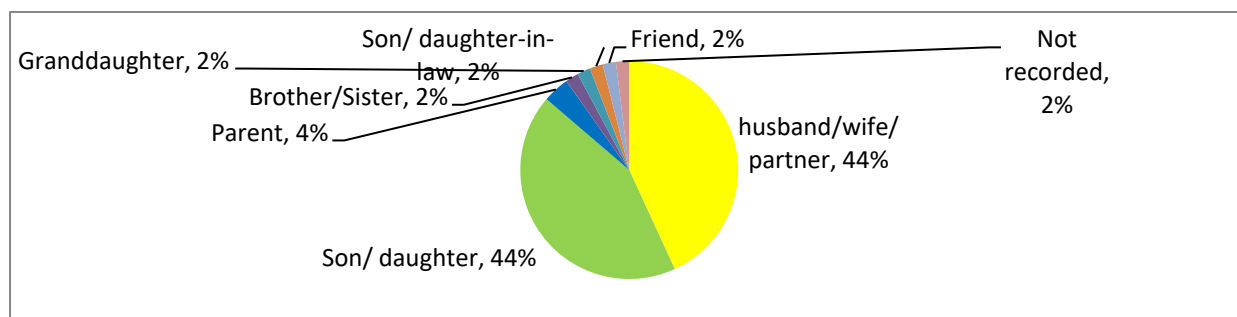
#### Age of respondent



#### Age of deceased



## Respondent's relationship to patient

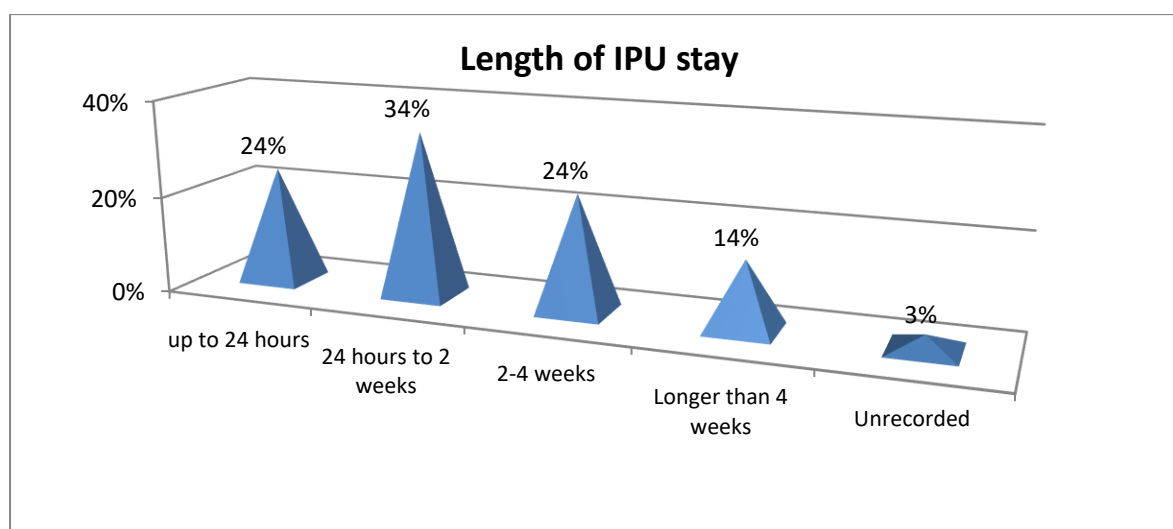


48 (87% c.f. 90% in 2023) of the 55 respondents who answered the question identified themselves as being 'White' (British/Irish/Other) with 7 (13%) identifying themselves as: 3 "Asian Indian," 2 "Black African," 2 "Asian Other." 0 did not record an answer. 45 (82% c.f. 88% in 2023) of the 55 patients who had the question answered on their behalf were identified as being white and the other 10 (18%) as: 3 "Asian Indian," 3 "Asian Other," 2 "Black African," 1 Mixed Other and 1 "Mixed White and Asian."

## Inpatient Care on Hospice Ward

### Inpatient Stay

**Q2)** 29 (53% c.f. 45% in 2023) of the 55 respondents stated that the patient had stayed in the IPU at some point. Of these, 10 (34% c.f. 59% in 2023) had stayed between 24 hours and two weeks, 7 (24% c.f. 14% in 2023) stayed between two and four weeks and 4 (14% c.f. 9% in 2023) stayed for longer than 4 weeks. Seven (24% c.f. 18% in 2023) stayed for less than 24 hours. One (3% c.f. 0% in 2023) did not record an answer.



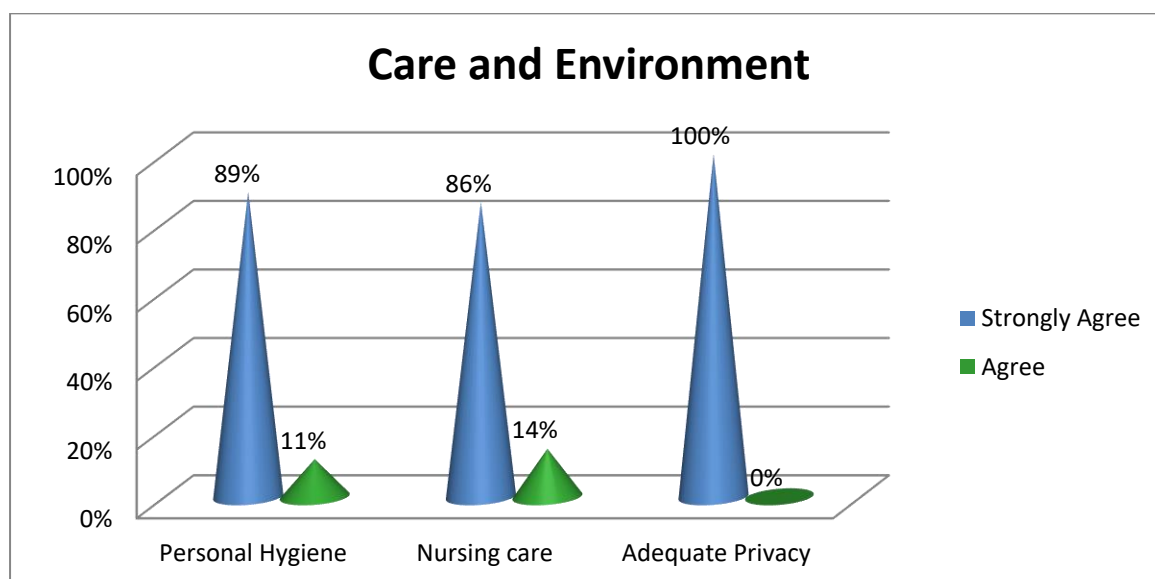
## Care and Environment

Respondents were asked to rate the personal care available relating to hygiene and privacy. A five point Likert scale was used. The responses were overwhelmingly positive in both audit periods.

**Q3A)** 89% ‘strongly agreed’ that there was enough help with personal care such as washing, personal hygiene and toileting needs (c.f. 86% in 2023), 11% ‘agreed’ (c.f. 14% in 2023). 1 (c.f. 0 in 2023) did not record an answer.

**Q3B)** 86% ‘strongly agreed’ that there was enough help with nursing care such as giving medicine and helping the patient find a comfortable position in bed (c.f. 82% in 2023), a further 14% ‘agreed’ (c.f. 18% in 2023). 1 (c.f. 0 in 2023) did not record an answer.

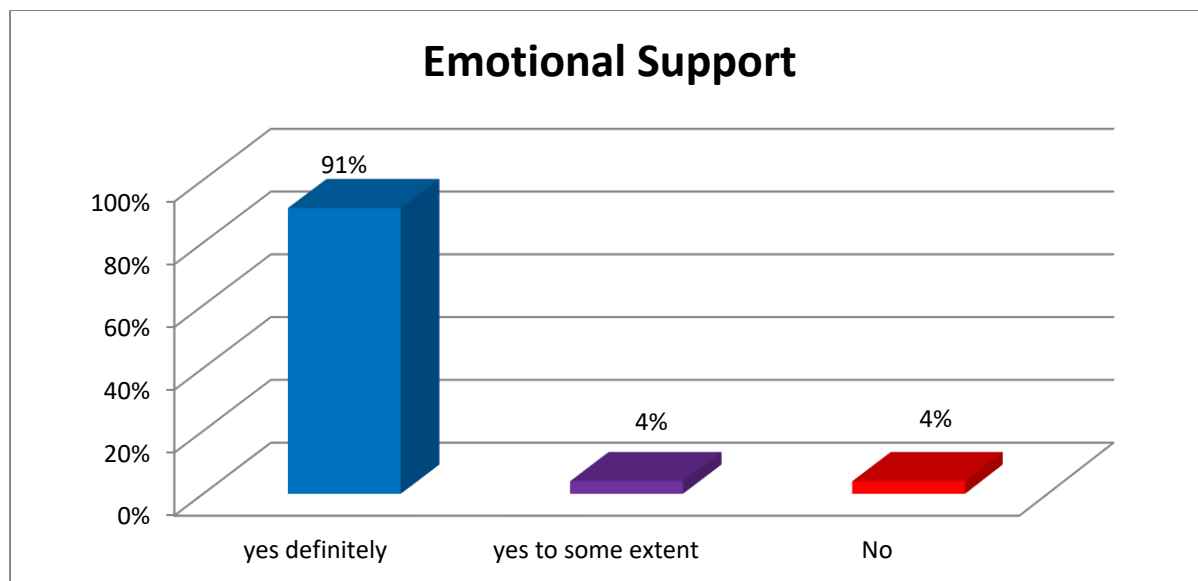
**Q3C)** With regards to the surrounding environment and bed area providing adequate privacy 100% ‘strongly agreed’ (c.f. 90% in 2023) and 0% ‘agreed’ (c.f. 10% in 2023). 1 (c.f. 1 in 2023) did not record an answer.



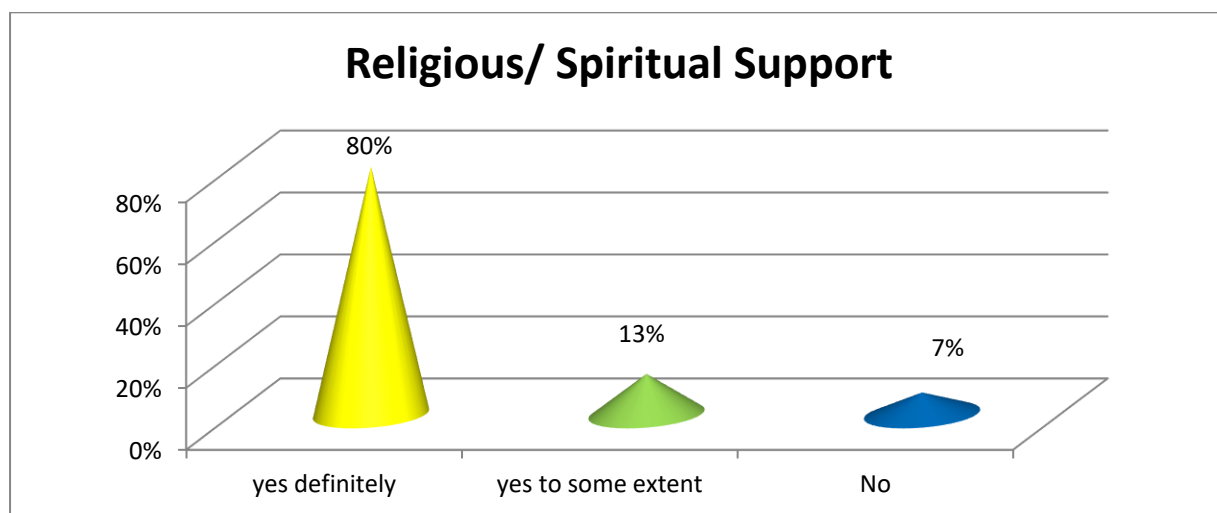
## Support

Respondents were asked their opinions of support available for the patient. A five point Likert scale was used with ratings from 'Yes definitely,' 'Yes, to some extent,' 'No, not when s/he needed it,' 'S/he did not need this type of help' to 'Don't know.'

**Q4A)** When asked if there was sufficient emotional support, 79% of respondents responded with a definite yes/no answer (c.f. 86% in 2023). Of these, 91% responded 'Yes, definitely' (c.f. 74% in 2023) and 4% responded 'Yes, to some extent' (c.f. 26% in 2023) and 4% responded 'No, not when needed' (c.f. 0% in 2023).



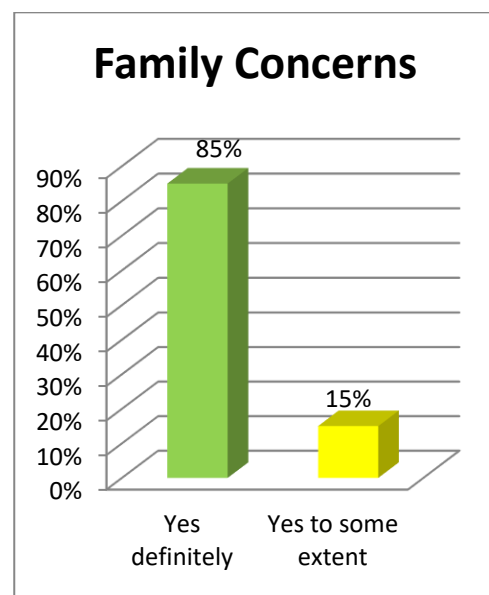
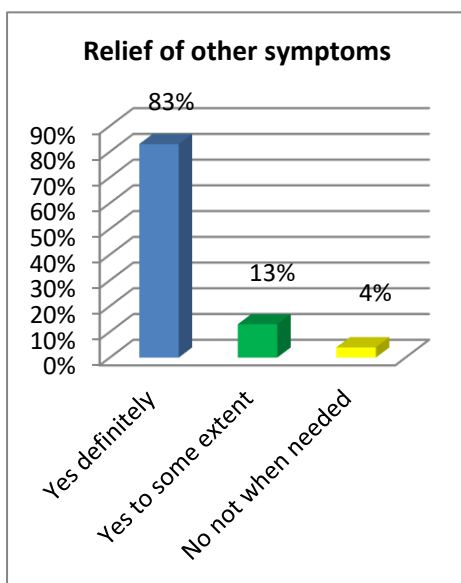
**Q4B)** Thirteen respondents felt the patients required religious/spiritual support. In answer to whether they received enough, 80% replied 'Yes, definitely' (c.f. 69% in 2023), 13% replied 'Yes, to some extent' (c.f. 31% in 2023) and 7% replied 'No, not when needed' (c.f. 0% in 2023).



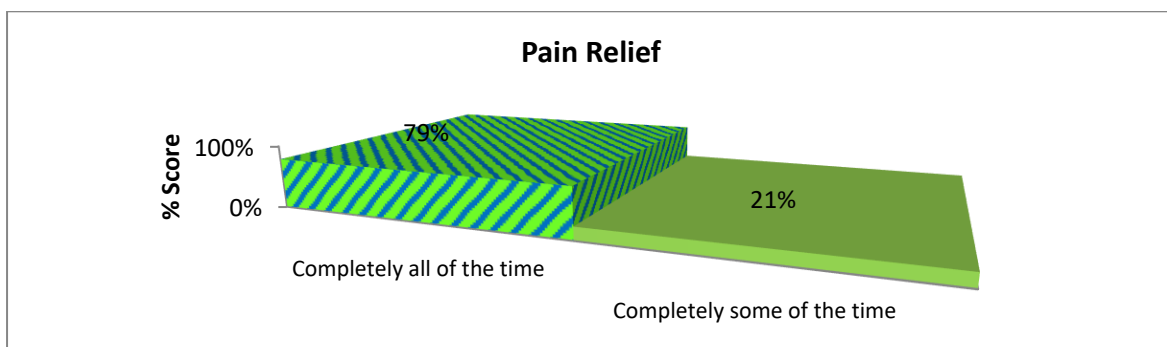
**Q4C)** 6 (21% c.f. 14% in 2023) respondents considered the patient to be in need of support regarding financial concerns or other practical problems. 4 (67% c.f. 67% in 2023) believed there was definitely enough support available and 1 (17% c.f. 0% in 2023) believed there was some support available and 1 (17% c.f. 33% in 2023) believed there was not enough support available.

**Q4D)** With regard to enough support for relief of symptoms other than pain, 79% of respondents responded either ‘Yes’ or ‘No’ (c.f. 77% in 2023). Of these, 83% considered there to have definitely been enough support (c.f. 88% in 2023) and 13% answered ‘Yes, to some extent’ (c.f. 12% in 2023) and 1 (4% c.f. 0% in 2023) answered ‘No.’

**Q4E)** 69% of respondents considered that there was a need for support in family concerns (c.f. 41% in 2023). Of these, 85% considered there was definitely enough support (c.f. 78% in 2023) and 15% replied ‘Yes, to some extent’ (c.f. 22% in 2023).



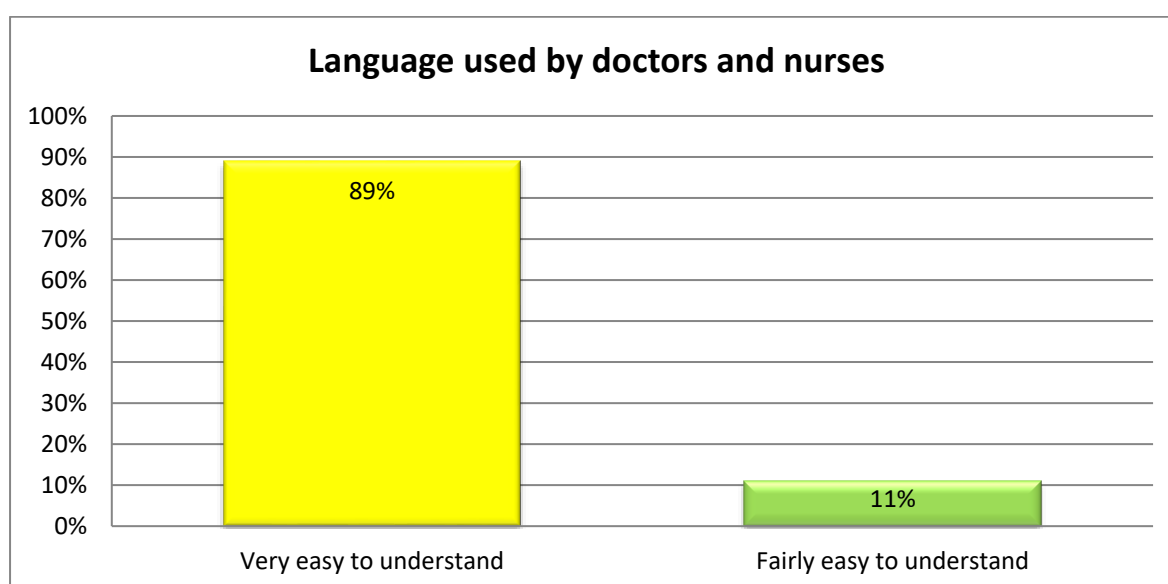
**Q5)** Respondents were asked how well the patient’s pain was relieved during their inpatient stay. None (0% c.f. 0% in 2023) said that the question did not apply because the patient had no pain. Of the 28 inpatient respondents who answered the question, 0% did not know the answer (c.f. 14% in 2023), 79% replied that the pain was relieved completely all of the time (c.f. 59% in 2023), 21% that it was relieved completely some of the time (c.f. 27% in 2023) and 0% considered it to have only been partially relieved (c.f. 0% in 2023).



## **Communication and involvement**

**Q6)** Relevant to 29 patients who stayed in the Hospice inpatient unit. 22 (79% c.f. 68% in 2023) reported that family members were always kept informed of the patient's condition, 5 (18% c.f. 27% in 2023) responded that this was usually the case and 1 (4% c.f. 5% in 2023) responded that this was sometimes the case. 1 did not record an answer.

**Q7)** The language used by doctors and nurses when explaining the patient's condition, treatments or tests was thought to be either 'very easy' to understand by 89% of respondents (c.f. 64% in 2023), fairly easy to understand by 11% (c.f. 32% in 2023). None found them fairly difficult to understand (c.f. 0% in 2023). 0% (c.f. 0% in 2023) responded that they never spoke to a doctor or nurse and 0% (c.f. 5% in 2023) responded that the doctors and nurses did not explain the condition/treatments/tests to them. 1 did not record an answer.

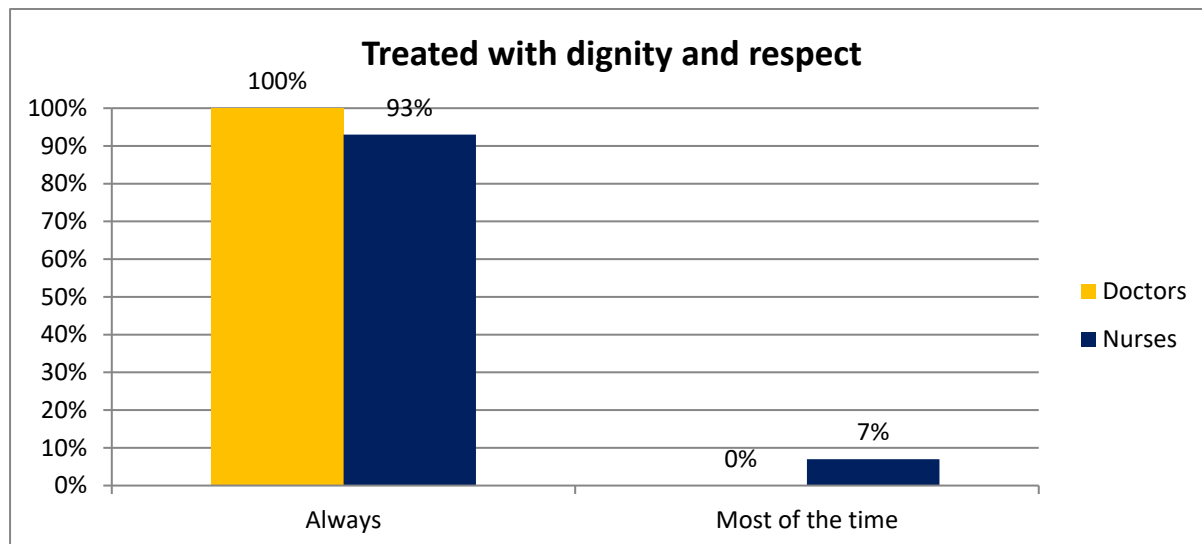


**Q8)** When asked the question: "During this admission, were there any decisions made about his/her care or treatment that s/he would not have wanted?" 81% responded with a positive 'No' (c.f. 86% in 2023), 11% replied that they did not know (c.f. 5% in 2023) and 7% replied with a negative 'Yes' (c.f. 9% in 2023).

'Making her urinate on the bed, not helping her get to the commode, making her extremely distressed and in pain.' – Daughter of patient

'As far as I am aware there were no concerns conveyed to me when I visited the patient.' – Husband of patient

**Q9)** The respondents were asked “How much of the time was s/he treated with respect and dignity by the Hospice doctors and nurses?” The questions were asked separately for both nurses and doctors. For doctors, 100% stated ‘Always’ and 0% stated ‘most of the time,’ and 0% recorded ‘Don’t Know’ (c.f. 100% stated Always and 0% stated most of the time and 0% did not know the answer in 2023). For the nurses, 93% stated Always and 7% stated ‘most of the time.’ (c.f. 95% stated ‘Always’ and 5% stated ‘most of the time in 2023.’)



**Q10)** Answering the question as to whether the respondent felt that the Hospice worked well with the patient’s GP and other external services : 59% stated ‘Yes definitely’ (c.f. 36% in 2023) and a further 7% agreeing ‘Yes to some extent’ (c.f. 36% in 2023). 30% answered ‘Don’t know’ (c.f. 27% in 2023), 4% recorded ‘No’ (c.f. 0% in 2023) and 0% recorded that they did not work together (c.f. 0% in 2023).

Comments on hospice working in collaboration with GP practices:

‘GP was unaware she was in hospice initially’ – Son of patient

‘NHS Croydon funding approved’ – Husband of patient

‘Our GP was notified twice, but never contacted us.’ – Wife of patient

‘Mum had only recently moved to the area, so the GP surgery were not always aware.’ – Daughter of patient

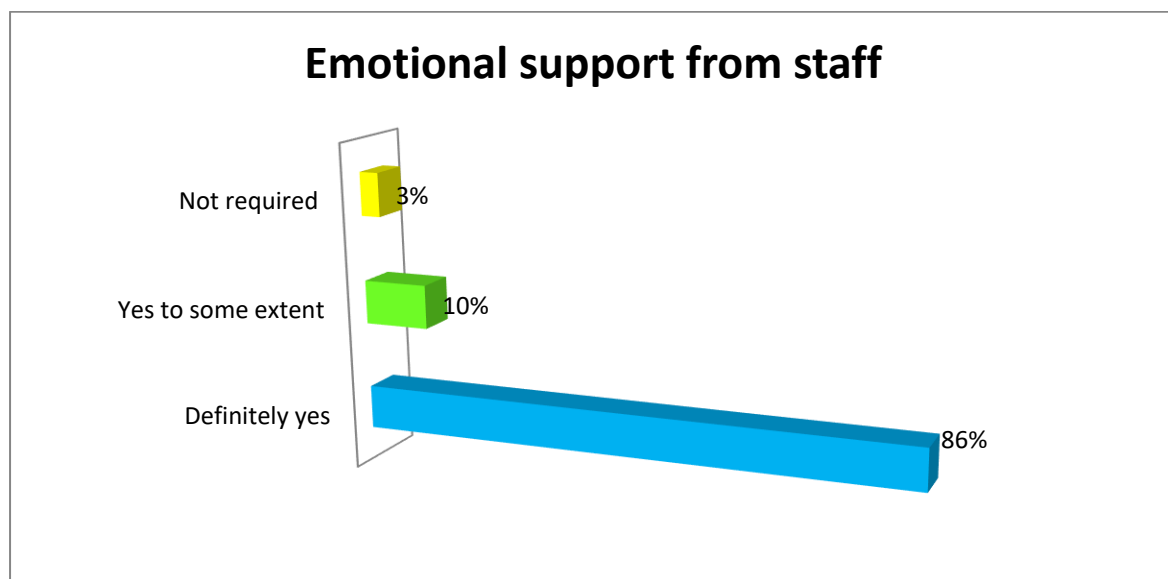
‘The only concern we had was when the hospice doctor and nurses couldn't insert a catheter. My husband was taken to St George's. They waited a long time, the catheter took minutes, then waited a long time for transport back - arriving after 11 PM’ – Wife of patient (See Actions taken ID 54 page 36)

**Q11)** Being able to stay in the Hospice overnight with their loved one was seen as important to 68% of respondents who recorded an answer (c.f. 41% in 2023). Of these, 95% were able to stay, and of these 95% who did get to stay, 100% found it helpful (c.f. 100% in 2023).

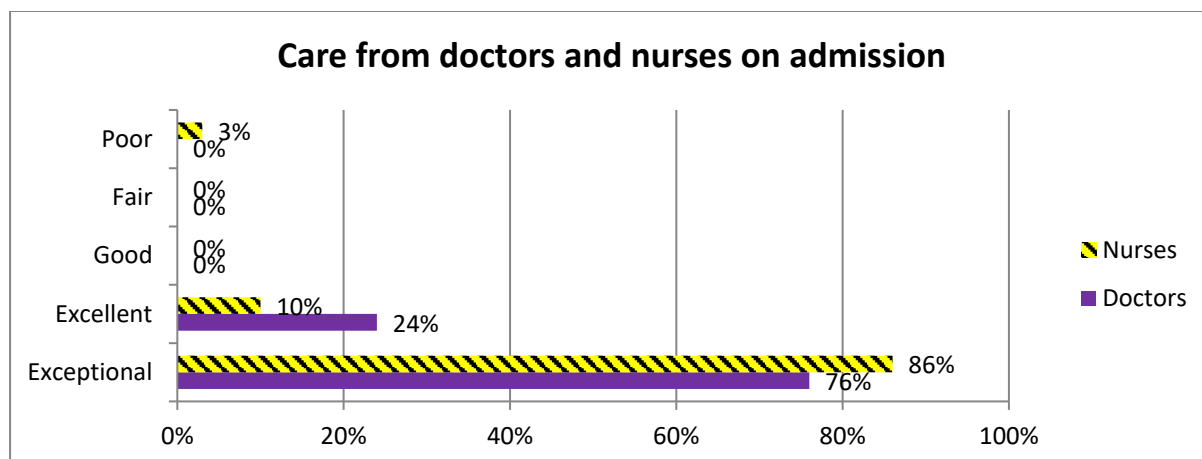
Comments on the subject of staying overnight:

‘Very accommodating to be with her at times when needed for us’ – Daughter of patient  
‘My son and I stayed with my husband several nights and were made comfortable and welcomed. It was a great comfort.’ – Wife of patient  
‘Was there until the early hours when he passed away.’ – Son-in-law of patient

**Q12)** Respondents were asked whether they felt that they had received sufficient emotional support from the Hospice staff. Responses showed 86% answering ‘definitely yes’ (c.f. 86% in 2023), 10% answering ‘yes, to some extent’ (c.f. 9% in 2023), and 3% replying that they did not require this kind of help (c.f. 5% in 2023). 0% (c.f. 0% in 2023) responded ‘no.’ 0% (c.f. 0% in 2023) recorded that they did not receive this kind of help, despite requiring it. 0% (c.f. 0% in 2023) recorded that they did not know the answer.

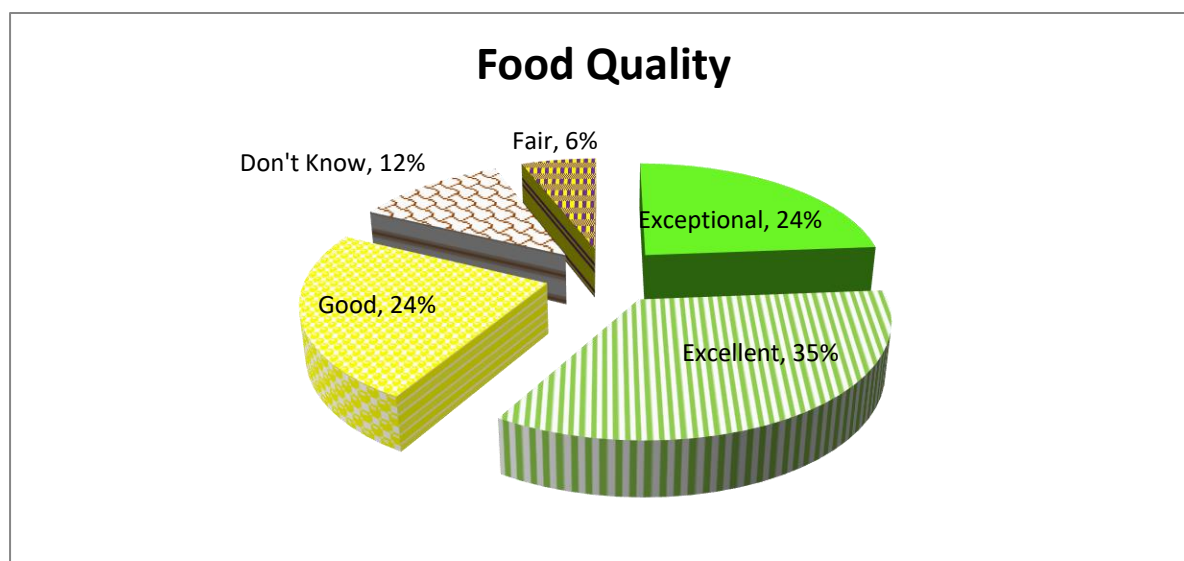


**Q13)** Respondents were asked to rate care given to the patients by doctors and nurses on admission and the responses were universally positive. 76% considered doctor care on admission to be ‘Exceptional’ (c.f. 64% in 2023), 24% considered it to be ‘Excellent’ (c.f. 27% in 2023), 0% considered it to be ‘Good’ (c.f. 5% in 2023), 0% considered it to be ‘Fair’ (c.f. 5% in 2023) and 0% recorded ‘Don’t Know’ (c.f. 0% in 2023). Responses relating to nursing care were even better, with 86% rating nursing care as ‘Exceptional’ (c.f. 77% in 2023), 10% as ‘Excellent’ (c.f. 18% in 2023), 0% as ‘Good’ (c.f. 5% in 2023), 0% as ‘Fair’ (c.f. 0% in 2023), 3% as ‘Poor’ (c.f. 0% in 2023) and 0% recorded that they did not know the answer (0% in 2023).



### Food and Catering

**Q14)** It should be noted that 41% of respondents who answered the question about the quality of food provided for patients at the Hospice replied that their loved one did not have any food at the Hospice (c.f. 33% in 2023). Of those who replied that their loved one did partake of hospice food, 24% answered that the food was ‘Exceptional’ (c.f. 21% in 2023), 35% that it was ‘Excellent’ (c.f. 21% in 2023), 24% that it was good (c.f. 50% in 2023), 6% that it was ‘Fair’ (c.f. 0% in 2023), 0% that it was ‘Poor’ (c.f. 0% in 2023) and 12% of the respondents (c.f. 7% in 2023) did not know what rating to give it.



Seven general written comments about the Hospice IPU were altogether positive:

‘Choices and recommendations were always given depending on how the patient felt.’ – Daughter of patient

‘Didn't have normal food, only liquids. I would like to add that even the kitchen staff took time with the family giving emotional support. Mary was an absolute superstar. The doctors and nurses and HCAs were all amazing and went above and beyond to help.’ – Daughter of patient

‘She ate very little - custard mainly. The care and support from everyone, particularly the nurses were exceptional and has had a profound impact on me and my family. I will always be thankful for the love and support we had and will always support and champion the hospice. (love heart icon)’ – Daughter of patient

‘I cannot fault the care my husband, myself and indeed my family received during his last days. The staff were exceptionally kind across the board and the nurses were like angels.’ – Wife of patient

‘The doctors and nursing team were exceptional. Very caring, understanding, friendly and really helpful. We cannot give enough gratitude. Thank you all for your care.’ – Son-in-law of patient

‘My father died at St Raphael's and received excellent, compassionate care, so I was very grateful that there was space for my mother. I felt so reassured that she was in your care.’ – Daughter of patient

‘Patient was only in the hospice for 24 hours. There wasn't a bed available for him whilst he was in St Georges, so he had a short stay, but the stay was absolutely lovely for him.’ – Friend of patient

Three general written comments about the Hospice IPU were critical:

‘On becoming an inpatient I feel the level of care from the night time nurses, especially one, was very poor, not kind, did not listen to mom or the family. This made her extremely distressed, scared and upset during her last 24 hours.’ – Daughter of patient (See Actions Taken ID 22 page 35)

‘Mum only really wanted soft boiled eggs, but not all the kitchen staff knew how to do this and often produced hard boiled eggs.’ – Daughter of patient

‘The only concern we had was when the hospice doctor and nurses couldn't insert a catheter. My husband was taken to St George's. They waited a long time, the catheter took minutes, then waited a long time for transport back - arriving after 11 PM.’ – Wife of patient (See Actions Taken ID 54 page 36)

One general written comment about the Hospice IPU was neither praise nor criticism:

‘Food. The patient found it difficult to eat. Soft food, such as ice cream, soup and other soft food was provided. I think that the lack of intake concerned the staff.’ – Husband of patient

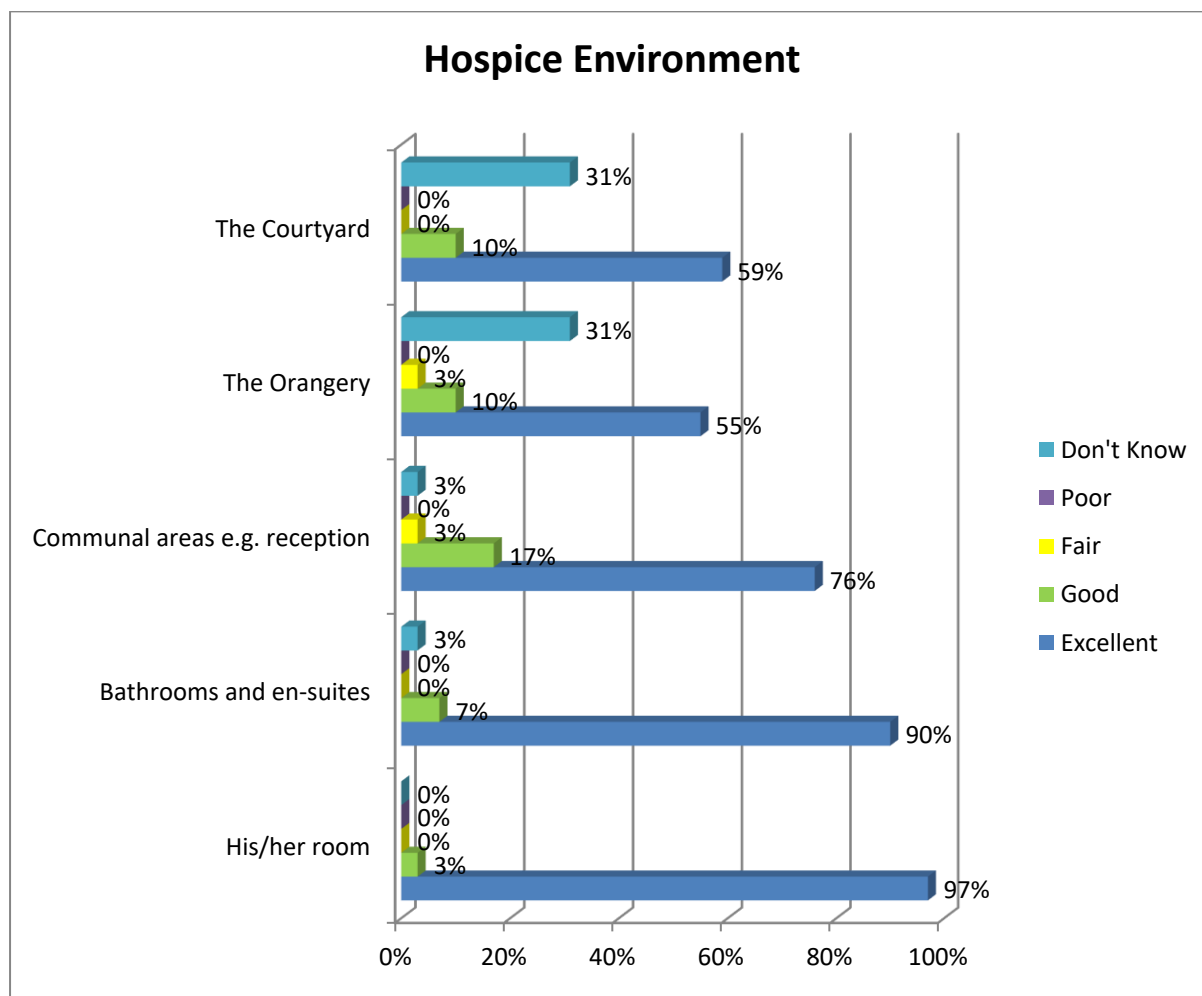
**Q15 A-E)** Respondents were asked to comment on different aspects of the Hospice.

The patient's room was considered to be 'Excellent' by 97% (c.f. 86% in 2023) and the remaining 3% rated the room as 'Good' (c.f. 14% in 2023). 0% considered it to be fair (c.f. 0% in 2023) and 0% did not know (c.f. 0% in 2023). 90% of respondents considered the en-suite bathrooms on the IPU to be 'Excellent' (c.f. 77% in 2023), 7% rated them as 'Good' (c.f. 18% in 2023), 0% rated them as 'Fair,' (c.f. 0% in 2023) and 3% did not know the answer (c.f. 5% in 2023).

When asked to rate the communal areas of the Hospice, such as the Reception, 76% of respondents rated them as 'Excellent' (c.f. 59% in 2023), 17% rated them as good (c.f. 36% in 2023), 3% rated them as fair (c.f. 5% in 2023) and 3% recorded 'Don't Know' (c.f. 0% in 2023).

When asked to rate the Orangery, 55% rated it as 'Excellent' (c.f. 59% in 2023), 10% rated it as 'Good' (c.f. 18% in 2023), 3% rated it as 'Fair' (c.f. 5% in 2023) and 31% answered that they did not know (c.f. 18% in 2023).

When asked to rate the courtyard, 59% rated it as 'Excellent' (c.f. 55% in 2023), 10% rated it as 'Good' (c.f. 36% in 2023), 0% rated it as 'Fair' (c.f. 5% in 2023), 0% rated it as poor (c.f. 0% in 2023) and 31% did not know how to rate the courtyard (c.f. 5% in 2023).



## St Raphael's Community Services

**Q16)** 33 of the total 55 respondents, 60% (c.f. 88% in 2023) stated that the patient received care from the St Raphael's Hospice Community Palliative Care Team's (CPCT) Clinical Nurse Specialists, three were unsure whether they had or not and three answered 'no' they had not. The following data is extracted from responses relating to the 33 patients (60%) who were recorded as having definitely received care. The total number of respondents varies slightly per question, since not all respondents answered every question.

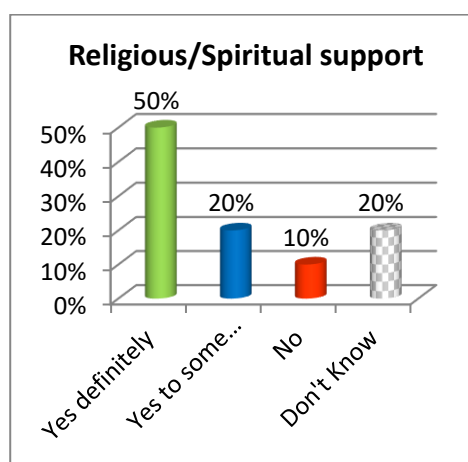
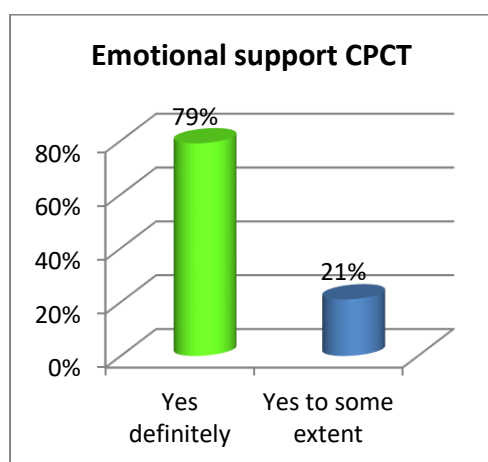
### Responsiveness

**Q17)** Most respondents felt that the team visited as often as needed - 84% (c.f. 84% in 2023) and 13% felt that the team 'only sometimes' visited as often as needed (c.f. 9% in 2023), 0% replied 'no' (c.f. 2% in 2023) and 3% replied "don't know" (c.f. 5% in 2023).

**Q18)** The respondents were asked to comment on different aspects of CPCT care:-.

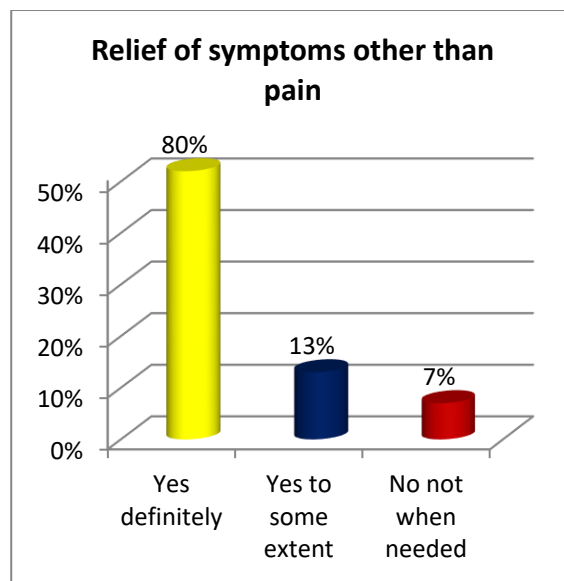
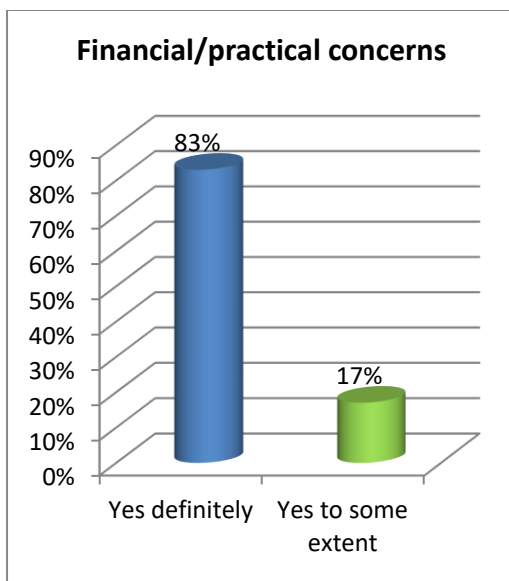
**Q18A)** When asked whether patient's received enough emotional support from the CPCT team, 29 (91% c.f. 93% in 2023) of the 32 respondents who answered the question acknowledged that the patient had a need for emotional support and of these, 79% replied 'Yes definitely' (c.f. 69% in 2023), 21% 'Yes to some extent' (c.f. 26% in 2023), 0% recorded 'No, not when needed' (c.f. 5% in 2023) and 0% recorded 'Don't know' (c.f. 0% in 2023).

**Q18B)** 10 (31%) of the 32 respondents who answered the question stated that the patient did require some kind of religious or spiritual support. In response to whether they received enough religious or spiritual support from the CPCT, 5 of these (50% c.f. 48% in 2023) answered 'Yes definitely' and 2 (20%) replied 'Yes to some extent' (c.f. 17% in 2023), 1 (10%) replied 'No, not when needed' (c.f. 13% in 2023) and 2 (20%) replied 'Don't Know' (c.f. 22% in 2023).

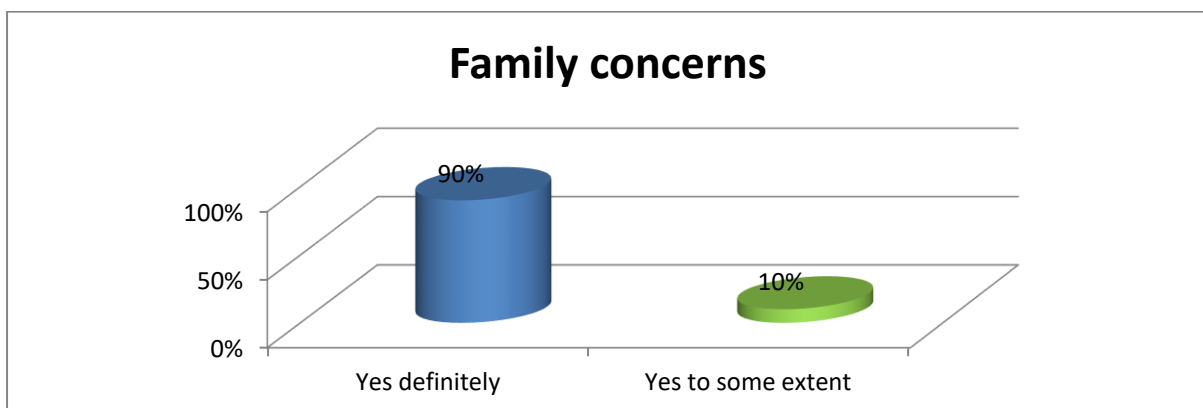


**Q18C)** 59% of respondents felt that the patient did not require help with financial concerns and other practical problems (c.f. 55% in 2023) and 3% respondents (c.f. 5% in 2023) did not know. Only 12 respondents felt that this support was needed and, of these, as to whether enough support was received, 83% replied ‘Yes definitely’ (c.f. 50% in 2023), 17% ‘Yes to some extent’ (c.f. 44% in 2023) and 0% ‘No not when needed’ (c.f. 6% in 2023).

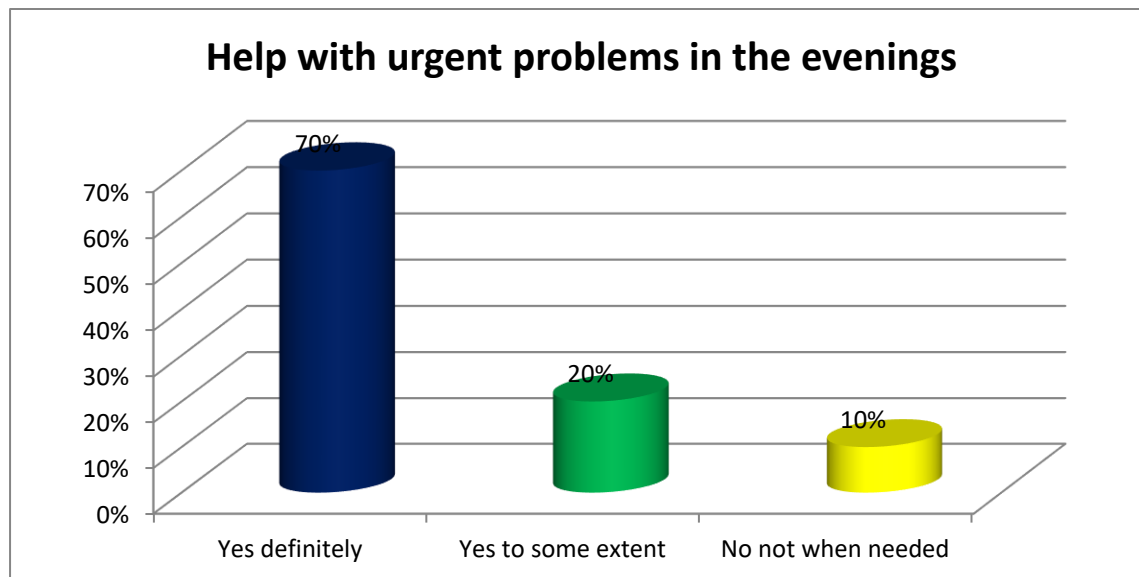
**Q18D)** 6% of respondents felt that the patient did not require help with relief of symptoms other than pain (c.f. 10% in 2023) and 0% respondents (c.f. 0% in 2023) did not know and 1 did not record an answer. 30 respondents felt that this support was needed and of these, as to whether enough support was received, 80% replied ‘Yes definitely’ (c.f. 72% in 2023), 13% ‘Yes to some extent’ (c.f. 22% in 2023) and 7% ‘No not when needed’ (c.f. 6% in 2023).



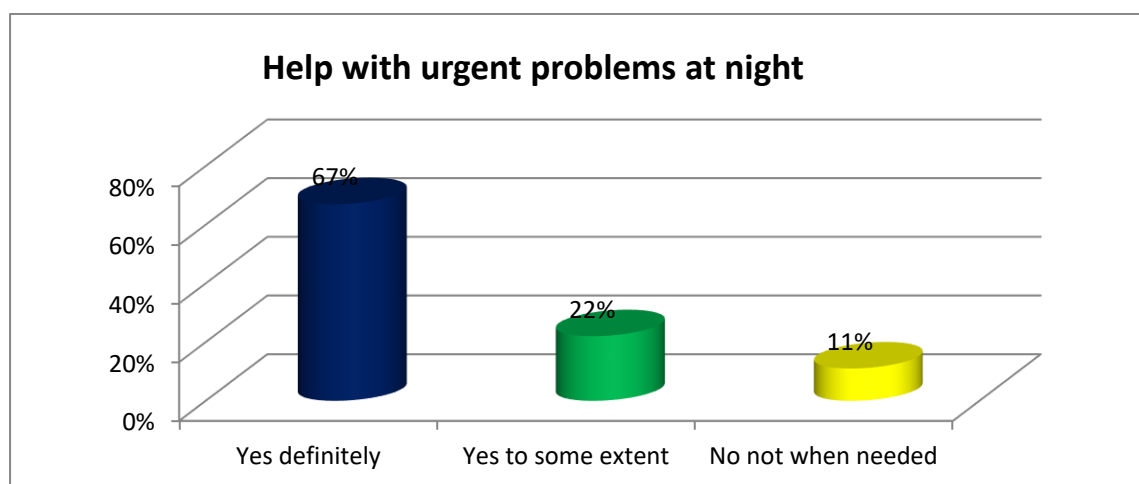
**Q18E)** 35% of respondents felt that the patient did not require help with family concerns (c.f. 48% in 2023) and 0% respondents (c.f. 10% in 2023) did not know and 2 did not record an answer. 17 respondents felt that this support was needed and of these, as to whether enough support was received, 90% replied ‘Yes definitely’ (c.f. 47% in 2023), 10% ‘Yes to some extent’ (c.f. 47% in 2023) and 0% ‘No not when needed’ (c.f. 6% in 2023).



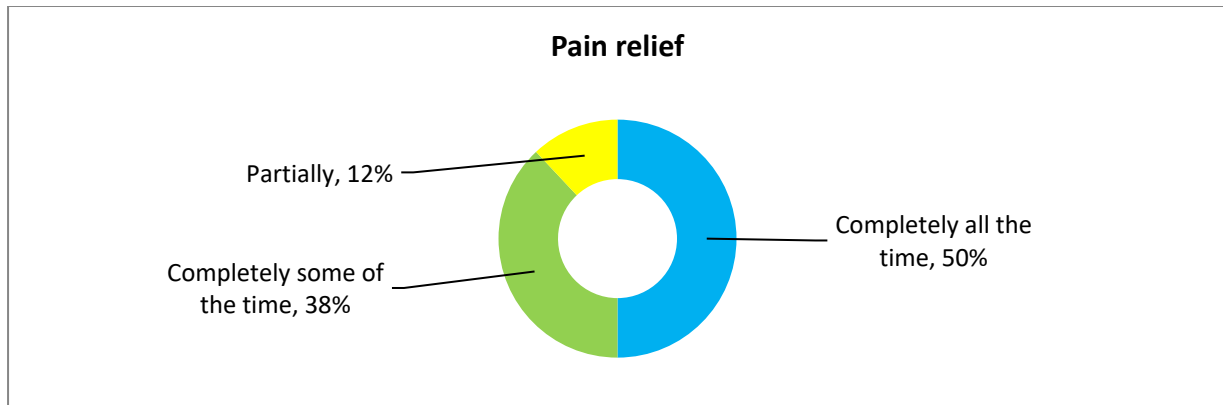
**Q18F)** 38% (c.f. 31% in 2023) of respondents felt that the patient did not require help with urgent problems during the evenings (between 5 PM and 11 PM) and 0% did not know (c.f. 3% in 2023). 20 (63% c.f. 67% in 2023) respondents who recorded an answer felt that this support was needed and of these, as to whether enough support was received, 70% replied ‘Yes definitely’ (c.f. 50% in 2023), 20% ‘Yes to some extent’ (c.f. 42% in 2023) and 10% ‘No not when needed’ (c.f. 8% in 2023).



**Q18G)** 41% of respondents felt that the patient did not require help with urgent problems during the nights (between 7 PM and 9 AM) (c.f. 29% in 2023) and 3% respondents (c.f. 7% in 2023) did not know. 18 respondents - 56% (c.f. 63% in 2023) of those who recorded an answer, felt that this support was needed and, of these, as to whether enough support was received, 67% replied ‘Yes definitely’ (c.f. 54% in 2023), 22% ‘Yes to some extent’ (c.f. 38% in 2023) and 11% ‘No not when needed’ (c.f. 8% in 2023).



**Q19) Regarding Pain Relief:** “Completely all the time” 50% (c.f. 50% in 2023), “Completely some of the time” 38% (c.f. 31% in 2023), and “Partially” 12% (c.f. 19% in 2023) and “Not relieved at all” 0% (c.f. 0% in 2023).



**Q20)** 31 of the 33 respondents answered the question relating to whether they and their family got enough help and support from the Hospice CPCT. See table below.

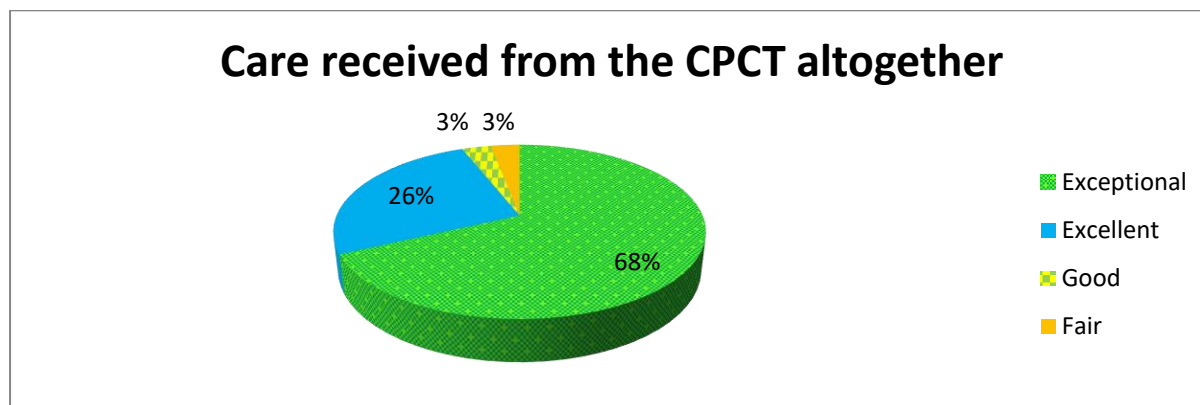
	2023-2024	2023	2022-23	2022	2021-22	2021	2020-21	2020	2019-20	2019	2018-19	2018	2017-18	2017
Yes as much as we wanted	87%	86%	81%	84%	82%	85%	81%	85%	89%	82%	85%	79%	78%	83%
Yes, some, but not as much as we wanted	6%	5%	10%	8%	9%	5%	9%	8%	8%	9%	8%	12%	7%	17%
No, tried to get more	6%	5%	0%	8%	3%	5%	7%	3%	3%	6%	2%	4%	6%	0%
No, did not ask for more	0%	0%	6%	0%	6%	5%	0%	5%	0%	3%	4%	5%	7%	0%
Did not need	0%	5%	3%	0%	0%	0%	3%	0%	0%	0%	2%	0%	2%	0%

Communication with the CPCT team was altogether positive.

**Q21)** The way in which the CPCT team explained the patient’s condition, treatment or tests was considered ‘Very easy’ to understand by 83% of respondents (c.f. 72% in 2023) and ‘fairly easy’ by 17% (c.f. 23% in 2023), ‘fairly difficult’ by 0% (c.f. 0% in 2023) and none (0%) recorded that they did not explain anything (c.f. 2% in 2023). None (0% c.f. 2% in 2023) recorded that they never spoke with the team. Three respondents did not record an answer.

**Q22)** 31 of the 33 respondents answered the question relating to whether the CPCT team had time to listen to them and 94% responded ‘Yes, all the time’ (c.f. 88% in 2023) and 6% responded ‘Yes, some of the time’ (c.f. 10% in 2023), none (0% c.f. 3% in 2023) recorded ‘No, not when needed,’ and none (0% c.f. 0% in 2023) responded that they did not know the answer to this question.

**Q23)** Overall impressions were very positive. When asked their opinion on the care as a whole from the CPCT team, 31 of the 33 respondents recorded an answer and of these, 68% recorded 'Exceptional' (c.f. 60% in 2023), 26% 'Excellent' (29% in 2023), 3% 'Good' (7% in 2023), 3% 'Fair' (c.f. 0% in 2023), and 0% recorded 'Poor' (c.f. 5% in 2023).



**Q24)** All 43 respondents recorded an answer to the question as to whether the CPCT involved them in decisions about the patient's treatment and care as much as they wanted. 97% recorded that they had been involved as much as they wanted (c.f. 88% in 2023), 0% recorded that they would have liked to have been more involved (c.f. 9% in 2023), 3% (c.f. 2% in 2023) recorded 'Don't know.'

12 respondents wrote a comment that related to their experiences of CPCT care. There were 9 written comments that were very complimentary, showing positive experiences.

ID	24 CPCT COMMENT
8	They were so kind and supportive. (Wife of patient)
9	The staff and nurses were wonderful to him and me. (Wife of patient)
10	We received an exceptional service. The team were very kind and compassionate. Whilst they were all so kind, Lorraine was so lovely towards us. We will forever be grateful. (Wife of patient)
14	All information was clear and direct. All questions answered. (Daughter of patient)
18	Support arranged via "attendance allowance" for a few weeks. Support arranged via occupational therapist: equipment provided to assist within the home towards the end of life. Thank you (Son of patient)
25	The care and support we received was exceptional - the carers and nurses went the extra mile to help us (Wife of patient)
35	The nurse was very caring and my mother was comfortable and happy with the help provided. (Daughter of patient)
45	Thank you all for your exceptional care. (Son-in-law of patient)
53	I was constantly reassured that help was on the end of the phone morning/ noon/ night and St Raphael's didn't let us down with unwavering support ever. (Mother of patient)

Two comments were critical

ID	24 CPCT COMMENT
22*	I feel mum was not informed. These were her last days/ weeks and so she did not know. (Daughter of patient)
32	My husband was very poorly during Christmas/ New Year period - his needs were not completely met. (Wife of patient)

\*(See Action Taken ID 22 page 35)

One comment was neither praise nor criticism

ID	24 CPCT COMMENT
12	It was a shock when at a meeting at home, they seemed to know he would not last as long as we hoped. (Wife of patient)

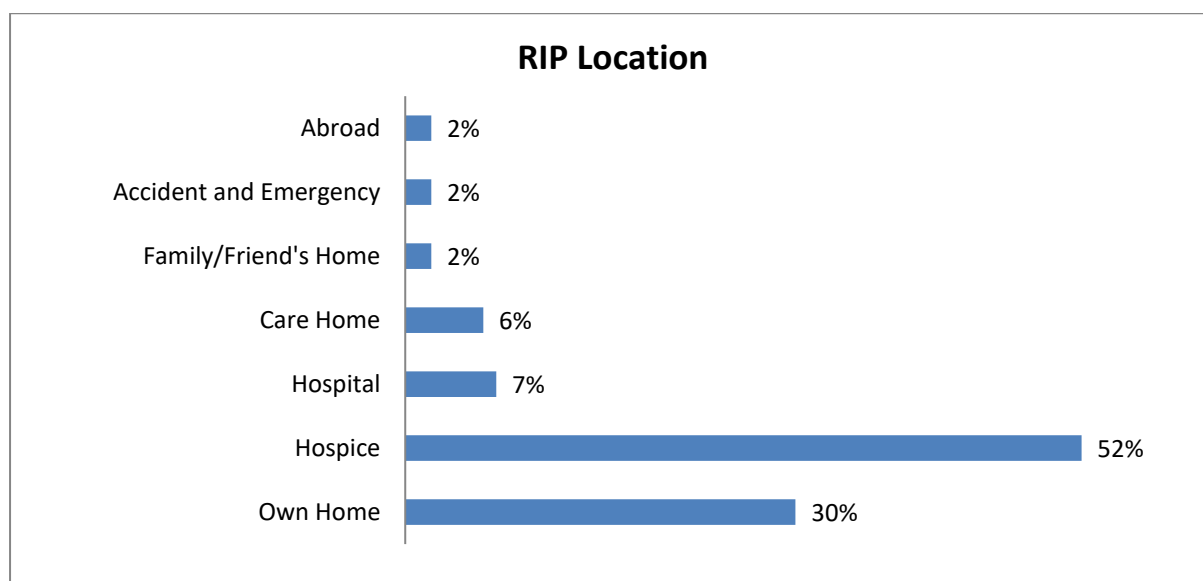
## **St Raphael's Hospice Wellbeing Centre**

**Q25) & Q26)** 3 of the 55 respondents said that the patient had visited the Wellbeing Centre (c.f. 3 of the 49 in 2023). All three said that the patient always benefited from attending.

### **Circumstances surrounding his/her death**

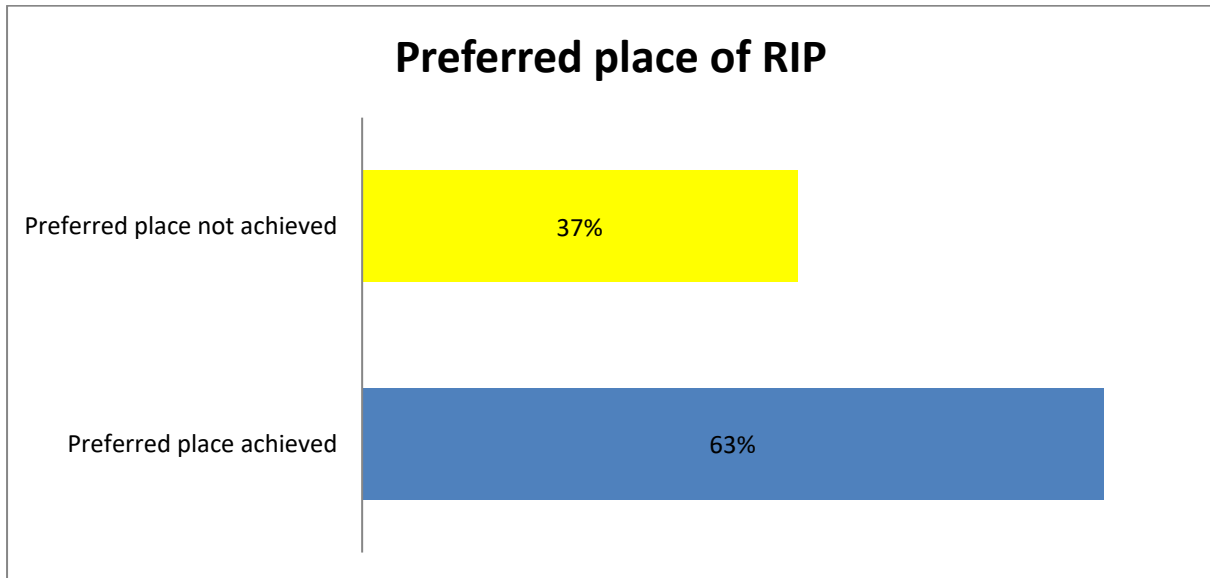
This section presents the views of the respondents regarding the circumstances of the patient's death and any expressed wishes. The questions were asked of all respondents.

**Q27)** 54 out of the 55 respondents recorded an answer to this question. Of these, 52% reported that their loved one died in the Hospice (c.f. 49% in 2023), 30% that they had died in their own home (26% in 2023), 7% that they had died in hospital (c.f. 17% in 2023), 6% that they had died in a care home (c.f. 4% in 2023), 2% that they had died in the home of their Family/Friends (c.f. 2% in 2023), 2% that they died in Accident and Emergency (c.f. 2% in 2023) and 2% that they had died abroad (c.f. 0% in 2023).



**Q28)** 43 respondents said that their loved ones explicitly stated where they wanted to die, 6 did not say, 4 were unsure and 2 did not record an answer to the question. Of the 43 who recorded that the patient stated their preferred place of death, 11 – 26% said they preferred a hospice (c.f. 46% in 2023), 29 (67% c.f. 49% in 2023) their own home, 0 (0% c.f. 3% in 2023) said they preferred a hospital, 3 (7% c.f. 3% in 2023) changed their mind and none (0% c.f. 0% in 2023) did not mind.

**Q29)** Of the 40 respondents who recorded that the patient had explicitly stated a specific preferred place of death (so not including the one who changed their mind), this was achieved in 25 (63%) of the 40 cases (c.f. 69% in 2023).



The table below illustrates the preferred places of death for those patients who had a specific preference:

Preferred place	Achieved 2023-24	Not 2023-24	Achieved 2023	Not 2023	Achieved 2022-23	Not 2022-23	Achieved 2022	Not 2022	Achieved 2021-22	Not 2021-22	Achieved 2021	Not 2021	Achieved 2020-21	Not 2020-21	Achieved 2020	Not 2020	Achieved 2019-20	Not 2019-20
Hospice	10	1	14	3	7	2	7	1	8	4	5	2	10	4	6	7	13	3
Either Home or Hospice	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Own Home	15	14	10	8	15	7	7	10	17	7	20	10	27	8	15	8	11	9
Somewhere Else	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
Friend/Family Member's Home	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Son's Home	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Daughter's Home	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospital	0	0	1	0	0	1	0	0	0	0	1	0	0	0	0	0	0	0
Care Home	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
<b>TOTAL</b>	<b>25</b>	<b>15</b>	<b>25</b>	<b>11</b>	<b>22</b>	<b>10</b>	<b>15</b>	<b>11</b>	<b>25</b>	<b>11</b>	<b>26</b>	<b>12</b>	<b>37</b>	<b>12</b>	<b>21</b>	<b>16</b>	<b>24</b>	<b>13</b>

**Q30)** Respondents were asked whether their loved ones had enough choice about where they died. Of the 40 that did say where they wanted to die, 1 did not record an answer. Of the other 39, 32 – 82% reflected their loved one had had enough choice about where they died (c.f. 85% in 2023), 2 (5%) were ‘Unsure’ (c.f. 6% in 2023) and 5 (13% c.f. 9% in 2023) said they did not have enough choice.

Actual place of death	Yes	Unsure	No	N/R
Hospice	16	2	1	
Hospital	2		1	
Own Home	13		2	1
Family/Friend Home	1			
Care Home			1	
<b>Total</b>	<b>32</b>	<b>2</b>	<b>5</b>	<b>1</b>

Three respondents who believed the patient did not have enough choice recorded these comments:

<b>30 COMMENT ON ENOUGH CHOICE</b>
He wasn't allowed to go home from hospital. (Friend of patient)
Unfortunately, the hospice was full. (Son of patient)
Only one option. (Husband of patient)

A respondent who was unsure whether the patient had enough choice recorded this comment:

<b>30 COMMENT ON ENOUGH CHOICE</b>
He wanted to be at home but it wasn't safe. We made the best decision. (Daughter of patient)

Four of the respondents who believed the patient did have enough choice recorded the following comments:

<b>30 COMMENT ON ENOUGH CHOICE</b>
The hospital recommended a hospice as there were concerns for the nursing needs. (Husband of patient)
Wanted to die at home, provided he could be comfortable. He was comfortable dying in a hospice if that was best for his comfort. (Son of patient)
Unfortunately, due to the medical condition had to be in hospital. (Wife of patient)
In the end she was content and at peace being at the hospice. (Daughter of patient)

**Q31)** On balance, when responding to the question of whether the patient died in the right place, 54 of the 55 respondents answered the question and of these, 47 replied that they did – 87% (c.f. 87% in 2023), 3 (6% c.f. 0% in 2023) were unsure, and 4 – 7% replied that they did not (c.f. 13% in 2023).

<b>Actual place of death</b>	<b>Yes</b>	<b>Unsure</b>	<b>No</b>	<i>Not Recorded</i>
<b>Accident &amp; Emergency</b>	<b>0</b>	<b>0</b>	<b>1</b>	<i>0</i>
<b>Care home</b>	<b>1</b>	<b>0</b>	<b>2</b>	<i>0</i>
<b>Hospice</b>	<b>26</b>	<b>2</b>	<b>0</b>	<i>0</i>
<b>Hospital</b>	<b>2</b>	<b>1</b>	<b>1</b>	<i>0</i>
<b>Own home</b>	<b>16</b>	<b>0</b>	<b>0</b>	<i>0</i>
<b>Family/ Friend Home</b>	<b>1</b>	<b>0</b>	<b>0</b>	<i>0</i>
<b>Abroad</b>	<b>1</b>	<b>0</b>	<b>0</b>	<i>0</i>
<b>Not recorded</b>	<b>0</b>	<b>0</b>	<b>0</b>	<i>1</i>
<b>Total</b>	<b>47</b>	<b>3</b>	<b>4</b>	<i>1</i>

Five of the 47 respondents who believed the patient had died in the right place recorded this comment:

<b>31 COMMENT ON PLACE</b>
With the end-of-life care needed this was the right place. (Husband of patient)
Due to being able to receive pain relief as soon as needed which was extremely important in her case. (Daughter of patient)
Death could have been better - services were lacking because of Christmas/ New Year period. (Wife of patient)
The patient was in the right place and was not alone when they died. (Husband of patient)
The staff were so loving and caring until the end. (Daughter of patient)

Two of the four respondents who answered “No” recorded these comments:

<b>31 COMMENT ON PLACE</b>
I was informed by a neighbour five hours after parking. (Wife of patient)
Doctor did not turn up after being called four times from 10 AM to 4 PM - arrived at 5 PM and said that she was not contacted and I had to tell medical staff that my wife was dead, they did not know that she had passed away on the monitor. No blood pressure, no heart rate, no pulse. (Husband of patient)

One of the three respondents who was unsure recorded this comment:

<b>31 COMMENT ON PLACE</b>
On admission and what happened made me question my decision to bring her in. The morning and how calm and not in pain made it the right decision, but I was still not made aware it was hours, not days. (Daughter of patient)

### **Bereavement Support**

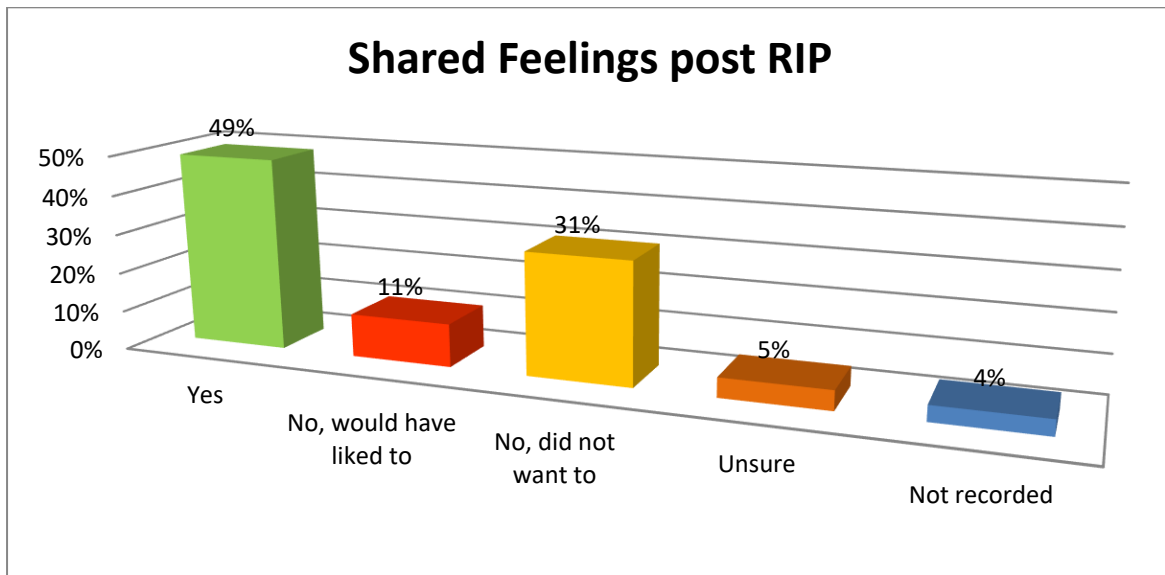
**Q32)** All 28 respondents who stated their loved ones died in the Hospice recorded an answer, and of these 100% felt that they were definitely given enough support by staff (c.f. 91% in 2023), 0% replied ‘Yes, to some extent’ (c.f. 9% in 2023), and 0% responded ‘No, not at all’ (c.f. 0% in 2023).

Five respondents recorded comments:

<b>32 FAMILY HELP COMMENT</b>
Everyone at St Raphael's was fantastic - helpful, empathetic, patient - just wonderful. Thank you all so much. (Wife of patient)
They were all wonderful. (Wife of patient)
Mostly brilliant - could possibly do with follow up call ref any emotional concerns/ help. (Daughter of patient) – (See Follow Up Actions Section, ID 16 page 35)
Above and beyond. (Wife of patient)
Really understanding, very caring and supportive. Thank you. (Son-in-law of patient)

**Q33) & Q34)** Respondents were asked whether since the patient’s death had they talked to anyone from St Raphael’s about their feelings regarding their loved one’s illness and death.

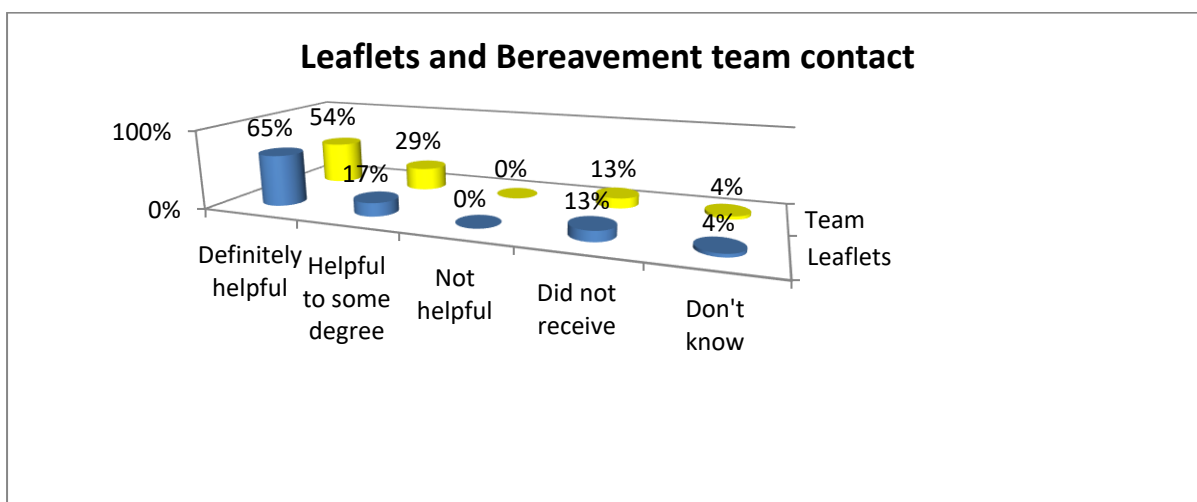
17 of the 55 respondents had not spoken to anyone and said that it had been their choice. 6 replied that they would have liked to, 3 were unsure and 2 did not record an answer. 27 replied that they had (c.f. 24/49 respondents had in 2023). Of these 27, 7 (26%) spoke with Bereavement Service Volunteers, 4 (15%) spoke with a counsellor, 4 (15%) spoke with a nurse, 2 (7%) spoke with a Bereavement Service Volunteer and a nurse, 2 (7%) spoke with a nurse and a doctor, 2 (7%) spoke with ‘other,’ 1 (4%) spoke with the CPCT, 1 (4%) spoke with a Bereavement Service Volunteer and a doctor, 1 (4%) spoke with a Bereavement Service Volunteer and a counsellor, 1 (4%) spoke with a Bereavement Service Volunteer, a counsellor, a social worker and a nurse, 1 (4%) was unsure who they spoke with and 1 (4%) did not share precisely who they spoke with.



**Q35)** Respondents were asked whether they felt able to talk to someone from the Hospice as soon as they wanted and of the 27 who had spoken to someone, 1 did not record an answer and of the other 26, 23 (88% c.f. 62% in 2023) responded that they had talked to them as quickly as they wanted to, 0 (0%) said they wanted it sooner (c.f. 14% in 2023), and 3 (12% c.f. 24% in 2023) were unsure.

**Q36 A)** When respondents were asked whether they had received a leaflet from the Hospice giving information about what to do after their bereavement, 3 did not record an answer, and of the 52 who did record an answer, 34 (65% c.f. 61% in 2023) found it ‘Definitely helpful,’ 9 (17% c.f. 15% in 2023) ‘Helpful to some degree,’ 2 (4% c.f. 7% in 2023) did not know, 0 (0% c.f. 0% in 2023) found it ‘Not helpful’ and 7 (13% c.f. 17% in 2023) did not receive it.

**Q36 B)** When respondents were asked whether they had received contact from the Hospice Bereavement Team, 7 did not record an answer and of the 48 who did record an answer, 26 - 54% found it ‘Definitely helpful (c.f. 52% in 2023),’ 14 - 29% ‘Helpful to some degree (c.f. 23% in 2023),’ 2 - 4% did not know (c.f. 7% in 2023), none - 0% found it ‘Not Helpful’ (c.f. 2% in 2023) and 6 - 13% did not receive contact (c.f. 16% in 2023).



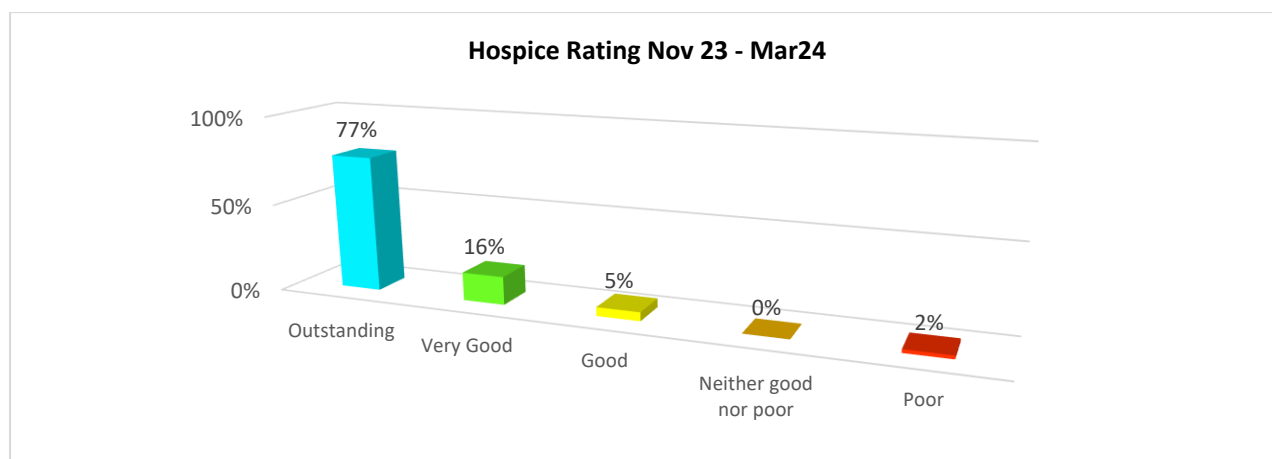
## Bereavement Comments

<b>36 COMMENT</b>
In my case was okay and felt if needed support was there and appreciated not being pushed in anyway. (Husband of patient)
They could not have done more. (Wife of patient)
Follow up call to see how things are going slightly after death 2-5 days? (Daughter of patient) (See follow up action section ID 16 page 35)
I have received a phone call regarding counselling, but I wasn't ready to discuss anything. (Wife of patient)
Six months after death - I am now being offered counselling. (Wife of patient)
I didn't need support after the death, but felt very supported during my mother's time in the hospice. (Daughter of patient)
After his death, the same day everyone helping you goes, hospice people, district nurses, carers etc. Etc. And the following days one feels abandoned, it is very difficult to explain, there is such an emptiness. You have lost your dear one and all the human contact you had around you! I had full attention for two years and intensified in the last five months and then nothing. (Wife of patient) (See follow up action section ID 50 page 35)

### Q36 a)

#### Friends and Family section

(Add the caveat used in the Executive Summary note). The statistics for November 2023 to March 2024, are as follows: There were 45 respondents for that time period, and two did not record answers. Of the 43 respondents who recorded answers for that time period, 33 (77%) rates the hospice as 'Outstanding,' 7 (16%) rated the hospice as 'Very Good', 2 (5%) rated the hospice as 'Good', 0 (0%) rated the hospice as 'neither good nor poor,' 1 (2%) rated the hospice as 'Poor,' 0 (0%) rated it as 'Very Poor,' and 0 (0%) did not know the answer to this question.



Below are general comments of praise:

ID	36A FRIENDS AND FAMILY COMMENTS OF PRAISE	43 YOUR RELATIONSHIP
1	All the staff at St Raphael's are excellent and also appreciated the sister's card. The care was excellent.	Husband
2	They were always on the end of the phone.	Husband
3	"Wonderful" providing equipment to enable me to look after my husband at home. Getting a disability badge for parking. Always at the end of the phone 24/7 if I had any queries and much more.	Wife
5	Arranged our wedding and made it very special.	Wife
6	I am so glad the patient was admitted to St Raphael's, he was looked after so well, he was not stressed or in pain at all. I am so grateful for everything and everybody at St Raphael's. Thank you so much.	Wife
7	Staff were excellent. Family was made to feel welcome by all staff and volunteers. All staff treated mum with care, dignity and respect.	Son
8	Everyone was so kind, they explained everything, and I will be eternally grateful for all they did to make his last moments good.	Wife
9	They were always there to help answer my questions. They gave a loving, caring feeling to me.	Wife
10	The staff were so caring, they even arranged for us to renew our wedding vows just before patient passed away. It was so special!	Wife
11	The service received left nothing to be desired.	Husband
12	The team that came to our house were excellent and some visited him when he was in hospital, but I was not kept in the loop.	Wife
13	The entire experience and the staff made my mum's death much less stressful. We were offered so much support, my mum in particular was so happy with the support of the nurses.	Daughter
14	Everyone made us feel welcome, got to know us and treated us like family.	Daughter
16	The nurses and doctors were compassionate and empathetic. They listened to my mother and spoke to her with the utmost respect. I cannot fault anyone for what they did for our family.	Daughter
17	The alternative, in an NHS hospital ward, would have been unthinkable.	Husband
19	Our family cannot thank everyone enough who have been involved with my husband during his illness for the exemplary care and time.	Wife
22	Morning nursing staff and doctor were very good.	Daughter
23	The whole team of nurses made our time in the hospice as comfortable as possible and were brilliant with patient care and wellbeing at all times.	Husband
24	The service was responsive and supported provision of care package and equipment.	Sister
25	The care and support we received was exceptional - the carers and nurses went the extra mile to help us.	Wife
27	I couldn't ask for better care for my partner during his final days. Both his daughters and I agreed that we could not care for him on our own. We cannot thank you enough.	Wife

ID	36A FRIENDS AND FAMILY COMMENTS OF PRAISE - CONTINUED	43 YOUR RELATIONSHIP
28	The people I met were all patient, professional and friendly in their approach to our needs. Well done.	Husband
29	Mum was well looked after, cleaned. She was only in for 15 hours. My dad was well looked after and offered food.	Daughter
30	Empathy demonstrated	Son
33	Overall, amazing service.	Daughter
34	All of the staff at the hospice from the doctors, nurses, volunteers and chaplain made an unbearable situation bearable.	Daughter
38	In the five days my husband was in St Raphael's hospice. He received excellent care, kindness and consideration. Myself and my family also received huge support and kind.	Wife
39	St Raphael's hospice in a friendly and welcoming place for those nearing the end of their life.	Husband
40	I just find it amazing how much help the hospice gives.	Daughter
41	From the moment my mother was admitted to St Raphael's, the care and support was excellent. Nothing was too much trouble. 24 hours a day at any point, day and night.	Daughter
43	My mum never actually came into St Raphael's, but the home visits and the knowledge received by the staff who came was amazing!	Daughter
45	Very helpful, caring, understanding, amazing team. Exceptional nurses and doctors.	Son-in-Law
46	My father's medical needs were met at all times and he was not in any extended periods of discomfort. At all times his dignity was preserved and guarded by all.	Son
47	I would like to thank the hospice team for all their support and advice in caring for my dad. In particular Avril was so kind and caring and professional, which I will always be grateful for.	Daughter
48	Caring, both for my mother and for me, professional, trustworthy/ reassuring/ calm/ kind/ upbeat - seem like a great team.	Daughter
49	The care my wife received was outstanding and helped the whole family. Always listening and providing answers and assistance when needed.	Husband
50	Everyone is very kind and caring with an incredible amount of knowledge, all very human.	Wife
51	Mum was the most important and she was so very well looked after.	Daughter
52	When no one understood and I didn't even understand, Becky did and supported me throughout. Very grateful.	Daughter
53	I could not have given son the dignity and respect and comfort he needed and deserved without the help and support of St Raphael's. It was all faultless. We remain forever grateful.	Mother
55	Very supportive and helpful.	Friend

Two comments were neither praise nor criticism:

ID	36A FRIENDS AND FAMILY COMMENT – NEUTRAL COMMENT	43 YOUR RELATIONSHIP
31	After own contact with St Raphael's - we had only two home visits before my husband died. So, we were just getting to know you.	Wife
36	Plans were put in place to move my son to a care home of some sort - although he was very sick. He died suddenly, so that didn't happen.	Mother

### What could we have done better?

ID	36A DONE BETTER	43 YOUR RELATIONSHIP
16	Ask if patient would like volunteers to visit them. This was a bit much at times. Ensure there is a greater stock of medical bits if that is what the patient requires - Fortisips ran out a few times and they were needed for mum who could only have a liquid diet. But overall, this was small, I cannot really fault anything that was done.	Daughter
22*	Listened to the patient and show more respect.	Daughter
26	Give more time to the family for a break. Family felt more time should have been given to us so we could have more of a break. One hour was not enough.	Daughter
32	Explanation of what may/ may not happen. Wasn't sure about what to expect - wasn't explained	Wife
46	The food options for patients and family.	Son
49	Nothing, but it would help if the link to other services was setup to help the hospice staff better.	Husband
51**	When mum could no longer eat, she was very thirsty, but got very upset during the nights, because her drink was either left out of reach or no one was available to help her. More nighttime checks please.	Daughter

\*Clinical Director replied to daughter of patient.

\*\*See ID 51 in Follow Up Action

## Follow Up Action

ID	SRH FOLLOW UP	Relationship to patient
12	<p>Follow up action by CD 19-4-2024: Spoke to wife – no concerns – just wishes that her husband had been at home or in SRH, but was grateful for all input and will send a donation</p> <ul style="list-style-type: none"> <li>• Referred from RMH early May 23</li> </ul> <p>15-4-2024: • Seen by AL and LJ at home on different occasions – good conversations about end of life care planning. Had carers and injectables/ACP in place at appropriate time in trajectory.</p> <ul style="list-style-type: none"> <li>• Wife known to counsellor as struggling mentally as well as physically.</li> <li>• Deteriorated at a weekend mid - Oct – called SRH and advised to go to A and E/Call ambulance <ul style="list-style-type: none"> <li>• Admitted to SHH on 15/10/23 with MSCC</li> </ul> </li> <li>• Discharged from SHH to Care home – wanted to die at home but not enough care/support. Wife unwell herself. <ul style="list-style-type: none"> <li>• 2nd preference was hospice but no bed</li> <li>• RIP 16/11/23 in Care home</li> </ul> </li> </ul>	Wife
16	The daughter was signposted to bereavement services on 4 <sup>th</sup> December 2023. She accessed counselling sessions from January to May 2024	Daughter
22	<p>Clinical Director contacted daughter.</p> <p>“I recall that she was calmer and said that she was upset because she felt one of the nurses had been abrupt with her mother. She was unable to give me any kind of idea who it was and therefore it was difficult for me to track this down. So I apologized on behalf of the hospice and she reiterated that she had been pleased with the care overall and still felt it was the right decision for her mum to be admitted to SRH.”</p>	Daughter
26	Feedback from TC 1-7-2024: NFA	Daughter
42	TC feedback 1-7-2024: No concerns – RIP SHH and issues around this. Had appropriate input from SRH service)	Husband
44	<p>Feedback from AH 1-7-2024: The husband and son of EMIS no 1108 received a condolence letter, which highlights that a bereavement support volunteer will call within a few months to see how they are coping so this was due for w/c 10th June. However, we had a support volunteer resign and others have been on holiday so our calls are running about a month behind at the moment.</p> <p>GT has been recruiting more volunteers (2 are confirmed to join) as I highlighted that we need more in order to keep on schedule with calls and to allow for calls to continue when volunteers are on holiday (each volunteer does 4 calls per week but do not do pick up extra when others are on leave ).</p> <p>Also as a point of note, the condolence letter states they can call me directly to self-refer for counselling support, however, I appreciate that some people prefer for us to contact them and as a result of the call, may then ask to be referred for bereavement counselling.</p> <p>Finally, I will ensure that I allocate for a call to be made to respondent (&amp; his son) this week.</p>	Son

ID	SRH FOLLOW UP	Relationship to patient
50	Feedback from DB: I have asked AH (bereavement support) to follow up with this lady if she would like any further support regarding her grief journey.	Wife
51	<p>JC Investigated night time care given: 5 Feb 14.59 - Pt becomes an inpatient.  7 Feb 18.41 – Pt watching TV in bed.  9 Feb 00.54 – Pt called for help to walk to toilet  10 Feb 04.57 Night report given. Assessments carried out.  11 Feb 04.16 Night report given. Assessments carried out.  11 Feb 22.15 Assessments carried out.  12 Feb 22.00 Assessments carried out. Eyes itchy with little relief resulting from saline drops, for review with doctors.  14 Feb 04.54 Night report given. Assessments carried out. 0.5 mg Lorazepam given at 03.20 for pt to sleep.  15 Feb 03.31 Night report given. Assessments carried out. 0.5 mg lorazepam given at 23.35 for pt to sleep.  15 Feb 22.10 – Pt reported leg pain, pain meds given. Assessments carried out.  17 Feb 01.00 – Meds given and pt assessed  18 Feb 12.15 - Assessments carried out.  19 Feb 21.11 – Meds reviewed and administered. Assessments carried out.  20 Feb 00.50 - Meds reviewed and administered. Assessments carried out.  21 Feb 00.10 – Paracetamol 1 g given. 04.30 All care needs assessed.  22 Feb 03.46 - Meds reviewed and administered. Assessments carried out.  23 Feb 00.30 - Meds reviewed and administered. Assessments carried out.  21.25 Meds reviewed and administered. Assessments carried out.  25 Feb 02.00 – Son staying the night. Pt declined eyedrops and flannel. Son felt she did not need her usual 100 mg pregabalin. Meds reviewed and administered.  Assessments carried out.  26 Feb 00.20 Meds reviewed and administered. Assessments carried out.  27 Feb 22.46 Care needs all assessed.  28 Feb 21.09 Meds reviewed and administered. Assessments carried out.  29 Feb 20.00 – Meds reviewed and administered. Assessments carried out.  2 March 21.43 – Pt has managed a few sips of strawberry milkshake and fortijuice.  3 March 04.25 - Meds reviewed and administered. Assessments carried out.  4 March, before 06.30. Meds reviewed and administered. Assessments carried out.  5 Mar 04.17 – Meds reviewed and administered. Assessments carried out.  6 March 02.00 Meds reviewed and administered. Assessments carried out.  7 March 05.55 Meds reviewed and administered. Assessments carried out.  22.00 – Meds reviewed and administered. Assessments carried out.  8 Mar 22.48 – Pt’s family buzzed – son and daughter arrived, son stayed overnight.  Meds reviewed and administered. Assessments carried out.  9 Mar 22.10 – Meds given  10 Mar 04.25 2.5 mg Meds given. Pt no longer eating or drinking</p>	Daughter
54	Scanned to Clinical Director – CD response: I can see from the notes that she was given a good explanation re the catheter at the time. I think she was just disappointed that it couldn’t have been done at the Hospice.	Wife
55	Scanned to Clinical Director - NFA	Friend

## **2023/4 Review Meeting held 17-02-2025 Comments**

Attendees:

AR – Alex Rudkin, Quality and Improvement, Chair

JC – Jonathan Cope, Audit support & Mins

RT – Rebecca Trower, Joint CEO, Clinical Director, Psycho-social, Wellbeing rep

NC – Dr Naomi Collins, Consultant in Palliative Medicine

MF – Maura Flint, Practice Education

FQ – Francis Quinon, Clinical Lead, IPU

TC - Tracy Christmas, Community Team Manager

- AR informed the meeting that the report shows a lot to be commended.
- The return rates vary but they are acceptable and exceed the SWLICB Quality Indicator marker of 15% by some distance – 31%.
- AR explained the time frame of the VOICES surveys and reports to FQ, including the gap of time left between the patient RIPs and the mailing.
- RT mentioned that staffing changes over the summer will change a lot of parameters.
- FQ highlighted the subjectivity with feedback about the food provided on the IPU. Carers and relatives answer on the patient's behalf, not the patient.
- Regarding food provided on the IPU, there is also subjectivity regarding the different dietary requirements of patients and indeed whether they are able to eat at all. RT observed this and JC agreed.
- FQ drew the attention of the meeting to item (k) in the executive summary. Doctors and nurses 'always treating inpatients with respect and dignity' achieved the same for doctors and slightly lower for nurses – 93% for nurses and 100% for doctors (c.f. 95% for nurses and 100% for doctors in 2023). The figure for nurses was brought down by just one respondent who had had a negative experience with an HCA. RT contacted the respondent and followed up on the issue. FQ pointed out that the respondents probably will not be able to differentiate between the different grades of nursing staff. NC observed that nurses must give instructions to the patient that include telling them to strip naked, go to the toilet etc. and given the subjective nature of the question, there might possibly be a few respondents who do not react to this so well, even though it is a part of a nurse's role.
- RT and TC informed the meeting that the CPCT service will be impacted by the changes in circumstances for the hospice and reduced resources.
- RT suggested that Ashley Harper see the report and AR will provide her with a copy for her perusal.
- TC commented on how the respondents to the survey might not be able to differentiate between the District Nurses and the Hospice personnel and on the IPU they might find it hard to distinguish between the nurses and HCAs.

**St Raphael's Hospice**  
**Meeting of the Clinical Quality & Governance Committee**  
**To be held at St Raphael's Hospice**  
**10am-12pm on Friday 2<sup>nd</sup> May 2025**

Members: Dr Carrie Chill – Trustee & Committee member (CC)  
 Alan Cogbill – Trustee & Committee member (AC)  
 Benard Marley – Trustee & Committee member (BM)  
 Norman McWhinney – Board Chair & Committee member (NM)

In attendance: Nick Stevens – Joint CEO (NS - apologies)  
 Rebecca Trower – Joint CEO (RT)  
 Alex Rudkin – Director of Quality and Governance (AR)  
 Dr Naomi Collins – Consultant (NC)  
 Francis Quinon – IPU Clinical Lead (FQ)  
 Anna Machin – Governance (AM)

Item	Time	Description	Purpose	Lead
1.	10.00 – 10.05	Welcomes, apologies for absence and declarations of interest	Discussion	Chair
2.	10.05 – 10.15	Review of minutes from Clinical Quality & Governance Committee meeting held on 17 <sup>th</sup> January 2025	Approval	Chair
		Actions List and update on matters arising	Discussion	
3.	10.15 – 10.25	Evidence of Excellent Practice Register	Discussion	RT
4.	10.25 – 10.55	Clinical Risk Register	Discussion	RT
5.	10.55 – 11.30	Clinical Quality & Governance Report inc. Clinical Action Plan	Discussion	RT, AR
6.	11.30 - 11.35	Committee Terms of Reference	Recommend to Board	Chair
7.	11.35 – 11.45	Minutes of internal meetings	Discussion	AR
8.	11.45 – 11.55	Safeguarding Update (verbal update)	Discussion	AR
9.	11.55 – 12.00	Any Other Business & Date of next meeting	Discussion	Chair

**Date of next meeting:** Friday 11<sup>th</sup> July 10am-12pm

**Actions log**

<b>Agenda item</b>	<b>Action</b>	<b>Responsible</b>	<b>Timeline</b>	<b>Ref.</b>	<b>Update</b>
6. CQ&G report	Invite IPU Lead to CQ&G meeting and future Board	Becca Trower	Next meeting cycle	17.01.25/01	Complete
	Draft letter of thanks to Community and clinical teams	Dr Carrie Chill	Immediate	17.01.25/02	Complete
7. Internal minutes	Report back on data on confidence around prescribing	Becca Trower	April meeting	17.01.25/03	In progress – to update at this meeting